Statutory Issue Paper No. 35

Accounting for Guaranty Fund and Other Assessments

STATUS
Finalized December 6, 1999

Original SSAP: SSAP No. 35; Current Authoritative Guidance: SSAP No. 35R
This issue paper may not be directly related to the current authoritative statement.

Type of Issue:
Common Area

SUMMARY OF ISSUE

1. Guaranty fund assessments represent a funding mechanism employed by state insurance departments to provide funds to cover policyholder obligations of insolvent reporting entities. Most states have enacted legislation establishing guaranty funds for both life and health insurance and for property and casualty insurance to provide for covered claims or to meet other insurance obligations of insolvent insurers in the state. Guaranty funds generally make assessments after an insolvency based upon retrospective premium writings for Life and Accident and Health Insurance Companies or prospective premium writings for Property and Casualty Insurance Companies. However, a small number of states have guaranty funds that prefund, that is they assess members before an insolvency occurs. Reporting entities are subject to a variety of other assessments, such as workers' compensation second-injury funds and funds that pay operating costs of the insurance department, health related assessments, or the workers' compensation board.

2. State laws often allow for recoveries of guaranty fund assessments through refunds from the guaranty fund, premium tax credits, policy surcharges, and future premium rate structures.

3. Current statutory accounting provides only limited guidance on accounting for guaranty fund and other assessments; requiring that assessments be charged to taxes, licenses and fees, but not addressing when to recognize liabilities for assessments. SOP 97-3, Accounting by Insurance and Other Enterprises for Insurance-Related Assessments (SOP 97-3) dictates GAAP guidance. This issue paper establishes statutory accounting principles for guaranty fund and other assessments that are consistent with the Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy (Statement of Concepts).

SUMMARY CONCLUSION

4. Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets (Issue Paper No. 5), requires accrual of a liability when both of the following conditions are met:

a. Information available prior to issuance of the statutory financial statements indicates that it is probable that an asset has been impaired or a liability has been incurred at the date of the statutory financial statements. It is implicit in this condition that it is probable that one or more future events will occur confirming the fact of the loss or incurrence of a liability, and

b. The amount of loss can be reasonably estimated.

For purposes of subparagraph 4 b., loss generally means assessment or assessment rate. Guaranty fund and other assessments shall be charged to expense (Taxes, Licenses and Fees) and a liability shall be accrued when those criteria are met except for certain health related assessments which shall be reported as a part of claims. Health related assessments that are reported as a part of claims instead of taxes,

licenses and fees are those assessments that are designed for the purpose of spreading the risk of severe claims or adverse enrollment selection among all partic

assessments rests with the policyholder rather than with the reporting entity. The reporting entity's obligation is to collect and subsequently remit the or assessment. When both the following conditions are met, an assessment should not be reported in the statement of operations of a reporting entity:

a.

15. The NAIC Annual Statement Instructions indicate that Taxes, Licenses & Fees should include guaranty fund assessments.

ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

E. (1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent (2%) and for the health account shall not in any one calendar year exceed two percent (2%) of the insurer's average premiums received in this state on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers,

The maximum assessment per year may be varied from state to state depending on the size of the base and the concentration of the business. The two percent maximum assessment per year should produce an adequate amount while at the same time not impose an undue strain in any given year on the assessed companies and their policyholders.

In order to prevent further financial difficult

become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to $10,000, against the Association. The deductible amount ($100) and the maximums ($10,000 for the return of unearned premium; $300,000 for all other covered claims) represent the subcommittee's concept of practical limitations, but each state will wish to evaluate these figures.

[Alternate Section 8A(1)

A. The Association shall:

(1) Be obligated to pay covered claims existing prior to the determination of the insolvency arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the determination. The obligation shall extend to covered claims reported pursuant to an optional extended period to report claims sold to the insured by the liquidator. The obligation as to covered claims shall be satisfied by paying to the claimant an amount as follows:

(a) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(b) An amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium;

(c) An amount not exceeding $300,000 per claimant for all other covered claims.

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 from which the claim arises. Notwithstanding any other provision of this Act, a covered claim shall not include any claim filed with the Guaranty Fund after the earlier of the final date for the filing of claims against the liquidator or receiver of an insolvent insurer or eighteen (18) months after the order of liquidation. The Association shall pay only that amount of each unearned premium which is in excess of $100.]

Comment: The Alternate Section 8A(1) should be used if the state includes a provision in its liquidation law giving the liquidator authority to sell a limited extended reporting period for claims-made policies.

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.

(3) Assess insurers amounts necessary to pay the obligations of the Association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due.

Comment: The maximum assessment per year may be varied from state to state depending on the size of the base. The figure used should produce sufficient funds to handle any possible insolvency, keeping in mind that the total amount may not be needed in one year. The two percent maximum used here would have produced in 1968 on a nationwide basis, from the kinds of insurance to which this Act applies, approximately $500,000,000.

Comment: The subcommittee feels that the board of directors should determine the amount of the refunds to members when the assets of the Association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

19. The 24-Hour Coverage Pilot Project Model Act provides the following discussion of guaranty fund assessments:

Section 15. Guaranty Fund Participation

The twenty-four hour medical insurance policy shall be classified as property and casualty coverage regardless of the carrier approved to provide the coverage. As such, the carrier shall be obligated to participate in the property and casualty guaranty association specified in [insert applicable section providing for participation in the property and casualty insurance guaranty association]. All premiums collected for the twenty-four hour medical insurance policy shall be considered assessable premiums for purposes of participation in the guaranty association. In the event of insolvency of the carrier, the guaranty association shall honor the full extent of the contractual obligation assumed by the carrier under the twenty-four hour medical insurance policy.

Section 16. Special Assessments

A carrier providing coverage to an employer through the twenty-four hour medical insurance policy is obligated to participate in the [insert reference to residual market mechanism, second injury fund or other fund that relies on assessments from workers' compensation insurance premiums]. For purposes of calculation of this special assessment, the commissioner shall establish by rule, or order, the amount of premium generated under the twenty-four hour medical insurance policy which shall be considered assessable premium.

Drafting Note: A state should consider the ratio of the workers' compensation standard premium to the total premium for both workers' compensation and the health insurance plan used by the employer in choosing an appropriate amount. States with relatively small residual market shares for workers' compensation may choose to exclude this section. States should consider loss based assessments, if applicable.

20. The Health Maintenance Organization Model Act contains the following:

Section 33. Insolvency Protection; Assessment

A. When a health maintenance organization in this state is declared insolvent by a court of competent jurisdiction, the [commissioner] may levy an assessment on health maintenance organizations doing business in this state to pay claims for uncovered expenditures for enrollees who are residents of this state and to provide continuation of coverage for subscribers or enrollees not covered under Section 15. The [commissioner] may not assess in any one calendar year more than two percent (2%) of the aggregate premium written by each health maintenance organization in this state the prior calendar year.

B. The [commissioner] may use funds obtained under Subsection A to pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under Section 15, and administrative costs. The [commissioner] may by regulation prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

C. (1) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(2) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the [commissioner] to the extent of the benefits received. The [commissioner] may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The [commissioner] is subrogated to these rights against the assets of an insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(3) The assignment of subrogation rights of the [commissioner] and allowed claim under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

D. When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the [commissioner] will distribute on a pro rata basis any amounts received under Subsection

OTHER SOURCES OF INFORMATION

23. The draft discussion material from previous Property/Casualty codification projects provides the following guidance:

> CHAPTER X
> GUARANTEE FUND AND OTHER ASSESSMENTS
>
> The expense for guarantee fund and other assessments should be reported as taxes, licenses and fees in the annual statement (and not as loss payments) when incurred. Specific assessment practices differ from state to state. In general, however, when an assessment is made, in addition to the amount requested, an estimate of the ultimate range of assessment may be indicated. Experience has shown that these ranges may change dramatically within a short time frame. The expense is incurred when an insolvency has occurred, an assessment is probable, and the amount can be reasonably estimated.
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> Accounting for Guarantee Fund and Other Assessments
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> Guarantee fund and other assessments are incurred, must be expensed, and a liability established when the following criteria are met:
>
> a. An insolvency has occurred which creates an obligation for a state guarantee fund. This obligation will usually be evident when a company receives a court order for liquidation.
>
> b. Information available indicates that it is probable that a liability has been incurred.
>
> c. The amount of the liability can be reasonable estimated.
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> The amount accrued must reflect the ultimate liability expected from the insolvency. The accrual will be determined net of anticipated premium tax offsets.
>
> If it is probable that a liability has been incurred from an insolvency, but it can not be reasonable estimate, a footnote should disclose the nature of the contingent liability and shall express the potential range of the anticipated loss exposure, when the potential liability is deemed material.
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> Reporting for Guarantee Fund and Other Assessments
>
> The expense for guarantee fund and other assessments should be reported as taxes, licenses and fees in the annual statement (and not as loss payments) when incurred.
>
> Assessment for which the Insurance company acts as Agent for the State
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> In certain circumstances, an insurance company acts as an agent for certain state agencies in the collection and remittance of fees or assessments. In these circumstances, the liability for the fees and assessments rests with the policyholder rather than with the insurance company. The insurance company's obligation is to collect and subsequently remit the fee or assessment. These situations differ from a premium tax liability whereby the insurance company is required to remit the premium tax whether or not the premium has been collected.
>
> When both the following conditions are met, an assessment should not be reported in the statement of operations of an insurance company:
>
> - The assessment is reflected as a separately identifiable item on the billing to the policyholder; and

- Remittance of the assessment by the insurance company to the state is contingent upon collection from the insured.

24. NAIC Technical Resource Group Proposed Draft Life Codification provides the following guidance in Chapter 22, General Expenses and Taxes, Licenses and Fees

6. All other taxes will include guaranty fund assessments and taxes of Canada or of any other foreign country not specifically provided for elsewhere. Guaranty fund and other assessments must be expended and a liability established when the following criteria are met:

- An insolvency has occurred which creates an obligation for a state guaranty fund; this obligation will usually be ev

State Regulations

- No further guidance obtained from state statutes or regulations.

Other Sources of Information

- Draft discussion material from previous Property/Casualty Codification Projects, Chapter X, Guarantee Fund and Other Assessments
- NAIC Technical Resource Group Proposed Draft Life Codification, Chapter 22, General Expenses and Taxes, Licenses and Fees

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