**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)

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*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

• 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.

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| **Checklist 6—Underwriting** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
| --- | --- | --- | --- | --- |
| ***Overview*** |  |  |  |  |
| 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. |  |  |  |  |
| 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. |  |  |  |  |
| Obtain copies of departmental procedures, underwriting, code and rate manuals. |  |  |  |  |
| 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. |  |  |  |  |
| Determine the underwriting department’s filing system, noting:* Locations of files and documents
* Filing method (e.g., alphabetical, numerical, terminal digit, etc.)
* Possible segregation by line of business
* Who has access to files and file sign-out procedures – modify as appropriate
* Whether files are copied to electronic media
 |  |  |  |  |
| ***Insurance***  |  |  |  |  |
| Locate, obtain copies and review all insurance policies and contracts:* General Liability
* Property
* Auto
* Workers’ Compensation
* Fidelity Bond
* Directors and Officers
* Large Deductible Endorsements
* Errors and Omissions

Professional Liability |  |  |  |  |
| 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
 |  |  |  |  |
| As you become aware, document any limited or unusual exposures that do not appear on the insurer’s policy registers. |  |  |  |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Checklist 6—Underwriting** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
| 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 |  |  |  |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Checklist 8—Accounting** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
| 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 |  |  |  |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Checklist 8—Accounting** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
| 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. |  |  |  |  |

Page 118 New Checklist

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Checklist 10A-****Large Deductible Policies** | **Project Assigned To** | **Date Completed** | **Completed By** | **Notes** |
| Overview* Meet with Manager of Large Deductible Collections (and/or other appropriate personnel) to discuss large deductible Collection procedures, personnel and responsibilities, staffing and what will be required from staff as a result of the order
* Conduct interviews of appropriate large deductible collection department personnel to determine policies and procedures. Document same.
* Establish a large deductible recoverable balance as of the receivership date
 |  |  |  |  |
| Gathering documentation* Determine location of large deductible records – secure and inventory. This should include:
* All policies containing large deductible endorsements
* Claims files arising under such policies
* Correspondence files
* Billing records
	+ Letters of credit, trust agreements, deductible reimbursement policies or other collateral
* For all LOCs, trust accounts, funds withheld:
	+ Secure all originals
	+ Notify all banks and trustees of the order
 |  |  |  |  |
| Documenting Large Deductible Collection Procedures* Review recent billings for all large deductible policies
* Obtain a list of large deductible payment history and determine whether insured payments have been ongoing or if payment from collateral has been required.
* Obtain a list of paid and unpaid bills updated after liquidation
* Obtain claim documentation for claims arising under large deductible policies
	+ By paid loss and loss reserves and ALAE paids and reserves
	+ List of claims in litigation/arbitration
* Review large deductible billing system; determine that all paid losses arising under large deductible policies have been billed.
* Determine whether large deductible endorsements provide that losses within the deductible are limited in the aggregate
* Evaluate recovery processes and determine if new procedures are appropriate
* Determine whether collateral is held by affiliated/unaffiliated third party via large deductible reimbursement policy, trust agreement or other vehicle, and evaluate whether collateral can be transferred to the receivership
* Document insured collection disputes
	+ Determine which functional group handles disputes
	+ Interview members of each group responsible for coordinating, monitoring and controlling large deductible collection disputes
* Audit large deductible collection-specific systems. Track data from source to final product to verify billings are correct and inclusive and internal controls are adequate
 |  |  |  |  |

Page 139- Chapter 2- Information System

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 requirement may be quite different from long-tail business in which claims will take a long time to develop. If the business included large-deductible or loss-sensitive features such a retrospectively-rated premiums, there will be additional system demands. This also will impact the amount of historical information that must be maintained in the systems.
* 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.

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I. Existing Systems

The receiver’s staff (or an independent consultant) needs to determine if the existing systems adequately process the business or if those systems must be supplemented with manual processing. If it is the latter, the receiver should then determine whether the level of supplemental manual processing required is acceptable, in terms of accuracy and the cost of processing. This will establish whether the existing system(s) are adequate to provide the receiver with the amount and types of information required.

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

* policies and contracts;
* accounting;
* claims;
* accounts receivable/payable;
* cash;
* reinsurance;
* guaranty fund claims counts and reserves by state; and
* Earned and unearned premium.
* Large Deductible Collections and Collateral

Page 194 – Chapter 3 – Accounting and Financial Analysis

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. Page 219 – Investigation and Asset Recovery
* VI. OTHER SIGNIFICANT TRANSACTIONS
* In addition to considering fraudulent transfer laws and voidable preference statutes, a receiver reviewing the reasons for an insurer’s financial problems and attempting to marshal its assets should determine whether there have been any suspect transactions. Suspect transactions are unusual transactions that would not normally occur in the ordinary course of business. Some of these 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 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 association‘s must also recognize that they will be required at times to communicate with Insurance regarding claims handling.
	+ 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 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’s 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 cancelation, 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.
* B. 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.

Page 288- Chapter 5 – Claims

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 or 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 recognizing the validity of the contract by acting upon it, performing under 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 § 104 K 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.”63 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]](#footnote-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 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\*.**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]](#footnote-2) (Refer to the following section III.H. and Exhibit 9-2.)

Page 539 I. Large Deductibles

**I. Large Deductibles**

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

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

As long as the insurer and the insured remain solvent, there are seldom any difficulties with large deductible arrangements. If the insured becomes insolvent and stops paying the deductible billings and if the collateral held is insufficient to pay current and future billings, the insurer’s ability to collect the amounts due will be adversely affected.”

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**

Overview of Large Deductible Worker’s Compensation A large deductible worker’s compensation policy or program is a method of insuring workers’ compensation risk with the employer assuming some of that risk in a deductible of $100,00, $250,000, or even higher per claim (varies by state) and an insurer takin 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.

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, enabling the Liquidator to perform the annual review process throughout the calendar year so that all policyholder account reviews are not due at the same time.

(OK provided)

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

Chapter 5/I. 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.

(FL- Provided)

**Policy and collateral definitions**

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

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.

(ME- Provided)

**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.”[[3]](#footnote-3) 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,[[4]](#footnote-4) 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.[[5]](#footnote-5) Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral,[[6]](#footnote-6) unless there is a formal written agreement assigning that right to the guaranty association.

Finally, there is always the hope that the policyholder’s reimbursement obligations will be oversecured, or will become oversecured as claims are run off. In that case, any excess collateral will revert to the policyholder or the policyholder’s guarantor. State law might expressly provide a process for determining when excess collateral is being held by or on behalf of the receiver,[[7]](#footnote-7) 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.[[8]](#footnote-8) 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, and 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.[[9]](#footnote-9) 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.[[10]](#footnote-10) Thus, claimants are fully protected, and for large deductible policies, this mirrors the structure of the policy for claims within the deductible. In states with guaranty association laws similar to the NCIGF Model, this is the same reimbursement right the guaranty association would have in the absence of the exclusion as the insurer’s successor.

If the policyholder is cooperative, the guaranty association has the option of negotiating an agreement where the policyholder advances funding for claims within the deductible. However, if the policyholder is not cooperative, guaranty associations have expressed concern that the pay-and-recover framework is burdensome and gives the policyholder too much leverage to avoid or delay paying its obligations in full. If PC GA Act’s Alternative 2 is modified to treat workers’ compensation claims the same as other third-party claims, then the guaranty association has no obligation unless the formerly high-net-worth policyholder has become insolvent.[[11]](#footnote-11) Otherwise, the claimant’s only recourse is against the policyholder or the insured’s estate. 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 policy 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]](#footnote-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. 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.[[13]](#footnote-13) 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.[[14]](#footnote-14) 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).[[15]](#footnote-15) Likewise, the court took for granted that the statute’s undefined term “deductible” included the contract provision at issue in the case, even though the insurer had assumed the unconditional liability to pay all claims in full. The opinion did not consider the possibility that the Legislature’s intent was simply to clarify that the guaranty association has no obligation to drop down and pay claims from the first dollar if the insurer would have had no obligation to pay those claims.

Therefore, if states determine that there is a need to include express provisions addressing deductibles and self-insured retentions in their guaranty association laws, it is essential to avoid unintended consequences. In particular, the key terms should not be left undefined. For this reason, IRMA coined the term “loss reimbursement policy” in its section addressing these types of policies, to distinguish them from true deductibles.

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. [↑](#footnote-ref-1)
2. See, e.g., *Rohm & Haas Co. v. Continental Assurance Company,* 58 Ill. App. 3d 378, 374 N.E.2d 727 (1978) [↑](#footnote-ref-2)
3. IRMA § 104(V)(1). [↑](#footnote-ref-3)
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.” [↑](#footnote-ref-4)
5. *Compare* IRMA § 712(C)(3) *with* NCIGFMA § 712(C). [↑](#footnote-ref-5)
6. *See* NCIGFMA § 712(E)(3). [↑](#footnote-ref-6)
7. *See, e.g.,* NCIGFMA § 712(E)(5). [↑](#footnote-ref-7)
8. *See* Property and Casualty Insurance Guaranty Association Model Act, NAIC Model Law # 540 (“PC GA Act”), § 8(A)(1)(a)(i). Almost all states have some provision requiring payment in full of workers’ compensation claims, but some states might have caps or other limitations on coverage.   [↑](#footnote-ref-8)
9. PC GA Act, § 13. [↑](#footnote-ref-9)
10. Alternative 1 applies the pay-and-recover obligation to all third-party claims. Alternative 2 excludes most third-party claims as well as all first-party claims, but requires the guaranty association to pay workers’ compensation claims, statutory automobile insurance claims, and other claims for ongoing medical payments. Alternative 3 excludes only first-party claims and claims by out-of-state claimants that are subject to a net worth exclusion in the claimant’s home state; this alternative does not create any statutory right of recovery when the guaranty association is obligated to pay a third-party claim. [↑](#footnote-ref-10)
11. PC GA Act, § 13(B)(2) Alternative 2. [↑](#footnote-ref-11)
12. PC GA Act, § 8(A)(1)(b). *Compare* LH GA Act, § 3(B)(2)(a), expressly excluding from life and health guaranty association coverage “A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner.” [↑](#footnote-ref-12)
13. Minn. Stat. § 60C.09(2)(4). [↑](#footnote-ref-13)
14. *Terminal Transport v. Minnesota Ins. Guar. Ass’n,* 862 N.W.2d 487 (Minn. App. 2015), *review denied* June 30, 2015. [↑](#footnote-ref-14)
15. Minn. Stat. § 60C.09(3). [↑](#footnote-ref-15)