RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Aug. 4, 2019, Minutes
Revisions to Guideline #1556 (Attachment One)
Receivership Large Deductible Workers’ Compensation (E) Working Group July 18, 2019, Conference Call Minutes
(Attachment Two)
Receivership Large Deductible Workers’ Compensation (E) Working Group May 8, 2019, Conference Call Minutes
(Attachment Two-A)
Results of the Survey Related to Collateral (Attachment Two-A1)
Presentation on the High Deductible Annual Statement Note (Attachment Two-B)
Comments on the Draft Revisions to the Handbook (Attachment Two-C)
Report on the MPI Referral from the Financial Stability (EX) Task Force (Attachment Three)
2020 Proposed Charges (Attachment Four)

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

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

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

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

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

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


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

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

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

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

Ms. Wilson made a motion, seconded by Ms. Slaymaker, to adopt the Working Group’s report, including its July 18 minutes (Attachment Two). The motion passed unanimously.
5. Adopted a Report on the MPI Referral from the Financial Stability (EX) Task Force

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

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

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

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

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

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

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

Mr. Kennedy stated that the third topic of the referral involved an evaluation of whether there are misalignments between federal and state laws that could be an obstacle to recovery and resolutions for U.S. insurance groups. He noted that the Task Force had adopted revisions to the Guideline #1556. Also, the drafting group received comments and feedback on the guidance in the Receiver’s Handbook for federal taxes and federal releases and determined that the handbook is outdated and needs to be revised. Drafting for both issues is recommended as a charge for Receivership Model Law (E) Working Group.
Mr. Hartz made a motion, seconded by Mr. Kaumann, to adopt the drafting group’s report (Attachment Three). The motion passed unanimously.

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

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

7. **Adopted 2020 Proposed Charges for the Task Force and its Working Groups**

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

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

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

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

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

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

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

Drafting Note: State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a twenty-four-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017 the Board of Governors of the Federal Reserve System (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a “stay” under several defined resolution regimes including Title II of Dodd Frank, the FDIA, as well as comparable foreign resolution regimes. Notwithstanding NAIC’s request for inclusion, stays under the state insurance receivership regime (State Receivership Stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize State Receivership Stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for QFCs. Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, FDIC and OCC have been amended to recognize State Receivership Stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize State Receivership Stays.

The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to require a stay with respect to the termination of a netting agreement or QFC of an insurer in insolvency:

**Stay on Termination of Netting Agreements and Qualified Financial Contracts**

A person who is a party to a netting agreement or qualified financial contract under [cite to applicable state law addressing qualified financial agreements] with an insurer that is the subject of an insolvency proceeding may not exercise any right that the person has to terminate, liquidate, accelerate or close-out the obligations with respect to the contract by reason of the insolvency, financial condition or default of the insurer, or by the commencement of a formal delinquency proceeding,

1. Until 5:00 p.m. (eastern time) on the business day following the date of appointment of a receiver; or
2. After the person has received notice that the contract has been transferred pursuant to [cite applicable state law addressing transfer of qualified financial contracts].

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**Chronological Summary of Action (all references are to the Proceedings of the NAIC)**


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The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call July 18, 2019. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Toma Wilkerson (FL); Justin Durrance (GA); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Matt Holman (NE); Christopher Brennan (NJ); and James Kennedy (TX).

1. **Adopted its May 8 Minutes**

Ms. Wilson presented the minutes from the Working Group’s May 8 conference call. (Attachment Two-A). Ms. Wilkerson made a motion, seconded by Mr. Baldwin, to adopt the minutes. The motion passed unanimously.

2. **Heard a Presentation on the High Deductible Annual Statement Note**

Ms. Wilson introduced Robin Marcotte (NAIC). Ms. Marcotte presented information on the high deductible disclosures in the notes to the property and casualty annual financial statement (Attachment Two-B).

3. **Reviewed Comments on the Draft Revisions to the Handbook**

The Working Group discussed comments received on the draft revisions for guidance for large deductible workers’ compensation to the *Receiver’s Handbook for Insurance Company Insolvencies* (Handbook) from Maine and the National Conference of Insurance Guaranty Funds (NCIGF) (Attachment Two-C). Members of the Working Group agreed to provide further revisions to the draft to Sherry Flippo (NAIC). Those revisions will be incorporated into the draft and redistributed. Ms. Slaymaker said the Working Group will plan to meet again via conference call to consider adoption of the draft revisions to the Handbook.

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

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The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call May 8, 2019. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Toma Wilkers on (FL); Mark Ossi (GA); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Matt Holman (NE); Christopher Brennan (NJ); and James Kennedy (TX).

1. **Exposed Draft Revisions to Receiver’s Handbook for Insurance Company Insolvencies**

Ms. Wilson provided an overview of the Working Group’s draft revisions to the **Receiver’s Handbook for Insurance Company Insolvencies** related to workers’ compensation. She thanked the states and interested parties that had participated in the drafting process. Sherry Flippo (NAIC) summarized the draft revisions.

Ms. Wilson stated that the draft revisions will be exposed for a public comment period ending June 24. Comments on the draft revisions should be submitted to Ms. Flippo at sflippo@naic.org.

2. **Discussed the Ultimate Ownership of the Collateral**

Ms. Wilson discussed the results of the Survey Related to Collateral, citing specific questions, namely question #21, question #22 and question #23 from the survey (Attachment Two-A1).

Mr. Wake stated that the question 22 “guaranty fund has a claim from first dollar” is confusing.

Mr. Kennedy agreed. He suggested that the Working Group look at the states that have a model based on the National Conference of Insurance Guaranty Funds’ (NCIGF) model. He noted that other states would have no model, because he is not aware of any states that have enacted Section 712 of the **Insurer Receivership Model Act** (#555).

Rowe Snider (NCIGF) agreed with Mr. Kennedy, stating that nine or 10 states have enacted a law based on the NCIGF model.

Mr. Baldwin agreed that question 22 is confusing.

Ms. Slaymaker asked the Working Group to discuss the difference between the NCIGF model and Model #555, Section 712.

Mr. Wake stated that there are two options: 1) reinsurance option approach, which led to Model #555, Section 712; and 2) secured claim approach, which led to the NCIGF model.

Mr. Wake stated that there are strong arguments for both options, which made the issue contentious when Model #555 was under development. Functionally, in both a scenario where there is a large deductible policy and an insurer is fronting for a captive reinsurer, the policyholder is economically responsible for the claim. He stated that the underlying accounting should be more similar to reinsurance; for example, the liability should be booked from the first dollar, with offsetting credit for deductible recoveries.

Mr. Wake said he believes the NCIGF approach is stronger due its consistency. There are scenarios where it is proper for the policyholder to pay the claims and there are scenarios where the guaranty fund should have an unconditional right of reimbursement. The difference between the large deductible and reinsurance is that there is a statutory right of reimbursement running from the employer to the claimant that preceded the policy. Therefore, it is reasonable to treat the policyholder reimbursed obligation as security for the benefits being paid to the claimant.

Mr. Kennedy asked if it would be useful to see how based on experience the distributions and net payouts differ between the approaches. Ms. Slaymaker agreed and volunteered to speak with Reliance and Legion concerning their experience.
Mr. Baldwin state that Illinois passed an early version of the NCIGF model. He stated that statutory accounting books the excess of the deductible. Therefore, in a receivership when a guaranty association steps in and starts paying claims, he asked whether it should pay an amount never recorded on the statutory statement or should it be entitled to the direct passthrough of the deductible recoveries. He said he believes the NCIGF model achieves passthrough.

Mr. Snider commented that the distributive variation between the two approaches would be minimal where there is appropriate collateral and an efficient collection process in place. The significant distributive variation occurs when the collateral is inadequate, comingled or dissipated. He stated that the NCIGF would be interested in commenting on this distributive variation between the two approaches.

Mr. Baldwin provided an example of the distributive variation in the Lumbermens’ receivership. In the receivership, at 100% collateralization, there is $150 million that is not an estate asset and would get passthrough to the guaranty fund under the NCIGF model. However, under Model #555, Section 712, that $150 million would be an estate asset and would be spread out to all the estate creditors. As such, he said the NCIGF model seems to be consistent with statutory accounting.

Mr. Wake asked the question as to the volume of policy-level creditors that are not covered by the guaranty association. Mr. Baldwin stated that approximately two-thirds are covered by the guaranty association and one-third is not.

Ms. Slaymaker stated that the Working Group plans to meet again via conference call to discuss the experience under both approaches.

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

**July 21, 2018**  
**Survey of States’ Large Deductible Workers’ Compensation Laws**

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<thead>
<tr>
<th>N/A or blank = 6</th>
<th>DE, KS, NC, NJ, OR, SC</th>
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If yes please describe (Please include the pertinent statutory/administrative regulation citation(s)).

State responded by listing various sections and statues of their laws.

### 21. Do statutes address who has the right to keep the deductible recoveries --receiver vs. GF?

<table>
<thead>
<tr>
<th>Yes = 4</th>
<th>FL, MI, NV, TX</th>
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<tbody>
<tr>
<td>No = 13</td>
<td>AR, CA, CO, CT, IL, MO, NE, NH, OK, PA, TN, WI, WV</td>
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<tr>
<td>N/A or blank = 10</td>
<td>AK, DE, KS, MD, NC, NJ, NM, OR, SC, SD</td>
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</table>

Responses with comments = 8

- **CA**: Receiver must collect and disburse to GA.
- **IL**: Yes. Deductible recoveries for claims paid by the estate are assets of the estate; deductible recoveries for claims paid by a guaranty association are passed through to the guaranty association, less a statutory 3% administration fee.
- **MO**: Yes, GF
- **NV**: Response from NIGA: There do not seem to be clear guidelines as to who keeps the deductible recoveries, and this has been disputed many times over the years. It is not as much of a problem in Nevada because of our inability to pay on deductible claims.
- **OK**: Collection by the Receiver of amounts due within the PEO deductible for pre-receivership paid losses are general assets of the estate. Collection by the Receiver of amounts due within the PEO deductible for post-receivership paid losses paid by SGAs are direct pass-throughs to applicable SGAs;
- **PA**: Yes, the estate must pay all deductible collections to the GFs less a 3% collection fee. GFs also have the right to pursue collections if the receiver does not.
- **WI**: Yes, the Receiver. This is not by specification of what happens to deductible recoveries, but is rather under the responsibilities of the Receiver.
- **WV**: WV Code 33-26

### 22. Are collections a part of estate assets, and

<table>
<thead>
<tr>
<th>GF has a claim from first dollar? = 5</th>
<th>CA, MI, NV, OK, WI</th>
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<tbody>
<tr>
<td>Do GFs get their payments that are within the deductible reimbursed from the recovery and then only have an estate claim for the excess over the deductible limit? = 5</td>
<td>FL, IL, MO, NH, PA</td>
</tr>
</tbody>
</table>
| Neither (please explain) Is there an automatic stay upon filing of a receivership? = 3 | NE- unclear as claims under the deductible are not covered claims  
TN- GF’s are reimbursed for payments made.  
TX- When a guaranty association pays claims, the |
**Receivership Large Deductible Workers’ Compensation (E) Working Group**  
**July 21, 2018**  
**Survey of States’ Large Deductible Workers’ Compensation Laws**

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<thead>
<tr>
<th>Blanks / N/A</th>
<th>AK, AR, CO, CT, DE, KS, MD, NC, NJ, NM, OR, SC, SD, WV</th>
</tr>
</thead>
</table>

23. **Who is responsible for collections?**

- Estate Liquidator- CA, CO
- Receiver- FL, MI, MO, NH, NM, NV, OK (with SGAs on case-by-case basis), TN, WI
- The liquidator is responsible unless the receiver fails to make a good faith effort within 120 days of receipt of claims payment report to collect reimbursement due, in which case the GF may pursue collection- PA, TX

No answers or N/A from other states.

24. **If the receiver is responsible, is the statute clear that the receiver has the right to collect from the insured even though GF has made the payments?**

| Yes = 10 | CA, FL, IL, MI, MO, OK, PA, TN, TX, WI |
| No = 3  | CO, NM, NV |
| N/A or blank = 14 | AK, AR, CT, DE, KS, MD, NC, NE, NH, NJ, OR, SC, SD, WV |

25. **Is deductible collateral:**

| An Asset = 5 | NE, NV, TN, TX, WI |
| A contingent asset = 1 | NH |
| Not an asset of the estate = 6 | CA, FL, IL, MI, MO, PA |
| Other (please explain) = 1 | OK- If collateral is commingled with estate assets and thereby lost its identity, it is a general assets of the estate; if collateral is segregated in an account for a specific PEO it is a secured asset; |
| Unknown no receivership/ No answer = 14 | AK, AR, CT, CO, DE, KS, MD, NC, NJ, NM, OR, SC, SD, WV |

26. **Is cash collateral that is commingled with estate assets handled differently?**

| Yes = 3 | NV, OK, TN |
| No = 4  | IL, MI, PA, WI |
| N/A or blank = 20 | AK, AR, CA, CO, CT, DE, FL, KS, MD, MO, NC, NE, NH, NJ, NM, OR, SC, SD, TX, WV |

If yes, please explain.
- **NV**- Response from the Nevada Insurance Guaranty Association: This depends entirely on the state of jurisdiction. I have seen the commingled cash collateral handled as general assets of the estate.
- **OK**- If collateral is commingled with estate assets and thereby lost its identity, it is a general assets of the estate; if collateral is segregated in an account for a specific PEO it is a secured asset;
- **TN**- No explanation
July 2, 2019

Laura Slaymaker and Donna Wilson  
Co-chairwomen, Large Deductible Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Ste 1500  
Kansas City, Missouri 64106

Dear Co-chairs,

Thank you for allowing the NCIGF to comment on the draft revisions to the Receivers Handbook prepared by members of the Large Deductible Working Group. Our comments track to the page numbering on the printed copy of the materials exposed for comment.

1) The carryover paragraph on page 12 reads “Guaranty associations must also recognize that they will be required at times to communicate with Insurance regarding claims handling.” We believe Insurance is meant to be “insureds.” We also suggest that the following be added to this paragraph:

   All parties should be mindful of security concerns related to communication of sensitive claims data. The SUDS server hosted by NCIGF is a useful tool for communications between receivers and guaranty associations. Guaranty funds may opt for telephonic communications with insureds.

   It may also be helpful to add the following text:

   The collection process should proceed with minimal delay as the passage of time will impact success of collection efforts. In these efforts it is imperative that the guaranty associations and the receiver work together and offer consistent messages to the insured regarding any collection issues. It should also be noted that the release of collateral from a receiver to a guaranty association may not fully satisfy the policyholder’s obligation for costs related to the claim under a state’s guaranty association law.

2) There may be a word missing on the third bullet on this page. Should this bullet read “Copies of deductible policies should be “made” available if required?”

3) Page 15 bottom. We note that throughout the text of the draft large deductibles are referred to as “advancement policies,” “large deductible policies” and “loss reimbursement policies.” In blanks the term “high deductible policy” is used. To avoid confusion on these complex...
products we suggest that consistent nomenclature be used throughout and the product be clearly defined somewhere in the text of the handbook.

4) On page 18, the second full paragraph may need to be reworded. We suggest:

Typically, a large deductible policy provides that the insurer will pay claims in full and then collect the deductible amount from the insured. (Conversely, first party claims against an auto policy with a deductible are paid minus the amount of the deductible.) To ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security…….

5) On page 20 reference is made to putting in place an agreement between the receiver and the involved guaranty funds when no specific statutory guidance is in place. We support this idea and offer a template agreement which is attached to this letter.

6) Also attached is a redline of the Maine submission for the Handbook. We worked with Bob Wake of the Maine department and the redline is a reflection of changes we mutually agreed to.

Thank you for your attention to our comments.

Very truly yours,

Barbara F. Cox
Attorney at Law
Barbara F. Cox, LLC
Proposed Changes to Receiver’s Handbook for Insurance Company Insolvencies

re: Large Deductibles

(INSERTS INTO EXISTING HANDBOOK in RED)

(Provided by PA-Reliance and Legion)

Chapter 1 – Takeover & Administration

VIII. CLAIMS

The receiver should become familiar with the insurer’s records and procedures.

A. Control the Claim Department’s Records

In initial takeover, the receiver’s first responsibility is to rescind all claim payment authority of the insurer’s claim department and to identify and control the insurer’s records. Original claim documentation may be found in the claim department in either hard copy files or computer files, or at off-site locations such as branch offices or TPA locations.

The receiver needs to become familiar with the computer processing systems for claim files and policy files. Controlling computerized files and systems requires determining whether the information systems are centralized or decentralized. In a decentralized operation, secure data on personal computers and servers, including that stored on all storage media and computer printouts. In a centralized operation, the information systems department should evaluate existing security procedures and revise them if necessary. In addition, obtain the latest reports relating to claim processing.

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

• Actual claim processing flow;
• The level of claim file documentation required;
• The coverage confirmation process;
• Claims reserving and settlement philosophy;
• Claims settlement authority;
• Litigated claims;
• Aggregate policy procedures;
• Large Deductible Policy Procedures including collection, collateral and aggregates;
• Reinsurance recovery procedures;
• Theories relevant to property/casualty insurers, such as trigger theories for asbestos and environmental claims; and

1
The insurer’s relationships with and responsibilities to managing general agents, TPAs, outside claim adjusters, reinsurance intermediaries and other outside parties.

If no manual exists, the receiver should interview claim department personnel to develop an understanding of actual procedures and document them.

<table>
<thead>
<tr>
<th>Checklist 6—Underwriting</th>
<th>Project Assigned To</th>
<th>Date Completed</th>
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<tbody>
<tr>
<td><strong>Overview</strong></td>
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<tr>
<td>Meet with underwriting manager (and/or other appropriate personnel) to discuss the insurer’s procedures, management/ supervisors and their responsibilities, staffing and duties required as a result of the order.</td>
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<tr>
<td>Interview the underwriting manager (and/or other personnel as appropriate) to discuss the insurer’s underwriting function and operation to determine the progression of documents through the department. Document same.</td>
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<tr>
<td>Obtain copies of departmental procedures, underwriting, code and rate manuals.</td>
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<tr>
<td>Determine whether the insurer used an off-site storage facility and coordinate with other team members to ensure that any off-site records are inventoried and accounted for.</td>
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<tr>
<td>Determine the underwriting department’s filing system, noting:</td>
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<tr>
<td>• Locations of files and documents</td>
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<tr>
<td>• Filing method (e.g., alphabetical, numerical, terminal digit, etc.)</td>
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<tr>
<td>• Possible segregation by line of business</td>
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<tr>
<td>• Who has access to files and file sign-out procedures – modify as appropriate</td>
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<tr>
<td>• Whether files are copied to electronic media</td>
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<tr>
<td><strong>Insurance</strong></td>
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<tr>
<td>Locate, obtain copies and review all insurance policies and contracts:</td>
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<tr>
<td>• General Liability</td>
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<tr>
<td>Checklist 6—Underwriting</td>
<td>Project Assigned To</td>
<td>Date Completed</td>
<td>Completed By</td>
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<tr>
<td>• Property</td>
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<tr>
<td>• Auto</td>
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<tr>
<td>• Workers’ Compensation</td>
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<tr>
<td>• Fidelity Bond</td>
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<tr>
<td>• Directors and Officers</td>
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<tr>
<td>• Large Deductible Endorsements</td>
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<tr>
<td>• Errors and Omissions</td>
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<tr>
<td>• Professional Liability</td>
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</tbody>
</table>

Determine that insurance coverage is adequate or modify as appropriate for property lines.

Check on status of pending claims filed against the insurer.

Obtain payment status on all coverage.

Renew coverage as necessary.

Gathering Documentation

Determine location of all underwriting records – secure and inventory. This should include:
• Blank policies, binders and/or applications
• Pending policies, endorsements and applications
• Underwriting procedure manuals
• Issued policies and associated underwriting files
• Specimen copy of each type of insurance contract written by the insurer, including all endorsements, side letter agreements and other forms that may have been used with each policy; document any unique or special forms, exclusions, etc.

Determine types and lines of business written by the insurer. Obtain a listing, by state and policy line, detailing the following information:
• Valuation of policies
• Number of policies in-force
• Annual premium volume
• Reserves
• Unearned premium
• Audit Premiums
Checklist 6 — Underwriting

<table>
<thead>
<tr>
<th>Project Assigned To</th>
<th>Date Completed</th>
<th>Completed By</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>As you become aware, document any limited or unusual exposures that do not appear on the insurer’s policy registers.</td>
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Checklist 6 — Underwriting

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<thead>
<tr>
<th>Project Assigned To</th>
<th>Date Completed</th>
<th>Completed By</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Large Deductible Policies - Review underwriting, billing and collateral records to determine which policies have large deductible endorsements and the status of collateral held, billings, and reserve calculations</td>
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Checklist 8 — Accounting

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<th>Project Assigned To</th>
<th>Date Completed</th>
<th>Completed By</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Identify letters of credit, trust agreements and other collateral held to secure obligations of policyholders under large deductible endorsements, and review and/or establish procedures for reviewing the adequacy of such collateral</td>
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</table>
### Checklist 8—Accounting

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<th>Project Assigned To</th>
<th>Date Completed</th>
<th>Completed By</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Review large deductible billing procedures to determine that all amounts are billed timely. Determine that there are no outstanding items for billing, and obtain an aging of outstanding receivables.</td>
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<tr>
<td><strong>Documenting Large Deductible Collection Procedures</strong></td>
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<tr>
<td>• Review recent billings for all large deductible policies</td>
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<tr>
<td>• Obtain a list of large deductible payment history and determine whether insured payments have been ongoing or if payment from collateral has been required.</td>
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<tr>
<td>• Obtain a list of paid and unpaid bills updated after liquidation</td>
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<tr>
<td>• Obtain claim documentation for claims arising under large deductible policies</td>
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<tr>
<td>o By paid loss and loss reserves and ALAE paid and reserves</td>
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<tr>
<td>o List of claims in litigation/arbitration</td>
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</tbody>
</table>

- **Determine location of large deductible records – secure and inventory. This should include:**
  - All policies containing large deductible endorsements
  - Claims files arising under such policies
  - Correspondence files
  - Billing records
    - Letters of credit, trust agreements, deductible reimbursement policies or other collateral
  - For all LOCs, trust accounts, funds withheld:
    - Secure all originals
    - Notify all banks and trustees of the order
• Review large deductible billing system; determine that all paid losses arising under large deductible policies have been billed.

• Determine whether large deductible endorsements provide that losses within the deductible are limited in the aggregate.

• Evaluate recovery processes and determine if new procedures are appropriate.

• Determine whether collateral is held by affiliated/unaffiliated third party via large deductible reimbursement policy, trust agreement or other vehicle, and evaluate whether collateral can be transferred to the receivership.

• Document insured collection disputes:
  a. Determine which functional group handles disputes.
  b. Interview members of each group responsible for coordinating, monitoring and controlling large deductible collection disputes.

• Audit large deductible collection-specific systems; track data from source to final product to verify billings are correct and inclusive and internal controls are adequate.
8. Email

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

8A. Large deductible recoverables can be a large asset of the receivership, and, like reinsurance, collection is highly dependent on reliable policy and loss information. Use of information systems in recording and tracking this information is fairly common. As with reinsurance, this system may be a part of, or at least closely connected with, the accounting or claims systems.

9. Other

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C. Types of Business Written

Initially, it will be necessary to identify general characteristics of the insurer’s business practices. This analysis will provide a general idea of systems sizing and related requirements and should include an analysis of:

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

- **Insurance/reinsurance/both** - If the insurer wrote only direct or primary insurance, the ability to process assumed reinsurance may not be of concern to the receiver. However, if the insurer ceded reinsurance, the ability to track and control ceded placements may need to be considered in the systems requirements. Also, if brokers or intermediaries processed reinsurance (assumed, ceded and/or retroceded), the receiver may need to determine if these arrangements are to be continued, or if this function needs to be brought under the direct control of the receivership. If it is not brought under direct control of the receiver, the receiver should carefully monitor this function and work closely with the intermediary.
The receiver’s staff (or an independent consultant) needs to determine if the existing systems adequately process the business or if those systems must be supplemented with manual processing. If it is the latter, the receiver should then determine whether the level of supplemental manual processing required is acceptable, in terms of accuracy and the cost of processing. This will establish whether the existing system(s) are adequate to provide the receiver with the amount and types of information required.

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

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

Large Deductible Collections and Collateral

D. Salvage and Subrogation (Property/Casualty Only)

1. Salvage

Salvage is an amount received by an insurer from the sale of damaged property or recovered stolen property for which the insured was indemnified by the insurer. In the claim settlement process, the insurer will obtain title to the property and sell it for its remaining value. This asset needs to be addressed quickly because property often is stored, and storage fees are being incurred. Salvage on surety bonds (e.g., construction performance bonds) may be of considerable amount. Due to the intricacies of the surety line of business, consideration should be given to the hiring of external experts to manage the salvage of uncompleted projects.

2. Subrogation

Subrogation is the legal right of an insurer to recover from a third party who was wholly or partially responsible for a loss paid by the insurer under the terms of the policy. In the case of a property accident, where there is a dispute between the parties, an insurer will often pay its policyholder’s claim and assume the policyholder’s right to pursue the negligent third party.

3. Accounting Practices
Until 1992, under statutory accounting practices, an insurer was not allowed to recognize salvage and subrogation recoverables until they were collected. In 1992, the NAIC Accounting Practices and Procedures Manual began allowing accrual of salvage and subrogation recoverables. However, certain states may still disallow the asset. GAAP requires that an insurer recognize an asset or reduce its liability for unpaid claims for the amount of salvage recoverable on paid and unpaid claims. Therefore, an insurer should have records, systems and procedures to identify and follow up salvage and subrogation recoverables on both paid and unpaid claims.

4. Summary

A receiver should ascertain how an insurer identifies and follows up on its salvage and subrogation recoverables. This becomes more difficult when claim files are turned over to a guaranty fund. Salvage and subrogation practices may vary among the guaranty funds. Salvage and subrogation collected by a receiver or guaranty funds may have to be held in trust for certain beneficiaries (e.g., where the policyholder’s claim is subject to a deductible or the loss is a reinsured loss and the reinsurer previously reimbursed the insurer for the full amount of the claim). The right to the salvage and subrogation proceeds should be discussed with legal counsel.

D.1. Salvage and Subrogation (Property/Casualty - Large Deductible Recoveries - Only)

1. Large Deductible Recoveries

Large deductible recoveries are amounts received by an insurer from an insured covered under a policy having an endorsement providing that the insured is responsible to indemnify the insurer for certain losses and LAE incurred. While these policies share some characteristics with retrospectively-rated policies, the accounting treatment of recoveries under the two types of policies is different.

Accounting Practices

Under statutory accounting practices, recoveries under large deductible policies are not treated as premium. Unpaid losses are booked net of the deductible, except where the deductible is deemed not to be collectible, in which case the losses are booked on a gross basis. Because losses within the large deductible limit are not booked, it is important that the receiver examine the records, systems and procedures to identify and follow up large deductible recoveries on both paid and unpaid claims. Because these recoverables do not appear on the balance sheet unless uncollectible, but may be a significant recoverable amount, the receiver should examine the scope of the large deductible business written, and the collection and collateral procedures employed by the company. The High Deductible Disclosures, Note 31 in the Annual Statement Disclosure should aid the regulator in this review.
transactions may at first glance appear to be ordinary, but upon closer examination are found to have not been entered into for the benefit of the insurer. These are transactions that may have deceptively portrayed the insurer’s financial condition, delayed discovery of its insolvency, or resulted in actual losses for the insurer. Included in the category of suspect transactions are transactions that did not comply with applicable legal requirements, were not commercially sound or lacked financial viability.

- A receiver may advance various theories to recover funds for the estate regarding losses or damages caused by suspect transactions. For example, causes of action for recovery may be based upon common law fraud, violations of the federal Racketeer Influenced and Corrupt Organizations Act (RICO), fraudulent transfers or breach of fiduciary duty. These and other causes of action are addressed fully in other sections of this Handbook and are not repeated here.

- This section focuses on identifying potentially suspect transactions that are not discussed elsewhere in this Handbook. The transactions identified do not frame an exhaustive list of all suspect transactions, nor are the identified transactions necessarily fraudulent. In fact, if properly negotiated and administered, the transactions may be perfectly legitimate. However, the receiver should review the following types of transactions for due diligence. Suspect transactions may be difficult to detect and may consist of combinations or variations of one or more of the transactions described.

**A. Large Deductible Policies**

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

**General Considerations**

- The receiver’s recovery of large deductible recoverables is dependent on the claims handling and reporting of both claims covered and those not covered by guaranty funds.
- The key to effective collection and collateral administration is insuring that the historical records for paid losses under the deductible policies and the program design are maintained and available. Another key is retaining the personnel that have knowledge and history of the insurer’s deductible business operations.
- Collateral for Large Deductible Balances
  - The importance of collateral cannot be overstated. But adequate collateral must be established prior to liquidation as it is unlikely to be collected after liquidation.
  - Large Deductible balances frequently will be secured to ensure collectability and preserve the insurer’s statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. Particular attention should be paid to security arrangements where the insured’s collateral is held by third parties, especially affiliates of the insurer.
  - Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations.

**Communication** – deductible collection, in addition to requiring collateral, is dependent on communication of all parties (i.e., between receiver and insured, receiver and guaranty associations, guaranty association and insured). It must be quickly established with insured as to procedure for ongoing claim processing, continuation of their responsibility to reimburse the deductible payments and responsibility to maintain appropriate collateral.
Guaranty associations must also recognize that they will be required at times to communicate with insureds regarding claims handling. All parties should be mindful of security concerns related to communication of sensitive claims data. The SUDS server hosted by SCIGF is a useful tool for communication between receivers and guaranty associations. Guaranty funds may opt for telephonic communication with insureds. The collection process should proceed with minimal delay as the passage of time will impact success of collection efforts. In these efforts it is imperative that the guaranty associations and the receiver work together and offer consistent messages to the insured regarding any collection issues. It should also be noted that the release of collateral from a receiver to a guaranty association may not fully satisfy the policyholder’s obligation for costs related to the claims under a state’s guaranty association law.

Deductible collection procedure

- A working process must also be established quickly between the receiver and the guaranty associations to provide claim handling, payment information and all other required claim financials to allow the receiver to bill and collect loss payments.
- The information would include the receiver providing the guaranty associations all pertinent information to establish the policies that are deductibles along with effective dates, deductible limits, treatment of ALAE and deductible aggregates where available.
- Copies of deductible policies should be made available if required.
- Guaranty Association’s will provide, through the establishment of UDS data feed, all financial information regarding deductible claims that they are handling.
- Receiver will collate data from guaranty associations and review historical billing information to invoice the insured on a monthly or quarterly basis.
- Receiver will calculate and track the payment history pre-liquidation and post Liquidation within the deductible and within a deductible aggregate for the policy if applicable. This ensures that the insured is only billed for amounts that remain within their deductible.
- To assist in the collection process, receiver and guaranty association should work to provide sufficient information and explanation to allow the insured to recognize its obligation. In the event where the insured refuses to pay, the receiver will either begin litigation or draw on collateral or both. This should be coordinated with the guaranty associations.

Professional Employer Organizations (“PEOs”)

- Policies issued to PEOs often have large deductible endorsements
- Because of the prevalence of abuse in the underwriting of PEOs, post-liquidation collection of deductible payments may be challenging
  - Clients may have been added without notice (or payment) to the insurer. Client class of business may have been misrepresented or expanded to include riskier classes of business – all of which may lead to inadequate or exhausted collateral
  - Client companies of PEO may not have received notice of cancellation, leading to coverage disputes
If collateral is inadequate and PEO does not have assets to pay, collection from client companies is likely not possible, as their arrangement with the PEO was most likely on a first-dollar coverage basis.

Commutations

Generally, commutations are negotiated terminations of the rights and liabilities between insurers and large deductible insureds. A commutation is a settlement of all obligations, both current and future, between the parties for a lump sum payment.

There are many valid reasons for commutations of large deductibles. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between insurer and insured, and provide some protection or limitation of exposure from the insolvency of the insured. Commutations of long tail business (i.e., workers’ compensation) may be essential for the early termination of the receivership.

Commutations, however, may be a detriment to the receivership if the commutation is consummated for less than fair consideration. A receiver should carefully review the commutation to determine whether the benefit to the insurer outweighs the disadvantages.

Reinsurance

Reinsurance balances often represent significant assets and liabilities of insolvent companies, whether from assumed or ceded business. It is commonly the case in a property and casualty insurer insolvency that these balances will represent the largest asset to be marshaled. Because reinsurance transactions are complex and involve large sums that may have a material effect on the balance sheet, these transactions present numerous opportunities for fraud, misappropriation or mismanagement by or upon the insolvent company. The receiver’s investigation should, therefore, include a review of the company’s reinsurance structure, and especially any extraordinary transactions in the years immediately preceding the company’s demise.

V. PAYMENT OF APPROVED CLAIMS

Theoretically, distribution of the insurer’s assets to claimants in a liquidation proceeding is different from normal business practice. While claims against an insurer in rehabilitation may be paid either in the normal course of business as they become due or pursuant to a rehabilitation plan, in a liquidation proceeding, the insurer’s assets must be distributed to creditors in the order set forth in the priority of distribution statute. This section addresses some of the many issues the receiver must address once the claims evaluation and approval process has been completed and the asset distribution process begins. See generally IRMA Article VIII.

A. Priority of Distribution in Receiverships

All state receivership statutes and IRMA Section 801 provide a priority of distribution scheme. The liquidator must become familiar with the priority of distribution scheme of the domiciliary state’s receivership statute at the outset of the receivership process. Typically, statutory priority schemes require that claims in a higher priority class must be paid in full or funds reserved to pay them in full.
before any payment may be made to lower priority claims. Also, the statutes typically require that all claims in a class must receive substantially the same pro rata distribution.

The receiver must keep in mind that the same claimant may hold several claims, not all of which have the same priority. There also may be different types of claims within a particular class of creditors; for example, landlord claims, vendor claims and assumed reinsurance claims are different types of general creditor claims. A receiver must avoid creating subclasses within a priority class. (See In re Conservation of Alpine Insurance Company, 741 N.E. 2d 663 (Ill. Ct. App. Dist. 1. Div. 4. 2000).) The following discussion is based on the scheme of priorities established by IRMA Section 801. Secured creditors and special deposit claimants are outside the scheme of priorities established by Section 801. Secured creditors are covered by IRMA Section 710, and special deposit claimants are covered by IRMA Section 1002C.

1. Secured Creditors

Secured creditors include anyone holding a perfected security interest in or lien against the property of the insurer, e.g., mortgages, trust deeds, pledges and security interests perfected under applicable law (excluding special deposit beneficiaries). Once determined, the value of the security is applied against the creditor’s claim, with the deficiency, if any, treated as an unsecured claim. The priority of the deficiency claim depends upon applicable state law. IRMA also provides guidance to the receiver for the disposition of specific types of secured claims, i.e., claims involving surety bonds or undertaking, and obligees or completion contractors. (See IRMA Section 710 B.)

2. Special Deposit Claimants

Some states require deposit or trust accounts for the benefit of policyholders as a condition to authorization of the insurer to transact business in that state. Although owners of special deposit claims often are loosely referred to as secured, they do not, strictly speaking, have a “security interest.” Some special deposits are made for the benefit of all policyholders, while others specially protect residents, property or lines of business in the state where the deposit is established.

States differ in their treatment of special deposit beneficiaries’ claims in the domiciliary receivership. Some apply the rules applicable to holders of partially secured claims (i.e., treating the deficiency as an ordinary policyholder claim). Another method gives effect to the special deposit arrangements, but applies the “hotchpot” principle to payment of any deficiency. Under this method, special deposit beneficiaries receive no additional payment on their claim until all other claimants in the same class have received assets sufficient to make their percentage distribution equal to that of the special deposit claimants. The treatment to be accorded special deposit claimants may be articulated in the receivership statute.

There has been litigation in various state jurisdictions regarding the handling of special deposits for insurance company liquidations. A Massachusetts case provides that an insurance commissioner, acting as ancillary receiver of a foreign insurance company, cannot take any action to remove special deposit funds until all special deposit claims have been satisfied. (See generally, Commissioner of Ins. v. Equity Gen. Ins. Co., 191 N.E.2d 139 [Mass. Sup. Jud. Ct. 1963].)

In North Carolina, a “special deposit claim” has been defined as any claim secured by a deposit pursuant to statute for the security or benefit of a limited class or classes of persons (State ex rel. Ingram v. Reserve Ins. Co., 281 S.E.2d 16, 20 [N.C. 1981]. N.C. GEN. STAT. § 58-30-10 [19]). Special deposits are expressly excluded from general assets. Id.

In most receiverships, it is difficult for receivers to collect special deposits posted in other state jurisdictions without a court order and provision having been made for the payment of all policyholders in such state jurisdictions. Thus, the receiver will need to develop a claims distribution plan that takes
the special deposits into account and avoids unlawful preferences, being mindful that the state jurisdiction in which a deposit is posted may use the special deposit to satisfy unpaid policy claims in that state jurisdiction.

3. Class 1 – Receiver’s Administrative Expenses

The expenses of the receiver in marshaling and distributing the insurer’s assets are paid out of the unencumbered assets before any other claims are paid. Most statutes treat administrative expenses as claims having a first priority. Some statutes accord the same priority to a guaranty association’s administrative expenses. However, some guaranty association expenses may be classified as policyholder benefits, which is an area of disagreement between guaranty associations and receivers. As will be discussed below, IRMA Section 801 provides two alternatives as to classification of the priority of guaranty association claims. Reinsurers may argue that if the receiver is making reinsurance recoveries under reinsurance treaties, then all premiums due under the treaties should be treated as an administrative expense. Under general contract law, ratification of a contract may be found under a variety of circumstances, such as intentionally accepting benefits under the contract after discovery of facts that would warrant rescission, remaining silent or acquiescing in the contract for a period of time after having the opportunity to avoid it, or affirmatively acknowledging it (17A C.J.S., Contracts § 138). Reinsurers’ claims should be evaluated on a case-by-case basis, but there may be benefits to the estate from treating the reinsurers’ claims as administrative expenses. The reinsurance contract obligations may be binding on the receiver as administrative expense obligations if the receiver has legally “ratified” the reinsurance contract. The assets available to pay all other creditors are those remaining in the estate, net of the cost of recovering and administering them. The process of estimating administrative expenses is a difficult one, as it will depend on many factors, some of which are beyond the control of the receiver. The receiver should establish a contingency reserve for administrative expenses before recommending any payments on claims of lower priority.

4. Class 2 – Guaranty Association Expenses

Guaranty associations may have several types of expense claims, not all of which may have the same priority. IRMA provides two alternative priority schemes depending on how a state wishes to classify certain expenses of guaranty associations. The first alternative places expenses of the guaranty associations, including defense and cost containment expenses of a property/casualty guaranty association, in Class 2 (i.e., after administrative expenses of the receiver). The second alternative places the defense and cost containment expenses of property/casualty guaranty associations in Class 3 with other policyholder-level claims, while the remaining expenses of the guaranty associations are placed in Class 2. No significance or deference should be given alternatives under IRMA based on whether an alternative is labeled as alternative one or two. Receivers should note case law providing that however a guaranty association’s claims are classified, the claims of an out-of-state guaranty association should be of equal priority with the claims of the guaranty association in the receivership state (in re Liquidation of American Mutual Liability Insurance Company, 747 N.E.2d 1215 [Mass. 2001]).

5. Class 3 and 4 – Claims for Policy Benefits

Many state statutes accord priority status to claims for policy benefits behind only the administrative expenses of receivers and guaranty associations. This status applies not only to the claims of policyholders, but to those claiming through them, including guaranty associations and liability claimants whose claims were covered under one of the insurer’s policies. Claims under life insurance or annuity policies include claims for investment values as well as death benefit and annuity payments. Premium refunds and unearned premium claims, however, are treated as general creditor claims under the former Model Act, and some state statutes, although guaranty associations often cover such claims, at least in part. Some states and IRMA accord the same priority rank to policy loss and premium refund claims. A review of the applicable receivership statute generally will inform the receiver as to how to
treat such claims. As sub-classifications within a priority level should be avoided, case law provides that the receiver cannot divide policyholders into those who were insured only by the insolvent insurer and those who had additional insurance through other carriers (In re Conservation of Alpine Insurance Company, 741 N.E. 2d 663 [Ill. Ct. App. Dist. 1. Div. 4. 2000]).

a. Deductible and Limits

The policyholder’s claim is for the amount that the insurer should have paid. For some policies (e.g., workers’ compensation policies), the insurer is required to pay the claim and seek the deductible from the insured (hereafter, “Advancement Policies,” also known as “Large Deductible Policies” or “Loss Reimbursement policies”). It is common for insureds to post collateral with the insurer for deductible payments that may be made by the insurer, for which the insurer then seeks reimbursement from the insureds. With other policies, the insurer’s liability attaches after the deductible has been paid by the insured (“Non Advancement Policies”). IRMA Section 712 provides for the disposition of Large Deductible Policy or Loss Reimbursement Policy recoveries between receivers and guaranty associations. Individual state statutes (see, for example, 40 PA §221.43a) differ from IRMA Section 712 in certain respects.”

Page 518 – Chapter 9 - Legal Considerations

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

The preceding subsections have dealt with legal issues in connection with claims by people that may be entitled to a share of the insolvent insurer’s general assets. “General assets” are defined in § 104K of IRMA as follows:

K. (1) “General assets” includes all property of the estate that is not:

(a) Subject to a properly perfected secured claim;

(b) Subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons; or

(c) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.

(2) “General assets” includes all property of the estate or its proceeds in excess of the amount necessary to discharge claims described in Paragraph (1) of this subsection.

Discussed below are a few of the legal issues surrounding claims against assets that are restricted in one way or another, such as a “special deposit claim.” That term is defined in the Insurers Rehabilitation and Liquidation Model Act as follows:

“Special deposit claim” means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

If a regulator or a guaranty association in a non-domiciliary state where the insolvent insurer has assets, takes action to assert local statutory rights in the assets for the benefit of local policyholders, either in the receivership court or elsewhere, then it is likely that the receiver will be obligated to permit the local officials to conduct an ancillary receivership in that state with the insurer’s local assets. If, however, the regulator or guaranty association does not act,
and the rehabilitation/liquidation court makes a final determination as to the special deposit, the regulator or guaranty association will be bound by the court’s determination.1

1. Special Deposits

Any plan of rehabilitation submitted to the supervising court should include a separate section dealing with special deposits. All state regulators and guaranty associations should be given notice and an opportunity to be heard on that provision and all others in the proposed plan. That will give as much protection as possible under the law from later attempts by state insurance regulators to exercise control over local assets.

In a liquidation, if a regulator in a non-domiciliary state takes action with respect to a special deposit and attempts to initiate an ancillary proceeding, it will be up to the receiver to review the terms and the law under which the deposit was placed and to make sure that the foreign jurisdiction is not obligated to return the deposit.

IRMA §104 CC, defines “special deposit” as “…a deposit established pursuant to statutes for the security or benefit of a limited class or classes of persons.” § 104 DD defines “special deposit claim” as “any claim secured by a special deposit, but does not include any claim secured by the general assets of the insurer.” IRMA § 1002 specifies how deposits are to be administered in various scenarios by specifying what action the IRMA adopting state must take as to special deposits in its state. An IRMA state is required to return all deposits to the domiciliary state upon appointment of the receiver, except deposits where its guaranty association is the only beneficiary. See IRMA § 1002 B.

2. Collateral

The receiver needs to consider all other assets purportedly held by the insolvent insurer in some trust, collateral or other non-general capacity to verify that these assets are, in fact, not general assets of the estate and to ascertain what continuing obligations the receiver may have (i.e., who has rights to the funds and how and to whom the funds should be distributed). The entry of an order of liquidation does not abrogate these special situations and the receiver should take steps to assure that these assets and obligations are separately addressed and the rights of claimants protected.

3. Letters of Credit

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

1 Underwriters National Assurance Company (UNAC), 102 S. Ct. at 1357, involved a post-rehabilitation attempt by the state guaranty association in North Carolina to attach a special deposit in North Carolina made by UNAC prior to rehabilitation, even though the state guaranty association had participated actively in the UNAC proceeding in Indiana and had not raised any question about the deposit prior to the approval in 1976 of the plan of rehabilitation by the Indiana rehabilitation court. Justice Marshall writing for the court held that a judgment from one state court must be accorded full faith and credit in other states, even as to questions of jurisdiction, when those questions have been “fully and fairly” litigated and finally decided in the first court. See Underwriters National, 102 S. Ct. at 1366. The North Carolina guaranty association’s claims were fully and fairly considered by the rehabilitation court, so North Carolina had to give res judicata effect to the Indiana decisions. See id. at 1367-68. The only place where the North Carolina guaranty association could have advanced its argument that the North Carolina statutory deposit scheme should be followed was in the rehabilitation court, not in a collateral attack in North Carolina. See id. at 1371.
4. Separate Accounts

Another special form of assets are separate accounts, which are those accounts set up by an insurer to fund specific blocks of insurance or other benefits, such as pension plans and other viable products. Separate accounts are generally created and administered in accordance with specific statutory or regulatory guidelines. Such statutes usually provide that funds properly maintained in the separate accounts of an insurer will not be chargeable with the liabilities arising out of any other business the insurer may conduct, which has been held to include the insurer’s receivership.\(^2\) (Refer to the following section III.H. and Exhibit 9-2.)

I. Large Deductibles

 Many liability policies for large commercial insureds are being written with deductible limits that may exceed $100,000. The purpose of these large deductible amounts is to reduce premiums for the insured while permitting the insured to meet statutory or regulatory insurance requirements. Large deductible policies are most common in the workers’ compensation area but may be found in other types of liability insurance.\(^2\)

Typically, a large deductible policy provides that the insurer will pay claims in full and then collect the deductible amount from the insured (first dollar coverage). Conversely, first party claims against an auto policy with a deductible are paid minus the amount of the deductible; to ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security to ensure that the deductible will be paid. To ensure that the deductible will be paid, most insurers that write this type of policy will require the insured to post some form of security.

This can be a letter of credit, securities placed in a trust or escrow account for the benefit of the insurer, or some other form of a third-party commitment to reimburse for claims within the large deductible, such as a bond or large deductible reimbursement insurance policy. When the insurer pays a claim, depending on the agreement with the insured, the insurer may either submit a bill to the insured for the amount of the claim paid within the deductible or collect directly from the collateral.

As long as the insurer and the insured remain solvent, there are seldom any difficulties with large deductible arrangements. If the insured becomes insolvent and stops paying the deductible billings or funding the collateral account, the insured remains liable for injuries sustained prior to the termination of the policy. If the insured becomes insolvent and stops paying the deductible billings and if the collateral held is insufficient to pay current and future billings, the insurer’s ability to collect the amounts due will be adversely affected.\(^2\)

If the insurer becomes insolvent and is placed into liquidation, the property and casualty and workers’ compensation guaranty associations will be triggered to begin paying claims. Just like the insurer, the guaranty association will be responsible for first dollar coverage of the claims. After the guaranty association pays the claim, the liquidator can then collect the amount of the claim within the deductible from the insured or the collateral. Disposition of these proceeds has become a very contentious issue between the receivers and the guaranty associations. Receivers believe that the proceeds are claims based

Proposed Changes to Receiver’s Handbook for Insurance Company Insolvencies
re: Large Deductibles

NEW SECTION IN EXISTING HANDBOOK (IL-Provided)

Best Practices for Successful Billing and Collection of Large Deductible Programs In Liquidation

a. Overview of Large Deductible Worker’s Compensation

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

b. The administration of large deductible plans is impacted by entry of an order of liquidation. In such cases, there are two options available regarding statutory authority concerning Large Deductible Worker’s Compensation, namely:

1) Insurer Receivership Model Act (Model #555—IRMA) Section 712 Administration of Loss Reimbursement Policies; or

2) National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Act.

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

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

1. Claim payment, reserve, and reimbursement reporting. The administration of large deductible programs requires strong communication and reporting programs between the Liquidator, guaranty associations, and policyholders. Under the both Model Acts, the Liquidator is required to administer large deductible programs, and related collateral securing large deductible obligations, consistent with the policyholder’s policy provisions and large deductible agreement (“LDA”) as amended by the provisions of the Model Act. Both Model Acts make provision for two types of LDAs, those that permit self-funding by the policyholder, and those that require initial payment by the insurer or guaranty association with reimbursement by the policyholder. Both arrangements necessitate the reporting of claim payments and outstanding claim reserves to the Liquidator for billing, guaranty association reimbursement, and establishing collateral need requirements. The Liquidator’s uniform data standard or UDS should be deployed as the reporting protocol for guaranty association claim payments and outstanding claim reserves. Policyholders that continue self-funding under their LDA will need to...
continue or establish a claim information reporting protocol with the Liquidator through the policyholder’s third party claim administrator or through a proprietary claim information aggregator. Both Model Acts require the Liquidator to form an independent opinion on outstanding claim reserves reported by policyholders and guaranty associations, including a safety factor and incurred but not reported liability to ensure that collateral remains adequate throughout the administration of the program.

2. Agreements between Liquidator and guaranty associations. For states that have enacted the either of the two Model Acts or similar statutory framework for the Liquidator’s administration of large deductible programs an agreement between the Liquidator and the guaranty associations is not necessary. The Models provide a comprehensive framework for administration of the program. For states that have not enacted either Model, an agreement between the Liquidator and guaranty associations may be advisable. The Models can serve as an outline for the issues that should be addressed in such an agreement. Among other things, an agreement should address: whether large deductible recoveries are estate assets subject to the Liquidator’s distribution regime or directly pass through to the guaranty association on account of its prior claim payments, claim reporting protocols, frequency of collateral review and reimbursement activity, and administration of collateral for under collateralized non-performing policyholder accounts.

3. Converting policyholder accounts from an incurred to paid basis under the Model Act. The NCIGF Model Act provides for the conversion of a policyholder’s LDA at liquidation from an “incurred” to a “paid” basis. Conversion is beneficial to policyholders in several ways. Most importantly, conversion at liquidation treats pre-liquidation incurred loss payments made by the policyholder to the insurer as collateral, and thus property of the policyholder pledged to the insurer and restricted to the satisfaction of that policyholder’s claims, rather than as a general asset of the liquidation estate. Conversion also offers flexibility to a policyholder as to the type of security provided to an insurer in satisfaction of the collateral requirement. Conversion affords policyholders the ability to utilize a letter of credit to secure an insurer for the outstanding portion of their loss, rather than payment of cash, since the outstanding bill after conversion is reflected in the Liquidator’s collateral need analysis, rather than an incurred loss billing.

The NCIGF Model Act recognizes these important policyholder rights and provides incentive to policyholders to cooperate with the Liquidator’s administration of large deductible programs and guaranty association reimbursement. The Liquidator should consider notifying large deductible policyholders of these important policyholder rights at the inception of a liquidation proceeding and offer policyholders the opportunity to elect to convert their large deductible programs from an incurred to paid basis in accordance with the NCIGF Model Act, memorializing any elections with an endorsement that otherwise follows and requires the policyholder to adhere to the provisions of the NCIGF Model Act.

4. Large deductible billing by Liquidator. The Liquidator should establish a large deductible billing and collection program that bills policyholders on a periodic basis, e.g., quarterly, that meets Liquidator and policyholder expectations for claim payments made by the estate prior to liquidation and by guaranty associations after liquidation. The Liquidator’s invoice to policyholders should communicate a claim payment summary that includes detail such as the insurer or guaranty association’s check number, date of payment, payee, account year, and remaining large deductible limits. Large deductible programs that are self-funded by policyholders should also report their claim payments to the Liquidator on a similar periodic basis, so that the Liquidator can establish appropriate claim reserves, track the exhaustion of the policyholder’s deductible limits, report to reinsurers and collect reinsurance. Consideration should be given to using one of many proprietary billing and collection software
programs to automate the large deductible billing and collection process. Large deductible recoveries
that are subject to guaranty association reimbursements should be aggregated and distributed on a
quarterly or other periodic basis that balances the Liquidator’s accounting requirements and the guaranty
associations’ reimbursement needs.

5. **Annual collateral review by Liquidator.** The NCIGF Model Act, consistent with the typical LDA,
requires the Liquidator to perform an annual collateral review for each policyholder account to ensure
that the Liquidator holds adequate collateral to support a policyholder’s large deductible obligations and
to release any excess collateral held back to the policyholder. This review should include a report to the
policyholder on total incurred claims, claims paid, outstanding reserves, any additional safety factor and
total collateral need. The Liquidator’s collateral review should result in a report to the policyholder and
an invoice for additional collateral need or a release and distribution of excess collateral. The Liquidator
should consider whether any additional safety factor should be included for non-performing
policyholder accounts. The NCIGF Model Act provides flexibility on the timing of the annual review,
ensuring that the Liquidator to perform the annual review process throughout the calendar year so that all
policyholder account reviews are not due at the same time.

(OK provided)

**PROPOSED AMENDMENT TO RECEIVER’S HANDBOOK FOR INSURANCE COMPANY INSOLVENCIES**

Chapter 5/1. Large Deductibles

d. Administration Fees

Section 712 (G) OF IRMA provides:

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.

Further, Section 712(F) provides, in part:

The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a
claim in the delinquency proceeding at any priority; however, a guaranty association may net the expenses
incurred in collecting any reimbursement against that reimbursement.

Several states have adopted statutory provisions similar to the IRMA provisions regarding handling of large
deductibles in an insolvency and provide for the Receiver to retain reasonable actual expenses incurred from the
reimbursement to the guaranty association(s). Similarly, statutes may provide for the guaranty association to net
expenses incurred in collecting a reimbursement.
When there is no statutory guidance, receivers should include a provision for reimbursement of reasonable actual expenses in an agreement with the guaranty associations regarding the collection and allocation of large deductibles.

Policy and collateral definitions

It is important that state laws define large deductible workers’ compensation policies and large deductible collateral. Defining the treatment of such policies and associated collateral is imperative for developing policies and processes for administering the collection of assets.

Large deductible policies should be defined as a policy that requires the policyholder to either pay direct expenses or reimburse expenses for a claimant. Financial responsibility up to a specific dollar amount of expenses related to an individual’s claim is shifted to the policyholder. While many states might associate a minimum financial threshold, it is more important to consider the administration of the policy compared to a traditional policy. Deductible amounts can include claim-related payments by the insurer for medical and indemnity benefits, allocated loss adjustment expenses, such as medical case management expenses, legal defense fees and independent medical exam expenses. It is critical that the policy specify the claim-related payments that are the responsibility of the policyholder and not be in side agreements or other agreements outside of the policy.

Collateral held by the insurer should be defined as amounts held for loss reimbursement. The policy should provide acceptable financial instruments that can be held for loss reimbursements. Typical collateral requirements include: cash, letters of credit, surety bonds or other liquid financial means held for the benefit of the insurer.

Whether receiver or guaranty fund should collect large deductible reimbursements

It is critical to immediately establish the party responsible for billing and collecting large deductibles. While some states might have specific statutory language that specifies the entity responsible, some statutes might be silent. In the case where the statutes do not specify responsibility, it is recommended that the receivers and guaranty associations enter into an agreement that allows for the most efficient administration of the large deductible collections.

Specific consideration should be given to large deductible policies that provide coverage in multiple states and have claimants subject to the jurisdiction of multiple guaranty funds. If feasible, the most efficient approach for such policies would likely be for the receiver to administer the deductible billing and collection process. Throughout the life of the estate, claimants continue to incur benefit payments and expenses and deductible collection efforts may last beyond the life of the estate. The party responsible for collections needs the ability to compromise and settle the future obligations.

The receiver should make provisions in its discharge motion and Court order, to the extent possible, regarding the transition of ongoing deductible collections to the guaranty as well as the disposition of any collateral being held by the receiver.

Commented [FS11]: Discuss ME Comments:

I’m not sure defining a “large” deductible is really so important for our purposes (though a particular state might have other reasons why that state would consider it important). Is there any size threshold at which the rights and obligations of the parties should change? What might be more important is to define “deductible” – either to take the IRMA approach and expressly define these things to be something other than “deductibles,” or to accept common usage but clarify why they must be regulated differently from all other, more traditional, deductibles. But again, that difference doesn’t come from the “largeness” of the deductible, but rather from the insurer’s first-dollar payment obligation. A policy could have an extremely large SIR but claims within a true SIR should create no obligations for either the guaranty fund or, beyond the duty to be ready to step in if and when the SIR is pierced, for the estate. … OK, as I read further, I see that the proposal does seem to define “large” in terms of the nature of the parties’ obligations, so that a $500 deductible can be “large” and a million-dollar SIR can be “small.” I would agree that it’s important to define the difference between the two types of arrangements under which the policyholder retains risk, but I don’t think “large” is a useful synonym for what IRMA calls a “loss reimbursement” arrangement, because it already has a meaning and giving it a completely different meaning is confusing.
Treatment of Collateral in Receivership

When collateral has been posted by or on behalf of a large deductible policyholder, what does the receivership estate actually own? The answer is generally found in the documents pledging the collateral to the insurer.

The Insurance Receivership Model Act, NAIC Model Law # 555 (“IRMA”) defines “property of the estate” to include “all right, title and interest in property ... includ[ing] choses in action, contract rights, and any other interest recognized under the laws of this state.” In states without an explicit statutory definition, the common-law definition is substantially similar.

This means that the insurer’s right to draw on the collateral automatically becomes an asset of the receivership estate, but the collateral itself is not an estate asset unless and until it is drawn. In the first instance, the conditions and procedures for drawing the collateral should be spelled out in the relevant contract documents (which could include third-party instruments such as letters of credit or surety bonds), but state law could provide additional rights, and will specify what the receiver may do when the documents are silent, incomplete, or missing.

Possession and control over the collateral are distinct from ownership. The insurer could already be in possession of the collateral before the receivership, or the receiver might act to take possession by enforcing applicable contract rights or by negotiating an agreement. Nevertheless, this does not immediately give the receiver the right to use the collateral to pay claims. The defining characteristic of collateral is that it is intended to serve as a backstop in case the policyholder does not meet its obligations to pay all reimbursements promptly and in full.

Commonly, the right to draw on collateral only attaches after the policyholder has defaulted or has consented to a draw, or, if the collateral is a letter of credit, after the issuer has given notice of nonrenewal (in which case the receiver must act promptly to call the LOC or obtain replacement collateral). There could also be the opportunity to negotiate an agreement under which the policyholder turns over the collateral and makes a lump-sum payment to commute any further reimbursement obligations, or the collateral might have been structured from the outset as a “working” loss fund from which the insurer was expected to pay claims in the ordinary course of business.

In any case, while it is essential for the receiver to preserve and exercise the right to access the collateral as needed, it is also essential to ensure that collateral is not dissipated to pay claims that the policyholder should be funding. Special consideration needs to be given in situations where the policyholder is at risk of being or becoming judgment-proof, or where rights to the collateral are shared with other creditors of the policyholder and prompt action is necessary to preserve the receiver’s priority.

When the guaranty association is paying the claims, it is generally entitled to receive the proceeds of any policyholder reimbursements, including draws on the collateral. Under laws substantially similar to IRMA, these payments are considered early access distributions (but without the necessity for court approval) which may be subject to subsequent clawback, while laws substantially similar to the NCIGF Model treat them as the ultimate source of funding for the underlying claims, so that they belong unconditionally to the guaranty association.

Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral, unless there is a formal written agreement assigning that right to the guaranty association.

Finally, there is always the hope that the policyholder’s reimbursement obligations will be oversecured, or will become oversecured as claims are run off. In that case, any excess collateral will revert to the policyholder or the policyholder’s guarantor. State law might expressly provide a process for determining when excess collateral is

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3 IRMA § 104(V)(1).
4 For example, IRMA § 712(D) specifically provides that the relevant provisions of the policy are not controlling “where the loss reimbursement policy conflicts with this section.”
5 Compare IRMA § 712(C)(3) with NCIGFMA § 712(C).
6 See NCIGFMA § 712(E)(3).
being held by or on behalf of the receiver, or the ability to return collateral before the estate is closed might be part of the general powers of the receiver. However, because workers’ compensation is a long-tail exposure with significant risk of adverse reserve development, receivers must take great care not to make premature or excessive return distributions.

Issues Raised by Net Worth Exclusions and Deductible Exclusions

Unlike other lines of insurance, workers’ compensation insurance is generally exempt from the statutory caps on guaranty association coverage, so that the guaranty fund is usually obligated to pay workers’ compensation claims in full. However individual states may have adopted caps on guaranty association coverage. States have created this exception to honor their state’s promise that injured workers will be paid the full benefits to which they are entitled. The general purpose of these exclusions is to avoid any obligation for the guaranty association to pay losses that can and should be borne by the policyholder. Net worth exclusions make guaranty association protection unavailable to policyholders with net worth above a specified threshold, while deductible exclusions expressly prohibit guaranty association coverage for amounts within a policy deductible.

Unless these exclusions are drafted and implemented carefully, there is a risk that they could result in delays in claims payments or even a complete loss of coverage. In some states, claimants might be protected by an uninsured employer fund, but that is not the purpose of those funds, so even if such a fund exists in your state, it should be a priority to ensure that however it is done, the estate, employer, or guaranty association will provide for payment in full of all benefits due under the state’s workers’ compensation laws. If this is not possible under current law, regulators should advocate for a change in the law. A variety of successful approaches are available; there is not a single one-size-fits-all solution that is best for every state.

Net Worth Exclusions: The PC GA Act contains an optional section, with a variety of alternative provisions states can select, excluding coverage for high-net-worth insureds, whether they are individuals or business entities. The base version sets the threshold at $50 million, while one of the alternatives sets the threshold at $25 million. Many states have enacted some version of this clause or some comparable net worth exclusion.

The impact on workers’ compensation coverage depends on how the exclusion is structured. In states with provisions substantially similar to any of the three alternatives under the PC GA Act, coverage is excluded completely for first-party claims by high-net-worth insureds, but workers’ compensation claims against high-net-worth policyholders are administered by the guaranty association on a “pay-and-recover” basis: that is, the guaranty association has the obligation to pay the claim in the first instance, and the right to be reimbursed by the policyholder. Thus, claimants are fully protected, and for large deductible policies, this mirrors the structure of the policy for claims within the deductible. In states with guaranty association laws similar to the NCIGF Model, this is the same reimbursement right the guaranty association would have in the absence of the exclusion as the insurer’s successor.

If the policyholder is cooperative, the guaranty association has the option of negotiating an agreement where the policyholder advances funding for claims within the deductible. However, if the policyholder is not cooperative, guaranty associations have expressed concern that the pay-and-recover framework is burdensome and gives the policyholder too much leverage to avoid or delay paying its obligations in full. If PC GA Act’s Alternative 2 is applied the pay-and-recover obligation to all third-party claims. Alternative 2 excludes all third-party claims as well as all first-party claims, but requires the guaranty association to pay workers’ compensation claims, statutory automobile insurance claims, and other claims for ongoing medical payments. Alternative 3 excludes only first-party claims and claims by out-of-state claimants that are subject to a net worth exclusion in the claimant’s home state; this alternative does not create any statutory right of recovery when the guaranty association is obligated to pay a third-party claim.
modified to treat workers’ compensation claims the same as other third-party claims, then the guaranty association has no obligation unless the formerly high-net-worth policyholder has become insolvent.\(^{11}\) Otherwise, the claimant’s only recourse is against the policyholder or the insured’s estate. As stated above, the injured worker should be protected by some means in these cases.

When a guaranty association net worth exclusion and a large deductible both come into play on the same claim, it is imperative that the receiver and guaranty association stay in close communication in order to avoid any confusion regarding which entity is responsible for the collection. In both IRMA 712 and the NCIGF large deductible model statute, the guaranty fund is entitled to collect net worth reimbursements. Coordination of these collections with receiver efforts to collect on high deductible will do much to avoid duplication of billings and potential resulting collection delays.

This has the potential to result in gaps in coverage, especially in states with laws substantially similar to IRMA. If the policyholder’s large deductible reimbursements are a general asset of the estate, then the policyholder might end up being obligated to pay the same claim twice, or might be able to use the receiver’s draw on the collateral as a defense against paying the injured worker directly, leaving the worker with a substantial loss of benefits when the estate is unable to pay the claims in full. However, guaranty associations have represented that they have not seen these problems materialize in practice in states where net worth exclusions deny guaranty association coverage for workers’ compensation claims against high-net-worth employers. Regulators in states with such exclusions should take steps to verify that this is the case and that injured workers will not fall through the cracks if a high-net-worth employer has bought coverage from an insolvent insurer.

### Deductible Exclusions

The PC GA Act does not contain any explicit deductible exclusion. Instead, it simply provides that “In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.”\(^{12}\) However, some states have enacted explicit language further clarifying that there is no guaranty association coverage for amounts within a policy’s deductible or self-insured retention.\(^{13}\) For example, Minnesota law excludes “any claims under a policy written by an insolvent insurer with a deductible or self-insured retention of $300,000 or more, nor that portion of a claim that is within an insured’s deductible or self-insured retention” from coverage by the property and casualty guaranty association.\(^{14}\) A Minnesota employer entered into an employee leasing arrangement with a PEO, which obtained a workers’ compensation policy with a $1 million deductible. Both the PEO and the insurer became insolvent, and the Minnesota Court of Appeals held that there was no guaranty association coverage for workers’ compensation claims against the client employer because of the statutory deductible exclusion.\(^{15}\) The court observed that the Legislature deliberately chose to protect the guaranty association from unlimited exposure, without mentioning that the Legislature also deliberately created an exception making the cap on coverage inapplicable to workers’ compensation claims (which strongly suggests that the statute in question, which is tied to the statutory $300,000 cap on coverage, was not written with workers’ compensation in mind).\(^{16}\) Likewise, the court took for granted that the statute’s undefined term “deductible” included the contract provision at issue in the case, even though the insurer had assumed the unconditional liability to pay all claims in full. The opinion did not consider the possibility that the Legislature’s intent was simply to clarify that the guaranty association has no

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\(^{11}\) PC GA Act, § 13(B)(2) Alternative 2.
\(^{12}\) PC GA Act, § 8(A)(1)(b).
\(^{13}\) Compare LH GA Act, § 3(B)(2)(a), expressly excluding from life and health guaranty association coverage “A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner.”
\(^{14}\) Currently, the only states with language specifically excluding claims within policy “deductibles” are Iowa, Louisiana, Minnesota, Missouri, and Nevada. Louisiana’s exclusion applies only to policies issued to group self-insurance funds, and Missouri’s does not apply to workers’ compensation claims.
\(^{15}\) Minn. Stat. § 60C.09(2)(a).

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obligation to drop down and pay claims from the first dollar if the insurer would have had no obligation to pay those claims.

Therefore, if states determine that there is a need to include express provisions addressing deductibles and self-insured retentions in their guaranty association laws, it is essential to avoid unintended consequences. In particular, the key terms should not be left undefined. For this reason, IRMA coined the term “loss reimbursement policy” in its section addressing these types of policies, to distinguish them from true deductibles, where the insurer has no obligation to pay anything except the portion of the loss that exceeds the deductible.\(^\text{17}\)

This is the crucial difference between a “large deductible” workers’ compensation policy and an excess policy. Although “large deductible” policies transfer a significant amount of risk back to the policyholder, they do not extinguish the insurer’s liability. That is why “large deductible” policies, in states that allow them, are accepted as a mechanism for satisfying the policyholder’s compulsory coverage obligations, while excess policies, generally, are not. Usually, excess workers’ compensation policies may only be issued to self-insurers that have been approved by the state. It is the approved self-insurance program, not the excess policy, that satisfies the employer’s compulsory coverage obligation, and the insurer has no liability for any portion of a claim that falls within the employer’s self-insured retention.\(^\text{18}\) Thus, despite the terminology that is commonly used, it is the excess policy, not the large deductible policy, that functions as a “deductible” in the traditional sense of the term.

It is worth noting, however, that commercial self-insured retention and large deductible policies can vary widely in policy terms and sometimes “side agreements” supplement the policies. Arrangements can contain aggregate limits, can vary on the obligation for defense cost and expenses and, in some cases permit the insured to “self-fund” its claims with an account in the possession of the TPA which is handling the claims. Because of these complexities, policy terms and any related endorsements and side agreements should be carefully reviewed. Whether such side agreements are legally enforceable requires a thorough case-by-case analysis in light of applicable state laws.

\(^\text{17}\) For example, if a consumer has an auto policy with a collision deductible of $1,000, and the repair costs $5,000, the insurer’s liability is limited to $4,000. “Self-insured retentions” (SIRs) in commercial excess policies are designed to function the same way on a larger scale. If a business is found liable for a third-party claim is settled for $500,000, and its liability policy has an SIR of $300,000, the insurer is never responsible for more than the remaining $200,000, even if the policyholder is bankrupt.

\(^\text{18}\) In many states, a separate self-insurance guaranty fund protects claimants if a self-insured employer becomes insolvent. These funds typically operate entirely under the state’s workers’ compensation laws, not the state’s insurance receivership or insurance guaranty fund laws.
To: Receivership and Insolvency (E) Task Force (RITF)  
From: Receivership and Insolvency (E) Task Force Drafting Group  
Re: Report on Macroprudential Initiative (MPI) Referral from Financial Stability (EX) Task Force  
Date: July 17, 2019

I. Evaluate recovery and resolution laws, guidance and tools, and determine whether they incorporate best practices with respect to financial stability

The drafting group surveyed the powers that are typically vested in the Receiver under state laws based on the Insurer Receivership Model Act (Model #555, commonly referred to as IRMA) and its predecessor, the Insurer Rehabilitation and Liquidation Model Act (IRLMA). The drafting group agreed that these powers, in conjunction with the authority granted to the Receiver by court orders, generally provide the powers described in:

- International Association of Insurance Supervisors (IAIS) Insurance Core Principle (ICP) 12, Exit from the Market and Resolution;
- Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) material integrated into ICP 12; and
- Financial Stability Board’s (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions (KAs).

The drafting group identified powers under state laws that comport with the ICPs, ComFrame, and the KAs. In some cases, however, the powers under state laws are implicit rather than explicit. The following topics resulted in recommendations.

a. Bridge Institutions

Although state receivership laws do not expressly provide for the establishment of a bridge institution (Bridge), the drafting group agreed that the Receiver may establish a Bridge under those laws. While a Bridge is typically not needed in a receivership, the drafting group believes that a Bridge may be of benefit in a receivership to address an early termination on qualified financial contracts (QFCs). However, implementing a Bridge for this purpose would require the use of temporary stays on termination rights. As noted in #3 below, the current misalignments with Federal rules on the termination of master netting agreements for QFCs prevents the use a temporary stay in receivership on termination of QFCs, thereby preventing the use of a Bridge for this purpose.

Recommendation:

- The drafting group recommends RITF refer the following to the Receivership Model Law (E) Working Group:
  - Further explore if bridge institutions could be implemented under regulatory oversight as a pre-receivership mechanism to address the context of early termination of QFCs, and if appropriate, develop applicable guidance.

b. Providing Continuity of Essential Services and Functions
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 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 drafting group identified the following authority and tools:

- 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. The Insurance 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.

The drafting group noted that some of these remedies might not address the immediate need to continue services in some cases. One potential solution is to revise the definition of “insurer” under state insurance laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.

**Recommendation:**
- The drafting group recommends RITF refer the following to the Receivership Model Law (E) Working Group:
  - Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by other affiliated entities in a holding company group, including non-regulated entities. The Working Group should address this recommendation in consultation with the Group Solvency Issues (E) Working Group at it relates to affiliated intercompany agreements.

**c. Variances in States’ Receivership Laws**

The drafting group recognized that few states have adopted IRMA, and most have laws based on IRLMA or prior models. The drafting group’s review of the powers in the ICPs, ComFrame and KAs identified several key provisions that are contained in IRMA but are not explicitly addressed in IRLMA and previous models, including:

- IRMA §209, (effect of receivership order) and §302 (Conservator’s powers and duties),
- IRMA §612 (life and health reinsurance), and,
- IRMA §1001-1002 (interstate relations).

In 2017, the Financial Condition (E) Committee issued a memorandum to states to consider adoption of IRMA §1001-1002.1

**Recommendation:**
- The drafting group recommends RITF consider methods for further encouraging states to adopt provisions in law that address key areas of receivership in order to enhance efficiencies and effectiveness of the receivership process, including consideration of a request to amend the Financial Regulation Standards and Accreditation Program Part A standards for receivership and guaranty fund laws.

**2. Evaluate recovery and resolution planning tools for systemically important cross-border U.S. groups**


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The drafting group reviewed recovery and resolution planning in the KAs and ComFrame. While many topics were determined to be generally covered in the guidance for pre-receivership planning in the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook), a few topics were flagged for further consideration. Some topics were identified that may be captured elsewhere within the US solvency monitoring frameworks (e.g., ORSA, Supervisory Colleges, Crisis Management Groups, Examinations, etc.). The drafting group found that:

- The Dodd Frank Act’s provisions for resolution planning address the requirements of the KAs and ComFrame for an insurer designated as a Systemically Important Financial Institution (SIFI). Other jurisdictions may have similar planning requirements for international groups.
- The requirements in state laws for corrective action plans under risk-based capital (RBC) laws and hazardous financial condition laws may satisfy this requirement for insurers meeting those solvency benchmarks.
- Regarding crisis management groups and crisis management planning, the NAIC Insurance Holding Company System Model Act (Section 7) provides the commissioner with the authority to develop crisis management plans as part of supervisory colleges. Further, Model 440 Section 7.1, provides for authority for the commissioner to act as the group-wide supervisor of internationally active insurance groups (IAIG) and engage in group-wide supervision activities as outlined in the model, though not explicit to recovery and resolution plans. Additionally, the NAIC Financial Analysis Handbook contains guidance and a template for a crisis management plan. This authority and guidance provide states with the flexibility to discuss the necessity for crisis management plans within supervisory colleges and/or crisis management groups and to make the determination to develop such plans on a case-by-case basis.

Recommendations:

- The drafting group agreed that consideration of imposing recovery plan reporting requirements on insurers that are not in financial distress is outside the scope of the RITF, and may require consideration by U.S. group-wide supervisors of IAIGs and referral from the Financial Stability (EX) Task Force to other group(s) within Financial Condition (E) Committee.
- The IAIS is planning to develop an application paper on resolution planning. The drafting group recommends the RITF review and provide input to the application paper.

3. Evaluate whether there are misalignments between federal and state laws that could be an obstacle to effective and orderly recovery and resolutions for U.S. insurance groups

a. Temporarily Stay Early Termination Rights

The drafting group evaluated the impact of the federal rule recognizing temporary stays on terminating master netting agreements for qualified financial contracts (QFCs), which does not recognize stays in a state receivership proceeding. The regulators held discussions with federal banking authorities regarding the handling of QFCs and bridge institutions in banking resolutions. This information will be used to assess the utility of a stay on QFC terminations in an insurance receivership.

Recommendations:

- The drafting group proposed amendments to the Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556) to highlight the conflict with the federal rule to state insurance regulators who may be considering adoption of Guideline #1556. Revisions were exposed for comment by RITF at the Spring National Meeting and are pending adoption by the RITF (see RITF Summer National Meeting Agenda).
- The Receiver’s Handbook includes guidance for receiverships involving qualified financial contracts. The drafting group recommends RITF refer the following to the Receivership Model Law (E) Working Group:
  - Review the Receiver’s Handbook and draft updates relevant to this early termination issue. The Working Group should also identify pre-receivership considerations and, if necessary, make
referrals to other applicable groups to enhance pre-receivership planning, examination and analysis guidance.

b. Taxes in Receivership and Federal Releases

The drafting group has reviewed and identified topics where guidance for taxes in receivership and federal releases should be drafted in the Receiver’s Handbook.

Recommendation:
- The drafting group recommends RITF refer the following to the Receivership Model Law (E) Working Group:
  - Refer comments received through the drafting group’s review and draft revisions to the Receiver’s Handbook for guidance on taxes in receivership and federal releases.
Proposed 2020 Charges

The Receivership and Insolvency (E) Task Force will:

A. Monitor and promote efficient operations of insurance receiverships and guaranty associations funds.
B. Monitor and promote state adoption of insurance receivership and guaranty association related model acts and regulations and monitor other legislation related to insurance receiverships and guaranty associations.
C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
E. Provide ongoing review of maintenance and enhancements to the Receiver's Handbook for Insurance Company Insolvencies (Receiver's Handbook), other related NAIC publications and the Global Receivership Information Database (GRID), and make any necessary updates.
F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.
H. Monitor Federal Home Loan Bank (FHLB) legislation pending in and enacted by the states, and the impact on insurance companies in those states.

The Receivership Financial Analysis (E) Working Group will:

A. Monitor receiverships involving nationally significant insurers/groups within receivership to support, encourage, promote and coordinate multistate efforts in addressing problems.
B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) with regard to potential or pending the receiverships.

The Receivership Large Deductible Workers' Compensation (E) Working Group will:

A. Perform Complete work based on recommendations for possible enhancements to the U.S. receivership regime, as approved and directed by the Receivership and Insolvency (E) Task Force, resulting from a study of the states' receivership laws and practices related to the receivership of insurers with significant books of large deductible workers' compensation business. Complete by the 2020 Fall/Summer National Meeting.

The Receivership Model Law (E) Working Group will:

A. Review and provide recommendations on any issues identified that may affect states’ receivership and guaranty association model laws; for example, any issues that arise as a result of market conditions, insurer insolvencies, 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.
B. Discuss significant cases that may impact the administration of receiverships.
C. Complete work as assigned from the Task Force to address recommendations from the Financial Stability (EX) Task Force’s Macroprudential Initiative (MPI) referral as follows:
   1. Draft updated guidance for the Receiver's Handbook on taxes in receivership and federal releases;
   2. Explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of qualified financial contracts (QFCs), and if appropriate, develop applicable guidance. Review the Receiver's Handbook guidance on QFCs and if necessary, draft enhancements. Identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance; and,
3. 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. Complete by the 2020 Fall National Meeting.

A. Monitor, and provide recommendations for possible enhancements to the U.S. receivership regime and the states' receivership laws and practices based on, international supervisory and advisory developments regarding recovery, resolution, receivership and liquidation, including, but not limited to, the Financial Stability Board’s (FSB) Key Attributes of Effective Resolution Regimes for Financial Institutions (KA) and Assessment Methodology (AM) and the International Association of Insurance Supervisors' (IAIS) Insurance Core Principles (ICPs) and its Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) (particularly ICP 10, Preventive and Corrective Measures and ICP 12, Winding up and Exit from the Market, as well as related ComFrame materials). Complete by the 2019 Fall National Meeting.