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Chairperson's Corner

by Bernie Rabinowitz

I often wonder how our profession can play a greater role in today's healthcare industry.

When I was an actuarial student in South Africa, the CEOs of the major insurance companies were actuaries. Business acumen and intellect combined with a practical knowledge of risk and adverse selection theory put actuaries at the forefront of the insurance business. In fact our actuarial risk models were a major driver of the business.

Today things are more complicated. We are operating in a changing healthcare environment. Our industry has to effectively manage provider networks, satisfy

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A Health Insurance Insolvency Case Study

By Bill Howard

Editor's note: Portions of this article originally appeared in the *NOLHGA Journal.*

The Centennial Life Insurance Company was a Kansas-domiciled group health and long-term disability insurer that was placed in rehabilitation and then liquidation in 1998 by the Kansas Insurance Commissioner. Licensed in the District of Columbia and all states except Maine, New York, and Rhode Island and previously licensed in Puerto Rico, Centennial presented new challenges to the life and health insurance guaranty association system. It was the first major health insolvency that the guaranty association system faced since the passage of the Health Insurance Portability and Accountability Act of 1996.

What Happens When a Health Insurance Company Fails?

Life and health insurance guaranty associations are organizations created by state legislatures to protect the policyholders and beneficiaries of an insolvent insurance company, up to specified limits. By

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law in each state, the District of Columbia and Puerto Rico, all insurance companies licensed to write life or health insurance or annuities in a state are required to be members of the guaranty association. If a member company becomes insolvent, money to continue coverage or pay claims is obtained through assessments of other insurance companies writing the same lines of insurance as the insolvent company.

Life and health insurance guaranty associations cover individual policyholders, their beneficiaries, and certificate holders of insurance issued under group life or group health insurance policies. State law establishes limits on benefits and coverage.

All life and health insurance guaranty associations protect residents of their own states, provided the company was ever licensed there, regardless of where the failed insurance company is headquartered. If a policyholder has moved to a state where the company was never licensed, the guaranty association in the state where the company is domiciled provides protection.

Guaranty association coverage limits vary by state. The NAIC model act that most states follow sets limits of $100,000 for health insurance benefits, including disability benefits.

Guaranty associations provide coverage when a company has been declared insolvent and ordered liquidated by a court of law. Before benefits can be paid, associations must perform due diligence on who is insured and the type of coverage issued. Guaranty associations obtain this information from the receiver who has taken control of the failed company.

In most cases guaranty associations provide coverage as long as premiums are paid. They may do this directly, or they may transfer the policies to a solid insurance company. In any case, policyholders must continue making premium payments to keep their coverage in force.

How Does the Guaranty Association System Work?

The insurance commissioner, charged with monitoring and regulating insurance activities, determines when an insurance company domiciled in his state should be declared insolvent. The commissioner obtains authority from the state court to seize control of the company and operate it pending resolution of the insolvency.

When the insurance commissioner obtains control of a company, he is, by law, the rehabilitator of the company and may retain someone to serve as receiver to supervise the company's activities. The receiver may be either an independent professional or an employee of that state's department of insurance.

The guaranty association cooperates with the receiver in determining whether the company can be rehabilitated. If the receiver determines that further operation of the company would be hazardous to the policyholders, and that further efforts to rehabilitate the company would be futile, the company must be liquidated. When the court issues a liquidation order, the guaranty associations are "triggered" and step into the shoes of the failed insurance company to pay claims and continue coverage.

To obtain funds to pay claims and continue coverage, the guaranty associations assess the member companies in their state, typically up to 2% of premiums per year, averaged over the three years before the insolvency.

All 52 guaranty associations are voluntary members of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), a non-stock not-for-profit Virginia corporation with offices in Herndon, about 30 miles west of Washington, D.C. When an insolvent company is licensed in multiple states, NOLHGA establishes a task force of representative guaranty associations, whose members and their accounting, actuarial and legal advisors work with the receiver to develop a plan to protect policyholders.

What Is An 'Ideal' Insolvency?

NOLHGA has been involved in more than 30 multi-state insolvencies in the past 10 years. In reviewing their experience, NOLHGA staff and consultants identified 10 characteristics of an "ideal insolvency."

The "ideal" insolvency has the following characteristics:

1. Good relationships between the task force and the receiver
2. Good policy records
3. Few uncovered obligations
4. Facts and solution are clear and agreed on by the receiver and the task force
5. Joint solicitation of proposals and negotiation of an assumption reinsurance agreement with a strong reinsurer
6. No resistance to a court order of liquidation with a finding of insolvency
7. Prompt regulatory approvals of agreements among the receiver and the affected guaranty associations
8. Quick closing to move policyholders to a solid insurer
9. Guaranty associations obligations fully satisfied at closing
10. Task force involvement in asset recovery

How Did NOLHGA's Experience in the Centennial Life Insolvency Compare to the Ideal?

Because Centennial was NOLHGA's most significant national health insolvency, the task force faced many complicated legal, financial, and administrative issues that had not been faced before or even if they had, not to that magnitude. Centennial presented a variety of claim types, difficulty in calculating benefits, and complexity of valuing blocks of business. Centennial also demanded time and resource consuming efforts at processing and adjudicating claims. Customers were understandably dissatisfied during the delays in claim payments.

Interestingly, none of the insolvencies analyzed to produce the "ideal insolvency" criteria was a major health insurance insolvency.

What are the differences between an insolvency involving primarily group health insurance from one involving primarily life insurance or annuities?

How did the fact that most of the health insurance in Centennial was cancelable complicate, rather than simplify, the work of the task force?

1. From the beginning, the relationship between the Centennial receiver and the NOLHGA task force has been very effective and productive. This relationship began before the task force was formed, with meetings among NOLHGA staff, the MPC chair,[1] and the receiver. Soon after the task force was formed, a working group met with the receiver to discuss how the task force and receiver could best work together, and how resources could be shared.
2. Data on in-force coverages was adequate, but good data on the existing claim backlog, the number of claims processed per week, and duplicate claims filed did not exist at the beginning of the Centennial rehabilitation. This insolvency has remained "information challenged." The lack of solid information on how long before a particular claim would be processed was a continuing source of frustration for policyholders, benefit providers, guaranty association administrators, the task force and the receiver. In recent life and annuity insolvencies, basic policyholder records have been readily available. Even where the insolvent company's systems were inadequate, the task force could obtain accurate data on in-force life insurance and annuity policies, from which it could develop its own database. The wide variety of health insurance coverages in the Centennial health block (approximately 200 policy forms, with approximately 2,000 variations) resulted in claims showing a high error rate, which slowed claim processing, due to the need for internal review (initially) of 100% of claims over $100.
3. Centennial had only a small number of completely uncovered health claims, arising from policies sold to foreign nationals. Until the last health claim is filed, we will not know how many claims may exceed individual guaranty association limits. Fewer than 50 LTD claims exceed guaranty association limits. Some of these LTD claims are substantially over limits, however, and had the estate not recovered significant assets, these claimants faced significant reductions in monthly payments once the guaranty association limit was reached. Nonetheless, more than 90% of policyholder claims were 100% covered by the guaranty associations.
4. The urgent problems facing the receiver and the guaranty associations were clear, and the receiver and the task force quickly reached agreement on the solution. It was essential for guaranty associations to begin payments to the approximately 900 LTD claimants with minimal interruption. Less than 15 days after the May 27, 1998, liquidation order, guaranty associations began making LTD payments. The first claim payments on the Centennial Health block were made within 60 days of the liquidation order date. The need for prompt payment of health claims had to be balanced with the guaranty associations' perceived duty to make the correct payment. This inevitably caused delay, because the initial claims audit revealed an unacceptable error rate on claims that had been processed before the liquidation order and were awaiting payment. Again, the facts and solution were clear and agreed on. Because of the extensive variety of coverages, no commercial third party administrator could offer a promise of expedited claims adjudication. The receiver and the task force agreed that the best – indeed, the only – solution was for the receiver to process claims using the former Centennial claims personnel who knew the products and the system.
5. There were only two blocks of insurance that could be transferred to another carrier: the LTD block and the "other block" consisting of a small number on juvenile life policies, hospital indemnity policies, medical conversion policies, and live conversion policies. The receiver and the task force agreed on a plan to place these blocks, and the receiver agreed to fund the transfer with an early access distribution.[2]
6. Fortunately for the policyholders, there were no objections filed to the rehabilitator's April 21, 1998 petition for liquidation, and the liquidation order was approved from the bench the day of the hearing, May 27, 1998.
7. The liquidation court promptly approved the service agreement and the early access agreement negotiated between the task force and the receiver. The court also promptly approved the assumption reinsurance agreement for the "other block."
8. To the great frustration of policyholders, regulators, guaranty associations, the receiver, and the task force, this solution, which presumes an assumption reinsurance agreement for most if not all the guaranty associations' covered obligation, is simply not feasible when most of the health insurance is cancelable. Instead, the guaranty associations must act within the constraints of HIPAA[3] and their state laws regarding cancellation of group health insurance coverages. Although the guaranty associations have the same rights to cancel or non-renew group health coverages as do the companies, perceived political pressure often causes state insurance departments to delay approving cancellation.
9. Because most of the business could not be transferred by assumption reinsurance, the guaranty associations faced a long tail of health claims, stretching more than 18 months beyond the liquidation order date. Instead of a single closing, guaranty associations had to fund payments

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monthly to LTD claimants and health insurance claimants.

10. The Centennial estate's largest asset was a $35 - $40 million receivable from its primary reinsurer, who had stopped claim payments before the rehabilitation order due to a dispute with Centennial's former owners. The receiver and the task force negotiated a common interest agreement, under which the receiver was able to discuss his litigation strategy with the task force. This enabled the receiver to draw on NOLHGA's experience in other insolvencies. The receiver and the reinsurer ultimately settled for a $36 million payment by the receiver to the Centennial estate.

What Lessons Did Centennial Teach Us?

A few words of caution. First, this article has room for only a few highlights of what the task force, in cooperation with the Kansas receiver, did to satisfy guaranty association obligation under Centennial's health block and to get the thousands of claimants paid as promptly as possible. Second, no two insolvencies are alike, and it is impossible to take the task force's experiences in Centennial and try to establish a set of "rules" to follow in the future. Third, the guaranty associations have not yet satisfied all their obligations. Although virtually all the group health insurance claims have been adjudicated, and fewer than 100 certificates remain in force, the LTD claims are still being paid monthly by the guaranty associations. The task force and the receiver have only recently turned their attention to seeking a long-term solution to administering and paying those claims. Fourth, any opinions expressed are those of the author and do not necessarily reflect the views of the Centennial receiver, the task force, or NOLHGA.

Unlike life insurance or annuity coverages, where there is little demand for cash value benefits, LTD and health claims require that the guaranty association begin making payments immediately. When a new insolvency involves health coverages with immediate payment demands, there are five important elements of the task force and receiver joint work plan. Each of these elements includes issues, factual and legal challenges, and financial implications for receivers, guaranty associations, and the policyholders and claimants on whose behalf the receivership guaranty system toils.

First steps must include the following:

1. Policyholder communications— Inform policyholders about the current situation and plans for stabilizing it.
2. Claim payments — Start paying claims, and pay them regularly.
3. Short-term administrative arrangements — Rely on existing servicing relationships while conducting due diligence on policy forms, in-force lists, etc.
4. Long-term administrative arrangements — Select a claim processing servicing agent for the long term.
5. Improve administrative arrangements — Enhance claim-processing procedures and institute an audit or quality control process.

More specifically, here are my views on the priorities and order of decisions:

1. The task force must make a quick assessment of the situation to determine:
   - Status of claim handling and backlog
   - Quality and reliability of existing external relationships
   - Adequacy of estate assets to pay current claims
   - Number and amount over-limits claims
2. The task force must develop short-term plan with the receiver, under which the receiver would process claims over short term.
3. The receiver and the task force must develop joint communications with policyholders, claimants and providers.
4. Source of funds for claim payments:
   - If estate assets are to be used to pay claims, negotiate an early access agreement and implement procedures for guaranty association approval of early access claim payments.
   - If guaranty associations are to fund claim payments, implement procedures for guaranty association review, approval, and funding of claim payments.
   - Work closely with claim processor on initial claim batches to ensure correctness of matching explanation of benefits (EOBs) with checks and guaranty association or receiver reporting. Establish a procedure for guaranty association review of EOBs and inclusion of guaranty association name on the EOB or check as the source of funds.
   - Establish a mechanism for restricting claim payments to guaranty association limits early in the liquidation.
5. Evaluate and continue or revise or terminate existing external relationships with drug card providers, discount service providers and third party administrators.
6. Evaluate the receiver's ability to provide long-term claim processing; consider outside third party administrator alternatives.
7. Evaluate methods to reduce any claims backlog.

What Lessons Were Learned?

1. Health insurance company insolvencies bring a potential for claimant complaints and anxiety that does not exist in a life insurance or annuity company insolvency. The best (and maybe only) way to mitigate that potential is to have sound communication to all interest groups and to make timely claim payments. Reducing the claim backlog should be the number one goal.

2. Another goal should be minimizing the number of changes to pre-insolvency policy service and claim handling procedures so that policyholders and claimants do not suffer unnecessary confusion or disruption of service. Significant administrative changes can cause communication headaches and repetitive claim handling steps that may contribute to payment delays. It is also important to create a system for reviewing disputed (or appealed) health claims in such a way that the initial processing of original claims is not interrupted.
3. The administration of health business is almost always more complex and difficult to manage than anyone thinks at the beginning of the process. That usually leads to an underestimation of the time required. It is very important that the receiver and task force take the time to evaluate all external relationships the insolvent company had (such as discount service providers, drug card providers).
4. Given the amount of guaranty association money being disbursed periodically to claimants, the task force should consider some kind of outside audit or quality control process to give comfort to the guaranty associations. The guaranty associations in a health insolvency where no transfer of obligations is feasible must fund their obligations every month until all claims are paid. The guaranty associations writing the checks need assurance that the process is producing reliable data.
5. Any agreement that is reached with a servicing agent, either the receiver or an outside TPA, should clearly specify the accounting of post-liquidation premiums, including unearned premiums on the liquidation order date. Those premiums belong to the guaranty associations, which must assure its proper accounting and protection.
6. A task force should consider having a representative on site at the beginning of the process to monitor the policy service and claim handling functions and to give appropriate feedback, both to the servicing agent and to the task force.
7. As with so many other areas of insolvency practice, coordination between the receiver and the guaranty associations leading up to the entry of a liquidation order is very important in a health insolvency. The short-term nature of the health policy obligations calls for quick communications with policyholders and claimants on policy service and claims handling to prevent massive confusion, even panic, among policyholders, claimants, providers, regulators, and others. The receiver and the guaranty associations have to be on the same planning and communication page so that the stage is set for a thorough examination of the situation once the initial communications have stabilized the situation.
8. Another question that should be examined initially is whether there will be any kind of temporary moratorium and if so, whether there should be a set of hardship exceptions sanctioned by the receiver or the receivership court. If so, the task force should attempt to preserve as much flexibility as possible to accommodate state-by-state guaranty association requirements on hardship payments, since decisions about which claims should be paid in the face of a post-liquidation moratorium rest ultimately with the affected guaranty associations.
9. A single claims-paying procedure will not satisfy all guaranty associations, hard as task forces might try. Communication is important in insuring that the multiplicity of guaranty association payment procedures does not cause problems for everyone, including the receiver. A task force should recommend to the guaranty associations one payment method and explain clearly how uniformity is a plus in reducing the policy service and claim-handling backlog that almost always accompanies a major health insolvency. Nevertheless, any plan must accommodate the requirements of individual guaranty associations.
10. In a health insolvency, the servicing agent, whether the receiver or an outside third party administrator, should receive clear instructions from NOLHGA on what should be said and not said about guaranty involvement, procedures, limits, and coverage.
11. Policyholder communications are particularly important when there is a significant claim backlog and policyholders and claimants are calling the insolvent company constantly asking about the delay. There must also be consistent uniform and clear communications with providers.

The above summarizes some of the lessons NOLHGA learned in one major health insolvency. The atmosphere is markedly different from what the guaranty association faces in a typical life insurance or annuity company insolvency. The on-going experience in Centennial should serve as a guide for future health insolvency task forces.[4]

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[1]The NOLHGA Members' Participation Council consists of the guaranty associations affected by an insolvency. The MPC meets quarterly to hear progress reports by task forces and to take action on task force recommendations. The MPC chair is a guaranty association administrator, elected by the guaranty associations, and serves for one year.

[2]Under the liquidation act in most states, the receiver may make distributions to guaranty association before final determination of the amounts payable to the claimants in each class under the state's priority scheme. The guaranty associations and the receiver negotiate an early access agreement, under which the guaranty associations agree to return funds to the estate if the receiver needs them to make payments to claimants of equal or higher priority than the guaranty associations.

[3]The federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-91, 110 Stat. 1936 (codified as amended in scattered sections of 29 U. S. C. and 42 U. S. C.), places restrictions on the cancellation of health insurance. This act establishes minimum standards; each state may establish more restrictive standards.

[4]One year later, the task force for a smaller health insurance company insolvency benefited from the lessons learned in Centennial to fully satisfy virtually all guaranty association obligations in 99 days.