THE INSURANCE RECEIVER

INTERNATIONAL ASSOCIATION OF INSURANCE RECEIVERS
PROMOTING PROFESSIONALISM AND ETHICS

VOLUME 26 | NUMBER 2

IN THIS ISSUE

President's Message 1

@IAIR, #Whatsapp?
#SummerVacay
or #TheDailyGrind?? 2

Warr Penn – Warping the Statute 4

IAIR Designation Program 10

Kopp Named New Executive
Director of Missouri
Insurance Guaranty Association 11

Navigating
"The Quiet Times" 12

THE PERFECT RECIEVER NO 20
will you still feed me?
(when i'm 64) 14

Manufacturing Predictability
and Stability for Insurance
Business Transfers in Oklahoma 20

Board Members / Officers 22

Corporate Sponsors 22

James Kennedy, Esq.

PRESIDENT'S MESSAGE

As I write this, the Summer NAIC meeting is just days away. On August 3, IAIR and AIRROC will host our annual Joint Issues Forum, which will include a discussion of the runoff market, news from the New York Liquidation Bureau, a federal update, and the impact of cannabis legalization (no samples will be provided). Thanks to Kathleen McCain for her work in organizing these programs.

There will be much interest in two developments at the NAIC meeting. The first is the Long-Term Care Insurance Task Force, which was recently created to deal with long term care insurance issues. The Task Force will focus on developing a consistent national approach for reviewing long term care rate requests. It will also coordinate with the Restructuring Mechanisms Working Group to explore options to address inequities resulting from differing rate approval processes. The Restructuring Mechanisms Working Group is evaluating laws that permit insurance business transfers (IBTs) or corporate divisions of insurers, which have been enacted by several states. The impact of an IBT or a corporate division on guaranty association coverage is one of the critical issues that has been identified.

Looking beyond the Summer meeting, IAIR will be accepting nominations for the Board of Directors in September for three-year terms beginning in January 2020. Terms for five positions will be open, so nominate yourself, your colleagues, friends or frenemies.

In December, IAIR plans to hold a professional development event on identifying "red flags" of troubled insurers in conjunction with the NAIC meeting in Austin, Texas. This will be similar to the successful event that IAIR hosted in 2013 in Indianapolis. Work is also underway on next year's Insurance Resolution Workshop, 2020: Bringing receivership challenges into focus. The workshop is co-chaired by Jan Moenck and Doug Schmidt, and will be held Feb 26 -28, 2020 in historic Charleston, South Carolina.

I look forward to seeing you in New York!

@IAIR, #WHATSAPP? #SUMMERVACAY OR #THEDAILYGRIND??

By Amanda Barbera, Executive Director of Indiana Ins. Guar. Assoc. and Indiana Life and Health Ins. Guar. Assoc.

Let's talk about social media

With over 50% of the U.S. adult population using social media, it's not something we can ignore. Social media is becoming an intrinsic part of how our population obtains, consumes and shares information. It has created a goldmine of data for marketers, politicians, and others who have more nefarious purposes. It can make, disrupt or break a business or a career. It can build consensus for or against an idea, a person, a company, or a product. If we don't learn to use it and use it responsibly, then we are foolish. We may think we can avoid it altogether, but we can't. The use of social media has become such a pervasive part of our national and global culture, our way of conducting business, our way of sharing information that we cannot ignore it any more than we can ignore technology, digital information, and the Internet.

WHAT IS IT?

Social media is plural. They are Internet-based technologies that facilitate user-generated content and allow sharing of information, ideas, photos, videos, and other content which is allowed by a specific organization which owns the application or website. Wikipedia identifies 13 types of social media: "blogs, business networks, collaborative projects, enterprise social networks, forums, microblogs, photo sharing, products/services review, social bookmarking, social gaming, social networks, video sharing, and virtual worlds." (Wikimedia Foundation, 2019)

Traditional media (e.g. print, radio, TV) communicate ideas and information in monologue form. The source transmits the message without allowing interaction. Social media allows interaction and the creation of human networks.

WHO USES IT?

Twitter and Facebook are two of the most commonly recognized social media applications and much of the literature published in the last decade about the demographics and behavior of social media users has focused on use of these applications. The results of studies may be skewed by the source of funding, the purpose or objective, geographical location of the population, survey method, and other factors. One thing is clear. The use of social media, number and types of social media applications, and characteristics of those using social media have evolved rapidly. Pew Research Center has tracked social media platforms for over ten years. They report in their 2019 Fact Sheet that 72% of the public uses some type of social media. (The Pew Charitable Trust, 2019) While young adults were the earliest adopters of social media, older adults have begun using social media applications as social networks evolved and the benefits seemed more relevant. According to the Pew Research Center's 2019 survey, 90% of adults

under 30, 82% of adults in the 30 to 49 age group, and 64% of adults in the 50 to 64 age group use social media. As more adults have adopted social media, the demographics have become more representative of the general population in characteristics such as gender, race, income, and location.

WHERE AND WHY ARE THEY USING IT?

The most predominately used social media platforms are Facebook, and YouTube. (The Pew Charitable Trust, 2019) Other platforms commonly used include Instagram, Pinterest, LinkedIn, Snapchat, and Twitter. Some of you may also be familiar with WhatsApp, Reddit, GoFundMe, Flickr, Tumblr, Google+, Foursquare, or Giphy. There are also platforms, e.g. Hootsuite, which provide integration services, resources and tools to help businesses mange their online social media presence and messaging strategy.

Social media has a significant impact on how people share health information and interact with health networks, obtain news and gather information, participate in political and civil dialogue, form opinions and build consensus, initiate or join activist movements, develop and maintain personal and professional relationships, interact with businesses and government, and remain connected to social networks and nonprofit organizations. Social media can be used to influence elections, provide instruction to those affected by a local emergency, build a social movement that changes our values and our culture, facilitate a more informed or a more misguided population, and enable people or a business to provide a benefit to a person or segment of society that needs it most.

The increasing number of social media apps and predominate use of mobile devices place greater importance on the end-user experience. Smart businesses will learn how consumers locate and digest information and which platforms are most used by the business' target market or audience. Content must be visibly appealing, easily consumed, effortlessly interactive, concise, relevant, and engaging enough to bring the consumer back for more. Smart business owners will recognize that professional help from a social media expert may be needed to develop and implement a communication strategy. Where do we find these experts? You will probably find a social media strategist in a marketing company, a business consulting company or a business school. Small businesses might want to consider offering an internship to a promising young student at their local university.

HOW SHOULD I USE IT?

Responsible use of social media isn't much different than responsible use of the Internet. Be wary and cautious of links, videos, games, and downloads from unfamiliar and unknown sources. Keep your comments positive and be respectful of others. Report inappropriate content. Pause before you post. Find websites that educate on appropriate use of social media. Hootsuite is a great educational resource for adults and #ICANHELP is a website that helps students learn to use social media in a positive and safe way. If you don't understand the lingo, check out "All the social media definitions you need to know" at Hootsuite (https://blog.hootsuite.com/social-media-glossary-definitions/). Verify your information and validate sources before you post or repost/repeat something. Refrain from giving legal advice. Avoid violating any intellectual privacy (IP) laws, e.g. copyright laws. Don't affiliate your job with your personal medial profile. Investigate your privacy rights and the security policies of each social media platform. Familiarize yourself with the security and privacy settings in the social media apps on your devices and the sites you use. Read the small print before clicking.

THE FUTURE IS NOW

NAIC published an article on social media in 2015. They commented on the use of social media by insurance companies to increase visibility, promote their image and build trust with their customers, brand their products and expand market presence, provide customer service, and communicate with their customers and target markets. (https://www.naic.org/cipr_topics/topic_social_media.htm) Insurers also use social media to identify fraud, enhance underwriting and predictive analytics, improve the claim process, and disseminate post-catastrophe information. In the past decade, the insurance insolvency resolution system recognized our need to accommodate digital policy and claim information contained in imaging systems. Today, we need to learn how to leverage the information assets collected by insurers through social media and how we can use social media to communicate with policyholders, claimants, and other participants in the insurance insolvency resolution system.

WARR PENN – WARPING THE STATUTE

Douglas Hartz, Deputy Ins. Commissioner, WA Office of Insurance Commissioner

INTRODUCTION

Some of you may be familiar with the acronym RTFS. For those who are not, and keeping it clean, we will say it stands for "read the freaking statute." This story covers how the NAIC sent out a survey in December of 2018 on how to read a particular freaking statute involved in the Penn Treaty / ANIC proceedings (PT Liquidation), Washington responded in early 2019, and then the parties in PT Liquidation focused on how the statute would only apply to the over the guaranty-association-cap-claims (over the cap claims) in the PT Liquidation.

In fact, on or around May 22, 2019 the ACLI filed an Amicus in support of the Liquidator in the PT Liquidation on why the assets there should be used to cover the over the cap claims. Retrieved from https://www.penntreaty.com/Portals/0/ACLI%27s%20Application%20for%20Leave%20to%20File%20Amicus%20Curiae.pdf. This brief may be one of the best explanations of why Long Term Care insurance (LTC of LTCi) is so critical to so vulnerable a population. It also does a remarkable job distinguishing LTC coverages from the type of contractual liability insurance policies with which the Warrantech case (and many other warranty cases with which the author has been involved) related. There are other issues on over the cap claims, like what could be done if some percentage of the total claims in an estate are over the cap claims. The author also has had some experience with these situations, but that will need to wait to be covered in a future article.

It is a very good thing that the parties in the PT Liquidation focused on the over the cap claims, because the survey and our response to it were apparently based on the idea that the arguments would apply to the whole of the claims and not just the over the cap part, and on that basis there would be enormous damage to consumers. But, limiting the scope of the arguments may not affect the arguments about why this would be so damaging to consumers. Disadvantaging those with over the cap claims may be damaging the most vulnerable of a vulnerable population of consumers.

We will cover the survey, our response and some very brief (because that alone will cover several pages) conclusions below.

THE SURVEY

On about December 10, 2018 the NAIC sent out a survey to the states similar (some of what was in the original survey was read, as is shown in []'s below, to make sense to us in Washington, not that it will necessarily make sense to everyone) to what follows to the receivership folks in the states.

At the 2018 Fall National Meeting, the Receivership and Insolvency (E) Task Force discussed comments received regarding the Pennsylvania Supreme Court's decision in *Warrantech Consumer Products, Inc. v. Reliance Ins. Co. in Liquidation*, 96 A.3d 346 (Pa. 2014), and it's potential application to the Penn Treaty / ANIC liquidation and other long-term care insurance insolvency proceedings. The Task Force agreed to monitor the status of the [PT Liquidation] and survey the states regarding the continuation of coverage provisions in states' laws.

The *Warrantech* decision, Pennsylvania provision and related IRMA & IRLMA Model provisions [were] attached [to the survey email sent].

Specifically, the Task Force request[ed] the following survey information from states:

1. Whether your state has a continuation of coverage provision substantially similar to IRMA Section 502B, a prior version of Model #555, or language with similar characteristics as PA's law. E.g., does the provision provide:
    a. An exclusion for life, disability income, long term care or health insurance or annuities?
    b. That [certain coverages will not] continue in force unless further extended by the receiver with the approval of the receivership court?
    c. That [certain coverages will] continue in force only with respect to the risks in effect at that time?
2. Please provide the specific language and/or citation of your state's continuation of coverage provision.
3. Whether there have been any court cases interpreting and applying your state's continuation of coverage provisions. If so, please provide case name and citation.
4. Please provide any additional relevant information specific to your state's provision.

THE SURVEY RESPONSE

After some extensions, Washington State submitted the below response to the RITF survey above.

This response addresses each survey question in separate sections and uses an Exhibit to show the origin and evolution of the continuation of coverage or cancellation provision. The email by which responses to this survey were requested is reproduced [above]. The problem set this touches upon is extremely multi-faceted. Thus, there will be issues and aspects of issues that will not be dealt with in this response, despite its relative length.

This response is from the solvency condition and receivership perspectives and may not incorporate other regulatory perspectives. Differing perspectives could exist within this office as much as they could in other departments of insurance in the state-based national insurance regulatory system. That noted, from a receivership perspective this appears to take what was intended to be a consumer protection provision (originating in what was the NAIC Model Act from December 1968 to December 1977, the Wisconsin Insurer Receivership Statute) and turn it "180-degrees on its head" into an expediency provision that would likely lessen the obligations of guaranty associations, insurers paying assessments into those guaranty associations, and the resulting (where available) premium tax offsets, but at the cost of leaving large numbers of consumers with no recourse from what could be very damaging to them.

There is a good measure of explanation provided here. Mostly this is because there appears to be a need for some clarity to be made available regarding the issues with, especially, the possible application of the continuation or cancellation of coverages to long-term care (LTC) policyholder obligations and benefits. The possibility that many LTC coverages could be cancelled by application of an insurer receivership statute would be damaging to every segment of the insurance industry (Life & Annuity, Health and Property & Casualty) because the public (in most states – if not all states) does not distinguish between these segments or different industries. For most, LTC insurance is just insurance, meaning a failure to pay claims or to continue to provide insurance policy benefits or coverage in relation to LTC insurance will affect the public's confidence in every type of insurance.

1. In response to **survey question 1.a**, Washington State has a continuation of coverage provision that appears to have been based on the version of NAIC Model #555 in effect in 1993 (a.k.a. a version of the Insurer Rehabilitation & Liquidation Model Act or IRLMA). That continuation of coverage provision is under RCW 48.31.125. This RCW section is set out below (next page) to respond to survey question 2, although **survey questions 1.b &c and 3 and 4**, are addressed further below. This RCW is also shown in the attached, "Exhibit A to Washington State Response to RITF Survey Sent December 10, 2018," in that Exhibit's Segment 3.

RCW 48.31.125
Order of liquidation—Termination of coverage.

(1) All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation continue in force only until the earliest of:
(a) The end of a period of thirty days from the date of entry of the liquidation order;
(b) The expiration of the policy coverage;
(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;
(d) The liquidator has effected a transfer of the policy obligation; or
(e) The date proposed by the liquidator and approved by the court to cancel coverage.
(2) An order of liquidation terminates coverages at the time specified in subsection (1) of this section for purposes of any other statute.
(3) Policies of life or health insurance or annuities shall continue in force for the period and under the terms provided by an applicable guaranty association or foreign guaranty association.
(4) Policies of life or health insurance or annuities or a period or coverage of the policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2) of this section.
[1993 c 462 § 62.]

RCW 48.31.125(1) does not reference the "disability income, **long term care**" phrase noted in the survey question, however, that **may not mean** that such coverages would be subject to being cancelled within 30 days of the entry of a liquidation order. The cancellation of such coverages would, very likely, be very detrimental to the consumer / insurance policyholder who would, very likely, be unable to find any replacement coverage because of changes in circumstances or deteriorations in health, or be unable to find replacement coverage at a cost that would not be excessive.

2. In response to **survey question 1.b**, under RCW 48.31.125(2), an order of liquidation terminates coverages

at the time specified in RCW 48.31.125(1) for the purposes of any other statute.

Washington State does not have a provision that, "That [certain policy coverages] shall continue in force unless further extended by the receiver with the approval of the receivership court" because under the current version of NAIC Model #555 (a.k.a. the Insurer Receivership Model Act or IRMA) Section 502B (which Washington State has not adopted) it is, "Notwithstanding any policy or contract language or any other statute, all policies, [that would expire after 30 days]" that will continue in force. This part of 502B is new and it is a new idea that a receiver, with court approval, could extend the coverages of some insurance policies issued by an insurer that has gone into liquidation. This increases the ability of the receiver to reduce consumer hardships. Such seems to be in line with the purpose of the "continuation of coverage" provision from its inception.

The provision in Washington State goes on, and under RCW 48.31.125(3) provides, "**life insurance or health insurance or annuities** shall continue in force for the period and under the terms provided by an applicable guaranty association or foreign guaranty association. Further, **policies of life or health insurance, or annuities**, or a period or coverage of the policies not covered by a guaranty association or foreign guaranty association shall terminate under RCW 48.31.125(1) and (2)."

All of these provisions together reflect an intent to make sure that innocent policyholders (who may have invested large sums, over the course of many years and even decades, into these policies with an expectation that they would ultimately benefit from these policies) are not cut off. Such would likely lead to stories that an insurer just takes your money and then goes into receivership before you can get any of the benefits you paid for.

3. In response to **survey question 3**, we are not aware of any court cases interpreting and applying our state's continuation of coverage provisions.

4. Finally, in response to **survey question 4**, "any additional relevant information specific to your state's provision," the purpose and history of the provision here is relevant.

The 1993 Washington State legislation on the continuation of coverage provision was written as is shown further below. This was retrieved from - http://lawfilesext.leg.wa.gov/biennium/1993-94/Pdf/Bills/Session%20Laws/House/1855-S.SL.pdf?cite=1993 c 462 § 62 (last visited 1-31-2019).

NEW SECTION. Sec. 62. (1) All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation continue in force only until the earliest of:

(a) The end of a period of thirty days from the date of entry of the liquidation order;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The liquidator has effected a transfer of the policy obligation; or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order of liquidation terminates coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for the period and under the terms provided by an applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or a period or coverage of the policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2) of this section.

The above and the versions of the continuation of coverage provision set out in the attached, "Exhibit A to Washington State Response to RITF Survey Sent December 10, 2018," show that while there were some changes form the Wisconsin provision (i.e. 15 days to 30 days), the overall concept that consumers should be protected from having coverages, ones that they cannot easily replace, cancelled without any real recourse, remains. Protecting them from the damage cancellation would cause, remains the core of this provision both in how it was set out in the model and how it was adopted in Washington.

The explanations for the need for this provision in the Wisconsin Receivership Statute from Reference Handbook on Insurance Company Insolvency, pages and 88-89 (Cynthia J. Borrelli ed., 3rd ed.1993), are still applicable now, some 50 years later.

> *It has been traditional, in Wisconsin and elsewhere, to terminate the policy coverage as soon as the order of liquidation is issued. This rule is very unfair to an important class of creditors, who are cut adrift without protection.*

That "important class of creditors" that is "cut adrift without protection" are consumers. They are an insurer's customers. They are the people that buy insurance and if they stop buying insurance coverages because it starts to look like a scam, then such could result in a shrinking insurance industry.

It seems that the Wisconsin Receivership Statute did not envision L&H type coverages, but later versions of NAIC Model #555 surely did envision these by providing that these coverages would not be cancelled at all. This was

more than providing that they should be allowed 30 days for the coverage owners to find new coverage, as the Wisconsin Receivership Statute did, and a recognition that more was needed.

The Life & Annuity Industry ([through the ACLI]) is arguing that LTC is a L&H (these are called "Life and Health" since the guaranty association models and acts were adopted in the states before health insurance started separating as its own industry) type cover that should NOT be cancelled 30 days after a liquidation order. It is our understanding, that it is mainly health insurers that may be advancing the argument the LTC is more like a P&C cover that should be cancelled 30 days after a liquidation order.

CONCLUSION

The plain-talk way of looking at this follows. Property & casualty (P&C) types of insurance coverage are usually renewed annually and the condition of the insured interest (the property or the risk of a casualty) is usually not a huge cost driver for the consumer buying the coverage. L&H types of coverage can be much more difficult to replace and there may be huge cost changes for the insured, if conditions (meaning their health or situation) have changed. This is why L&H types of coverage are not cancelled 30 days after a liquidation order. The insureds cannot easily buy new coverage without possibly heavy cost increases, if they can find it at all as a similar coverage may not be offered by anyone, at any price.

Exhibit A to Washington State Response to RITF Survey Sent December 10, 2018.

There are four segments below regarding the cancellation or continuation of coverage in Washington State. The first (1st) Segment is from NAIC Model Law #555, Sec. 502 (https://www.naic.org/store/free/MDL-555.pdf, last visited 1/31/19) with additions from NAIC Model Law #555, Sec. 19 (1993 ed.), see Reference Handbook on Insurance Company Insolvency, pages 19-20 (Cynthia J. Borrelli ed., 3rd ed.1993), highlighted in yellow.

The second (2nd) Segment below shows the above cited Section 19 and in this segment the highlighting in yellow shows what is different between it and how Section 19 was adopted in RCW 48.31.125. RCW 48.31.125 (https://app.leg.wa.gov/RCW/default.aspx?cite=48.31.125, last visited 1/31/19) cf. NAIC Model Law #555, Sec. 19 (1993 ed.).

The third (3rd) Segment shows the above cited RCW and the highlighting in yellow shows what is different between it and how is was modified from Section 19 of NAIC Model #555. See RCW 48.31.125 (https://app.leg.wa.gov/RCW/default.aspx?cite=48.31.125, last visited 1/31/19) cf. NAIC Model Law #555, Sec. 19 (1993 ed.).

Finally, in the fourth (4th) Segment below, there are several excerpts from the "Wisconsin Laws of 1967" as contained in the last edition of the Reference Handbook on Insurance Company Insolvency. See Wisc. Laws of 1967, S.B. 303 (Aug. 4, 1967) Sec. 645.43, as reproduced in Reference Handbook on Insurance Company Insolvency, p. 53, 55 and 88-89 (Cynthia J. Borrelli ed., 3rd ed.1993). In this last segment of this Exhibit the highlighting in yellow simply shows what seems to be "additional relevant information specific to [our] state's provision," as this Wisconsin Law is a more than 50-year predecessor of our state's provision.

SEGMENT 1
Section 502. Continuance of Coverage

A. Notwithstanding any policy or contract language or any other statute, and unless ordered otherwise by the receivership court upon application by the receiver, all reinsurance contracts by which the insurer has assumed the insurance obligations of another insurer are cancelled upon entry of an order of liquidation.

B. Notwithstanding any policy or contract language or any other statute, [A]ll policies, insurance contracts (other than reinsurance by which the insurer has ceded insurance obligations to another person), surety bonds or surety undertakings, other than life, disability income, long term care or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force as provided in this section, unless further extended by the receiver with the approval of the receivership court, until the earlier of:

(1) Thirty (30) days from the date of entry of the liquidation order;

(2) The date of expiration of the policy coverage;

(3) The date the insured has replaced the insurance coverage with equivalent insurance with another insurer or otherwise terminated the policy;

(4) The date the liquidator has effected a transfer of the policy obligation pursuant to Section 504A(5); or

(5) The date proposed by the liquidator and approved by the receivership court to cancel coverage.

Drafting Note: The provision in Paragraph (5) is designed to allow for possible immediate cancellation of policies in

the event there is no guaranty fund coverage.

SEGMENT 1
Section 19. Continuance of Coverage

A. All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation continue in force only for the lesser of:

(1) A period of thirty (30) days from the date of entry of the liquidation orders;

(2) The expiration of the policy coverage;

(3) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(4) The liquidator has effected a transfer of the policy obligation; or

(5) The date proposed by the liquidator and approved by the court to cancel coverage.

B. An order of liquidation under Section 18 shall terminates coverages at the time specified in subsection (A) of this section for purposes of any other statute.

C. Policies of life or health insurance or annuities shall continue in force for the period and under the terms as is provided by an applicable guaranty association or foreign guaranty association.

D. Policies of life or health insurance or annuities or a period or coverage of the [such] policies not covered by a guaranty association or foreign guaranty association shall terminate under Subsections (A) and (B) of this section.

SEGMENT 1
RCW 48.31.125
Order of liquidation—Termination of coverage.

(1) All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation continue in force only until the earliest of:

(a) The end of a period of thirty days from the date of entry of the liquidation order;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The liquidator has effected a transfer of the policy obligation; or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order of liquidation terminates coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for the period and under the terms provided by an applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or a period or coverage of the policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2) of this section.

[1993 c 462 § 62.]

There are several provisions at Chapter 48.99 RCW, see, https://app.leg.wa.gov/RCW/default.aspx?cite=48.99&full=true. This was the old Uniform Insurers Liquidation Act from 1939. It was what was in effect in Washington State prior to the enactment showing as RCW 48.31.125. It is likely what was in place when the below comment to Wisconsin Section 645.43 was enacted. This reflects the situation that the consumer hardships that can be created with the cancellations of coverages were not well considered prior to 1967. Prior to that year, and the advent of the guaranty associations and their support for moving books of business to solvent carriers to run them out over decades, great efforts (such as three-plus-decades-long rehabilitations) were undertaken to protect policyholders from the calamitous results of having their coverages cancelled by the entry of a liquidation order.

SEGMENT 1
Wisconsin Laws of 1967, Chapter 8
Senate Bill 303
August 4, 1967

In 1967, Wisconsin substantially revised its insurance rehabilitation and liquidation provisions. Professor Spencer L. Kimball, currently Seymour Logan Professor of Law at the University of Chicago Law School, prepared the extensive annotation to the Wisconsin law upon enactment to explain the history, content and operation of these provisions. Between December 1968 and

December 1977, the National Association of Insurance Commissioners (NAIC) recommended adoption of the Wisconsin law as model legislation. The following was also used as one of the bases to develop the current NAIC Insurer Supervision, Rehabilitation and Liquidation Model Act. While the Wisconsin law is no longer recommended as NAIC model legislation, it is reprinted here as many of its provisions have been incorporated into the current NAIC Model Act and state laws.

BASIC PROBLEMS

Several major groups of problems can be isolated for consideration in a study of delinquency proceedings in insurance. As they appear in logical sequence they are as follows:

1. The causes of insolvency;

2. The detection of incipient difficulty in the insurance company operation;

3. The devising of ways to induce the insurance commissioner to take early action to correct remediable defects in insurer operation, before the sickness has become serious;

4. The provision of effective procedures for rehabilitation of companies seriously sick but still salvageable;

5. For companies that cannot be saved, the development of efficient, inexpensive, and expeditious procedures for liquidation that will distribute the unavoidable burden fairly, and;

6. The complications superimposed on the above problems by the existence of a federal system as the setting for delinquency proceedings.

§645.43 Continuance of Coverage.

(1) All insurance policies issued by the insurer shall continue in force:

(a) For a period of 15 days from the date of entry of the liquidation order;

(b) Until the normal expiration of the policy coverage;

(c) Until the insured has replaced the insurance coverage with equivalent insurance in another insurer; or

(d) Until the liquidator has effected a transfer of the policy obligation pursuant to s. 645.46 (8); whichever time is less.

(2) If the coverage continued under this section is replaced by insurance that is not equivalent, the coverage continued under this section shall be excess coverage over the replacement policy to the extent of the deficiency. Claims arising during the continuation of coverage shall be treated as if they arose immediately before the petition for liquidation. Coverage under this subsection shall not satisfy any legal obligation of the insured to carry insurance protection, whether the obligation is created by law or by contract.

Comment: *It has been traditional, in Wisconsin and elsewhere, to terminate the policy coverage as soon as the order of liquidation is issued. This rule is very unfair to an important class of creditors, who are cut adrift without protection. The person who has a fire the day before liquidation begins has a claim for his full loss and will receive his share in the liquidation; the person who has a fire the day after receives nothing. He may have no opportunity to replace his coverage and for some time will not even know of the liquidation. This treatment is shocking. At least the policyholder is entitled to some protection while he has a chance to be notified and replace his insurance. Termination of coverage 15 days after the order of liquidation at the latest does not depend on notice to the policyholder, however, for there is no practicable way to ensure that he will get notice within that time or even within 6 months or a year. If the records of the company are incomplete or in bad condition, it may be months before notices can be sent out. By s. 645.47 the liquidator is required to notify the policyholders of the impairment of coverage as quickly as possible; by s. 645.48 agents are required to do the same. The later duty is likely to be quickly and effectively carried out, so that most policyholders should have notice before the 15 days have elapsed. Some may have difficulty obtaining replacement coverage and some may not learn of the liquidation. These will be hardship cases, if a loss should occur, but not all hardship cases can be avoided when there is a liquidation. The dissipation of assets must stop as soon as possible or else no one will have a chance to recover anything. By providing up to 15 days of extended coverage, conflicting values are appropriately balanced. No more should be given even if there is in fact no notice. As it stands now, the provision is not a serious drain on funds, and provides a nice balance of conflicting interests, in doing justice while minimizing costs.*

Of course the coverage that there continued is an impaired coverage. If there is a loss, the claimant will only be able to share in the distribution, not get his full claim. But he is not just thrown to the wolves with nothing.

IAIR DESIGNATION PROGRAM

By Eric Scott, Director, Risk & Regulatory Consulting LLC

If you are reading this, you have already discovered IAIR and probably know what a valuable resource the Association can be for a practitioner dealing with the resolution of troubled companies. If you have not already done so, why not take the next step and apply for an IAIR professional designation?

IAIR serves as a credentialing organization for professionals who work on the resolution of insurance companies. IAIR currently offers two professional designations to qualified individuals, Certified Insurance Receiver (CIR) and Accredited Insurance Receiver (AIR). The CIR is available to IAIR members who have been substantially involved in the overall management of insurance company resolution proceedings. Think in terms of a Receiver or Deputy Receiver. The AIR is more like a board certification in a specialty for IAIR members who are highly skilled in one or more areas of insurance company resolutions. The designations let clients, judges, regulators and fellow professionals know that your skills and ethical standards meet an enhanced criterion.

Like all professional designations, you must meet some minimum requirements to earn an IAIR designation. The CIR and AIR designations have some requirements in common. For both designations, you must be a member in good standing of IAIR, have a bachelor's degree or at least ten years of business experience, and have attended approved continuing education events (CE) of at least thirty hours within the two calendar years preceding the date of the application. You also need to pay an application fee and complete a written application form. The application consists of a recitation of your professional experience and a demonstration that you have complied with the designation requirements. The application must also include a list of references.

Currently, applicants for both designations will complete an oral interview/examination conducted by members of the Accreditation and Ethics Committee. In the not too distant future, the requirements will also include a written examination. When your application is complete, IAIR's Accreditation and Ethics Committee will process the application and make a recommendation. IAIR's Board of Directors has final approval authority on all designation applications. Go to the IAIR website to find the application form and for more information on the CE requirements.

The CIR and AIR designations also have some specific requirements that reflect the differences between the designations. The focus of the CIR is on the direction and control of a resolution proceeding. To obtain the CIR designation, you must demonstrate that you have been directly involved in the day-to-day overall control and management of a troubled insurance company or receivership for a cumulative minimum of three years and have experience in the different areas of a receivership including reinsurance, claims, legal, accounting, and asset management. The CIR designation is available for three different practice areas based upon your experience with different types of insurance companies: Property & Casualty; Life, Accident & Health; and for individuals who meet the requirements for the first two practice areas, Multiple Lines.

Because the AIR designation is more specialized than the CIR, the AIR requirements focus on the applicant's experience in the specific insolvency practice area in which the applicant is seeking a designation. The applicant for an AIR designation must document substantial involvement and special competence in the designation specialization area. The specialization areas include Reinsurance, Claims/Guaranty Funds, Legal, Accounting and Financial Reporting, Information Technology, and Actuarial. The AIR designation also requires a minimum of five years of experience in the business of insurance.

Beginning January 1, 2020, the designation process will shift to a testing regimen. There will be an initial test and certification where an applicant will demonstrate that they have a base knowledge about insurance company resolutions. After an applicant successfully obtains the first certification and is also able to demonstrate they possess the required experience, there will be a second testing phase for designations in specialized areas of insurance company resolutions. Any designations earned and approved by the Board prior to December 31, 2019 will be grandfathered into the new designation program. A more detailed overview of the new designation process will be presented in a future newsletter.

I encourage you to apply for an IAIR designation and to talk to your friends and colleagues in the industry and encourage them to do the same. It is a great way to burnish your credentials and support IAIR at the same time.

KOPP NAMED NEW EXECUTIVE DIRECTOR OF MISSOURI INSURANCE GUARANTY ASSOCIATIONS

Jefferson City, MO: Tamara W. Kopp has been named the new Executive Director of the Missouri Insurance Guaranty Associations by the Associations' Executive Committee. Kopp takes the helm on October 1, 2019, when Chuck Renn retires after managing the Associations since 1992.

Kopp has spent her legal career with the Missouri Department of Insurance, most recently as receivership counsel representing the receiver for failed insurance companies. Kopp brings an understanding of government, insurance regulation, and company resolutions. She has served on the boards of directors for the International Association of Insurance Receivers (IAIR) and the Women Lawyers' Association of Mid-Missouri (WLAMM). Kopp also represented the Missouri Department of Insurance on various National Association of Insurance Commissioners (NAIC) Committees, Task Forces, and Working Groups. As Executive Director, Kopp will continue her involvement with NAIC and IAIR while adding the National Conference of Insurance Guaranty Funds (NCIGF) and the National Organization of Life and Health Guaranty Associations (NOLHGA) to her schedule.

"On behalf of the Missouri Insurance Guaranty Associations, we want to thank Chuck for his 27 years of outstanding service to the guaranty associations and to Missouri consumers," said Mike Voiles, Missouri Farm Bureau and Chair of the property and casualty guaranty association.

Tamara Kopp said, "Chuck has built a solid organization. I'm looking forward to continuing his level of excellent service for Missouri insureds to keep promises made."

Kopp earned her law degree from the University of Missouri – Columbia and her bachelor's degree from Northwest Missouri State University.

The Missouri Insurance Guaranty Associations provide protection within limits to insureds, beneficiaries, and claimants who are disadvantaged due to the insolvency of a member insurance company. Not all companies are member companies and not all types of insurance policies and coverage are subject to the protection provided by the Missouri Insurance Guaranty Associations. There are two insurance guaranty associations in Missouri that are jointly administered from one office. However, they have distinct responsibilities under their respective statutes. One association is responsible for insurance company insolvencies among the member life and health insurance companies, and the other association is responsible for insolvencies occurring among the member property and casualty insurance companies.

2020 IAIR RESOLUTION WORKSHOP

FEBRUARY 26-28, 2020 | THE MILLS HOUSE WYNDHAM GRAND | CHARLESTON, SC

NAVIGATING
"THE QUIET TIMES"

Roger Schmelzer, President & CEO NCIGF

A highly charged topic among insurance resolution practitioners is the obvious fact that insurance company failures are at an all-time low. As a result, inevitable questions are raised about the resources—human and financial-- committed to maintaining readiness for whatever insolvency activity may come along.

These conversations are not exclusive to the United States. NCIGF Vice Chair Chad Anderson of Western Guaranty Fund Services (WGFS) and I recently returned from a meeting in Taiwan with other resolution professionals from around the world. The resounding trend of these presentations? There is a lack of insurance company failures everywhere leading to some interesting outcomes for established guarantee mechanisms. For example:

- Taiwan is spending their time changing their mission to become a risk management "think tank."

- Our neighbors in Canada do a series of research papers on why companies fail and are actively counseling regulators on ways to avoid liquidations.

Guarantee structures in some countries have never had an insolvency and others have only had a few. And with an emphasis on recovery of a troubled company in most of the rest of the world, it's doubtful there will ever be a global spike in insurance insolvencies. In the United States, the decline in insurer failures requiring guaranty fund involvement can be traced to implementation of Risk Based Capital standards and the clearer picture this measurement to regulators of a company's potential for peril.

That insurance insolvency is not a growth business is a win-win-win proposition. Regulators have sharpened tools like RBC to give consumers security in their insurance choices; the reputation of the competitive industry remains intact and carriers pay less in assessments allowing them to grow their business through investment and product development.

These are indisputably good outcomes but beg the question about the infrastructure in place to manage a dwindling volume of insurance insolvencies. Here are a few thoughts I've shared with the NCIGF board and our membership:

1. Keep things in perspective. The property/casualty guaranty fund system is a bargain to stakeholders at around $70 million annually to operate. This is the cost of doing business to assure an effective safety net for insurance consumers. It's not just my opinion; I often hear this point made by industry thought leaders. Besides, with 29 P/C guaranty associations already part of cost-sharing arrangements in their states, real efficiencies are already in place.

2. That there is a "resolution system" should remain the mantra of guaranty associations and insurance receivers. U.S. insurance regulation is seen as even

more viable because there is a practiced and stable resolution mechanism. It's also often forgotten that Title II of the Dodd-Frank Act expressly singles out the state-based insurance liquidation system as the designated forum for resolving an insurer failure of any size. We have no choice but to be ready.

3. Maintaining a strong NCIGF is imperative. While not expressly statutory, NCIGF is mentioned over 40 times in the NAIC Handbook used by insurance receivers. An effective national coordinating entity is essential for numerous reasons, all vital but none more important than driving data management and security, now the highest priority in contemporary insurance resolutions. NCIGF also does the heavy lifting in relationships with industry, regulators (both nationally and internationally) and consumers. We provide trusted expertise to public policymakers who are not that familiar with how the safety net works.

4. Recognition of the value the insurance industry derives from a statutory insurance resolution system is especially worthwhile when activity is subdued. Oddly, it's participants in the resolution mechanism itself that could do a better job acknowledging the linkage and it's not a tough sell. By protecting insurance policyholders, guaranty funds and insurance receivers uphold the insurance promise and provide a safety net that encourages the commercial enterprise of selling and buying insurance. The statutory resolution construct fills inevitable gaps in the larger insurance food supply chain. The system is built to work exactly this way. As a result, the insurance industry fully supports the GA system, even at times when we aren't needed in great numbers on the front lines (like now).

NCIGF is always focused on providing operational support to our members and the entire resolution mechanism when the time comes. By looking at the big picture and addressing the right things in the right ways now, we can continue to present the P/C system as a dependable, flexible and durable consumer-protection mechanism fully capable of supporting the insurance promise as originally contemplated by policymakers and industry.

That's why an impactful level of value-added non-insolvency engagement is not only warranted but necessary, regardless of the number of claims in the system. At NCIGF we call this "uncoupling claims from costs" and our Canadian colleague makes a presentation titled "In Times of Peace Prepare for War." Taking a serious look at existing processes and challenging conventional wisdom is a wise and thoughtful course of action. To move these sentiments into pervasive thought will require candid, open discussions within NCIGF, regulators and the insurance industry. We are regularly having those conversations.

Readiness for the nosier times is not negotiable. Being unprepared will draw attention and someone who knows much less about the purpose of the U.S. resolution mechanism will seek changes based on limited exposure to the realities of insurance resolution. Experienced insolvency practitioners will almost certainly be unhappy with that outcome. And anyway, if insolvency pros aren't trying to do things better, then why are we here?

THE PERFECT RECIEVER NO 20: WILL YOU STILL FEED ME? (WHEN I'M 64)

By Patrick Cantilo, Cantilo & Bennett

Poll any random insurance commissioners you stumble across on your neighborhood streets and they will quickly tell you to watch where you are going, dammit! After dusting themselves off, they will also tell you that the toughest challenge for state regulators of the insurance industry today is long term-care insurance ("LTC"). Never intimidated by an assignment I am wholly incapable of fulfilling, herein I propose to offer an LTC primer for those who don't have a life to take them away from this article. "Why" you may ask "are you bothering me with this? I'm just an insurance receiver." For reasons I will discuss below[1], a lot of long-term care insurance blocks are in serious financial trouble. LTC receiverships are likely to become more common in coming months and years. Moreover, many recent regulatory changes have been prompted by the challenges created by the LTC industry. It is the subject of several NAIC committees, task forces and working groups, including two at the Commissioner level. In short, LTC is now one of those topics of which all insurance practitioners should have at least a passing understanding. Instead of that (which of course would have been really helpful) here I'll provide some specific terms (like "morbidity improvement assumption") that you can sprinkle in your cocktail conversations to demonstrate that you too are among the *cognoscenti*.

What is LTC?

Fundamentally, LTC insurance policies provide benefits in the nature of living assistance to those who need it for an extended period, typically really old people. Though classified generally as health insurance, it is not typical health insurance in that it does not pay for doctor or hospital bills. Rather it pays for nursing home, assisted living facility, and/or home care for those who cannot fully take care of themselves. A unique feature of LTC policies is that they tend to be purchased long before benefits are claimed under them. They have been marketed as "level-premium" products for which premiums cannot change due to age and health status although they can be increased with regulatory approval along with those of other similar policies. As we will see below[2], while premium rate increases were rare in the early years of the industry, they are now a very common and controversial. The contracts are also guaranteed-renewable[3] and cannot be terminated so long as premiums are paid. Notably, and unlike life policies, they do not accumulate cash values.

LTC insurance is classified as health insurance in most states although it can be written not only by life and health insurers, but also by property and casualty insurers. Nonetheless, it is the life and health insurance guaranty associations ("GAs") that are triggered when an LTC insurer is placed in liquidation. LTC insurance can be said to be health insurance because it pays upon the occurrence of adverse health conditions. It also resembles disability insurance in that payment due upon the occurrence of those health events need not go to healthcare providers and, in some cases, are the insured's to spend as he or she wishes. A lot of LTC insurance has been written by insurers that wrote little or nothing else. The industry is a young one, the first commercial LTC products having come on the scene in the 1970s and having become more common by the mid-1980s.

---

[1] This is an expression famous writers use to avoid having to explain something they don't understand. By the time you get to "below" hopefully you will have forgotten all about this.

[2] See? There I go again!

[3] Risking an accusation of being a purist, I will draw an important distinction here. The products are sometimes called non-cancelable but that is not technically correct. Non-cancelable policies have truly level premiums that cannot be raised by the insurer and for that reason are typically more expensive. The premiums of guaranteed-renewable policies, in contrast, can be raised by the insurer so long as it does so for the entire risk class and obtains regulatory approval. In both cases, however, (as long as premium is paid timely) individual premiums cannot be raised due to aging or changing health condition.

While the industry grew rapidly and eventually more than a hundred companies sold LTC products, as problems began to emerge and challenge their viability, many issuers abandoned the line of business and fewer than a dozen companies account for the vast majority of new LTC business at this writing. It is estimated that something over seven million such policies are in force now, more than one million of those having been written by Genworth Life Insurance Company and its affiliates.[4] Other major writers include Allianz, Bankers Conseco, John Hancock, Mass Mutual, NY Life, Prudential, Transamerica, and Unum.

How does the coverage work?

In the days of "Little House on the Prairie" and "Leave it to Beaver" people weren't allowed to get that old. If they tried, someone in the family was designated to fly them to Odo Island, Japan, where Godzilla would eat them. But if someone forgot to take them to Odo, then the family had to take care of them. Eventually the family said, "No More!" and stopped taking care of the old people. This upset the old people very much and they called up the insurance industry and asked it to develop an expensive product that could be bought with the kids' inheritance and would allow old people to pay other younger people to take care of them when the family didn't. The industry then immediately stopped working on the affordable health insurance project and began developing long-term care insurance products.

Long-term care generally includes skilled nursing, intermediate care, custodial care and home health care for a person who needs assistance due to a chronic illness or disability. Such care is typically provided to individuals in their homes or in nursing homes, assisted living facilities ("ALF"), or in adult day-care facilities. The types of benefits and coverage provided under LTC policies vary. Policies may only cover limited types of services such as home health care or may cover a broad array of services and needs in a comprehensive policy. Such services may include skilled nursing services; assistance with Activities of Daily Living ("ADL") such as eating, bathing, dressing, ambulating, transferring, toileting and continence; assistance with Instrumental Activities of Daily Living ("IADL") such as meal preparation, shopping and travel, light housekeeping, laundry, telephoning, money handling, and bill paying; adult day-care services; stays in nursing facilities ; residence in assisted living facilities; and/or hospice care. A LTC policy may only cover care provided in certain settings, such as a nursing home (including ALF), or may cover care in multiple settings such as the policyholder's home and/or in an assisted living facility or nursing home.

LTC generally pays for the types of care purchased in the policy, subject to eligibility triggers, elimination periods and limits on the amount of daily and lifetime benefits. In the older or "traditional" policies, the eligibility triggers consisted mainly of a doctor deeming the care "medically necessary." To the world's astonishment, many doctors didn't feel like saving the insurance companies money by not providing their patients a "medical necessity opinion" and we were off to the races. Newer policies use "Tax Qualified" (or "TQ") triggers. TQ policies were created as a result of HIPAA,[5] which included provisions for favorable tax treatment of qualified long-term care insurance contracts. TQ policies are required to cover services for a chronically ill individual, and do not have a "medical necessity" benefit trigger. A TQ policy requires that a person 1) be expected to require care for at least 90 days and be unable to perform 2 or more ADLs without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. Premiums paid for a TQ policy may be deductible from taxable income, and benefits from a TQ policy are not subject to federal income tax. Newer policies also impose "elimination Periods" as long as 120 days during which the insured must be receiving care before the policy's benefits kick in.

Benefits payable may increase due to "inflation riders" and the obligation to pay premium may be suspended due to "premium waivers" once the insured or spouse goes "on claim" and begins receiving LTC benefits. Some policies pay the cost of care ("reimbursement" or "cost of care" policies") while others pay the specified benefit limit regardless of cost incurred ("indemnification" policies).

---

[4] I won't say much here about Genworth's exciting history and recent adventures. That is for another day. As the biggest player in the industry Genworth has an enviable LTC data base. They publish an annual "Cost of Care" survey that is considered an industry standard. References below to the Genworth Survey are to the 2018 edition of this compendium.

[5] The Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 300gg, 29 U.S.C. § 1181 et seq., and 42 U.S.C. § 1320d et seq.

The generosity of older LTC policies is a large part of why the industry is in a state of crisis. They simply did not charge enough premium to pay for those benefits. If they had, no one would have bought the policies.

Now, I know you are wanting to grab the insurance industry by the lapels and ask: "Didn't that tell you anything, you dimwit?" The truth is that, though there were a few lone voices in the wilderness, pretty much no one foresaw how woefully inadequate initial premium rates would prove to be.

What is all this talk about rate increases?

If you know anything about LTC insurance, it is probably because you have heard so much about this segment of the industry being in deep trouble. Amazingly (don't try this at home!) I will try to explain why in a very few sentences. Fundamentally, the industry is facing claims costs higher by orders of magnitude than what had been assumed when the products were first designed and priced. Premiums charged for the coverage historically have therefore proven to be painfully inadequate. Many blocks of policies and their issuers are facing daunting shortfalls in the assets expected to be available for projected liabilities as their blocks of LTC insurance mature. This has led to a fervent pitch for approval of very large premium rate increases. Requests for approval of rate increases of 50 to 100% are common!

Given that buyers are typically older Americans of some means[6] resistance to rate increases can be vigorous and compelling. The average LTC policyholder is of middle-class economic resources and heavily burdened by material rate increases. They are frequently also frustrated because the policies were sold to them as "level premium" with some loose representations that rates would never rise. While regulators also resisted applications for premium rate increases for many years, that has changed more recently and, indeed, some regulators are now being criticized for not approving sufficient rate increases.

Why are these products so underpriced?

But why, you are no doubt asking, are these policies so underpriced.? There are several reasons, all tied to inaccuracy of the assumptions made when the rates were first set. At the time, LTC was a new line of business for which no precise experience data was available for actuarial projections. Data from other lines (life, annuity and disability in particular) were used to project such key factors as:

"Lapse Rates"	How long would these policies remain in force before they terminate by the death or decision (non-payment of premium) of the insured;
"Morbidity"	The frequency of illness qualifying for benefits among the insured population;
"Mortality"	The frequency of death among the insured population;
"Claim terminations"	How long claims would last (sometimes also called "duration");
"Severity"	How expensive claims would be (sometimes referred to as "claim cost"); and
"Investment Income"	The income they would earn by investing the premiums collected. A key feature of LTC insurance (like life insurance) is that the company will build up premiums for years before an insured goes on claim, and start paying them out much faster than it collects them once the insured becomes eligible for benefits. The accumulated premium is expected to produce substantial additional assets as they are invested.

These and other factors had to be projected to set the initial premiums and monitored to set reserves periodically. As it turns out early assumptions were materially incorrect for a variety of reasons. One critical

[6] Those of very limited means can't afford LTC insurance that costs thousands of dollars annually and instead depend on Medicare and Medicaid to pay for their LTC should it become necessary. These programs, however have substantial limitation and eligibility requirements. For example, to qualify for Medicaid one must have very limited financial resources. While Medicare may pay some health bills incurred by those in need of LTC, it generally does not pay for LTC itself. LTC insurance, therefore, appeals to those who want a comfortable lifestyle in their senior years, even if they need help, and are willing to pay now to be assured of more than "Medicaid nursing homes" as they reach their final years. Indeed, it has been suggested (perhaps a bit cruelly) that the medicaid nursing homes are the modern version of taking the old people to Odo Island for Godzilla's amusement.

misjudgment focused on lapse rates. Put simply, policyholders keep their LTC policies much longer than predicted. This is important because the industry had assumed that, after paying premiums for years, a given percentage of policyholders would abandon their policies before they went on claim and started collecting benefits. Thus, it was assumed that claims incidence would be reduced in part by policy terminations that have not in fact occurred. More insureds than predicted have retained their policies until they became eligible for benefits. Another disappointment was the decline in market yields. Investment income (critical in the case of long tail products) has been much, much lower than predicted when these policies were first sold in the 70s and 80s. As a result, insurers have earned a lot less money on invested premium to put aside for the eventual day on which claims have to be paid.

In addition, the world has changed a bit in fundamental and very relevant respects. People are generally living longer, both healthy and with chronic health conditions. Consequently more of them are reaching periods in their lives at which they need long-term care, and are living longer while receiving LTC benefits. Moreover, the emergence of very comfortable assisted living facilities in many cases has made moving to a facility much more attractive and expensive than staying home and having the family care of the infirm.

Many other similar trends have combined to make LTC far costlier for insurers than projected when they were sold. Even today, the industry is struggling to develop a product that can offer the desired level of care at affordable premiums.[7]

Have there been any LTC receiverships?

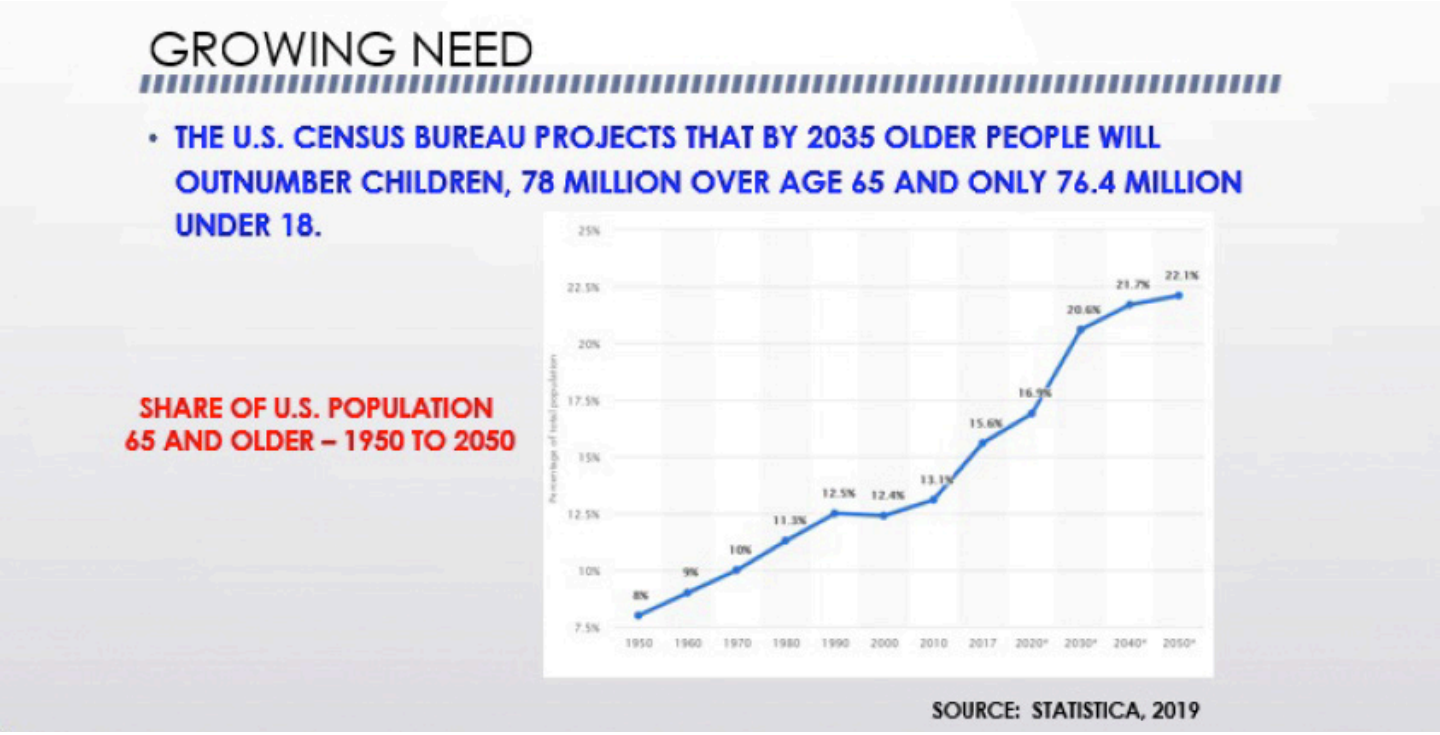
There has been one notable LTC receivership, that one a real doozy! One of the earliest sellers of LTC, Penn Treaty Network America Insurance Company ("Penn Treaty") began selling in the 70s, was placed in rehabilitation in 2009, and in liquidation in 2017.[8] By the time it went into liquidation Penn Treaty was down to about half of the 130,000 policyholders it had when it went into rehabilitation eight years earlier. It is estimated that guaranty associations will pay between two and two-and-one-half billion (yeah, billions with a "B") dollars in claims, and claims in excess of guaranty association limits are expected to exceed another billion dollars. Penn Treaty succumbed to many of the issues discussed above and an assortment of others we will leave for another day.[9] It has been the impetus for a vigorous debate among state insurance regulators about how to deal with troubled blocks of LTC business. One remarkable consequence of the Penn Treaty failure is the recent amendments to the NAIC Life and Health Insurance Guaranty Association Model Act -Model No. 520 (the "Life GA Act"). While these could also be the subject of a separate column in this series, some brief comments here are appropriate.

Penn Treaty's liquidation gave rise to several novel issues in insurance insolvency annals, of which I will touch on two here. First, though classified as health insurance, LTC is not a line typically sold by health insurers. Most has been sold by mono-line companies like Penn Treaty or life insurers. But because of that classification, a significant portion of the guaranty association assessment burden for Penn Treaty rests with health insurers, which have been understandably displeased at this result.[10] After vigorous negotiations a bargain was reached and codified in the 2017 amendments to the Life GA Act under which future LTC assessments will be split evenly between life and health insurers. Perhaps to guard against health insurers evading some of this burden by migrating their business to managed care platforms (historically not covered by guaranty associations), the bargain also resulted in adding health maintenance organizations to the Life GA Act. There is some irony in this result given that a) many had advocated vigorously for the inclusion of HMOs in the Life GA Act for decades with no success, and b) at this juncture some of the larger HMOs opposed this sudden change which admittedly received moderate scrutiny before being implemented. Second, after they were "triggered" for Penn Treaty the guaranty associations began seeking and obtaining premium rate increases for the LTC policies for which they thus became responsible. There is no real precedent for such guaranty association rate increases. Moreover, these premium rate increases were not for the purpose of paying claims, but rather to lessen the assessment burden on member insurers.

There are many more, still evolving, important aspects of the Penn Treaty insolvency that cannot be included in this

[7] Beyond the scope of this already painfully long article is discussion of new "hybrid" products that combine LTC with life insurance and annuities.

[8] The full story of Penn Treaty and its subsidiary, American Network Insurance Company, is fascinating and not yet complete. I will reserve it for another number in this series, both because it is too long to include here, and because I may need the material the next time I run out of ideas about what to write.



discussion.[11] Readers should never assume that any of my articles is a complete, let alone completely accurate, discussion of any subject. Nowhere, though, is this truer than in this case. Those familiar with Penn Treaty may wonder why I haven't addressed historical rate increases, the Moody's rollback debate, the Warrantech fight, the failed rehabilitation plans, the role of actuarial projections, the fate of the New York subsidiary, the unprecedented litigation regarding conversion of rehabilitation to liquidation, and countless other aspects of this first large LTC failure. The short answer is that I don't have enough paper and ink.

What can we expect in the future?

The need for LTC insurance is not going away. Not only do we have a LOT of old people in this country now, we are making many more:[12]

As the population ages, necessarily the proportion of old people in need will increase as the proportion of young people to care for the aging declines. Society will be compelled to address this growing need and thus far the government has not offered a solution.13 Inevitably, the market will have to respond to this growing need. The LTC industry is very much in an evolutionary stage. On the one hand, a lot of attention is being devoted to the development of LTC products that won't produce the same disastrous results as the "legacy" business of the 70s and 80s. Things like 5%annual increases in benefits, zero-day elimination periods (waiting periods), lengthy or unlimited benefit periods, and permissive non-tax-qualified benefit triggers are likely a thing of the past. Modern policies will continue to become less and less generous. Newer different products like hybrids linked to other products and short-term-care policies will become more common. The days of level premium are also behind us. The reality is that frequent premium rate increases are likely to be with us to stay. Pressure has been mounting at the NAIC for states that have historically been resistant to approval of applications for rate increases to become more accepting of them. Expect some initiatives on that front in the near future. There are still at least between one and two million LTC

[9] Another clever device used by famous authors to avoid talking about something they don't know.

[10] "You mean that even though I didn't sell this crap now I have to pay for it? Whiskey Tango Foxtrot!!!" the health insurance industry was overheard exclaiming the other day.

[11] Yep! I keep dodging shamelessly!

[12] Hah! You probably thought there weren't going to be any charts in this article

[13] I suppose we could build TWO walls and put the old people between them.

continued on next page

Cost of Care

Genworth

USA - National Median

Monthly Cost	2018
Home Health Care	
Homemaker Services	$4,004
Homemaker Health Aide	$4,195
Based on annual rate divided by 12 months (assumes 44 hours per week).	
Adult Day Health Care	
Adult Day Health Care	$1,560
Based on annual rate divided by 12 months.	
Assisted Living Facility	
Private, One Bedroom	$4,000
As reported, monthly rate, private, one bedroom.	
Nursing Home Care	
Semi-Private Room	$7,441
Private Room	$8,365
Based on annual rate divided by 12 months.	

15 Years of Cost of Care Trends

From 2004 to 2018, the cost for facility and in-home care services has risen on average from 1.5% – 3.8% per year. That's an increase of $700 annually for home care and up to $2,500 annually for a private room in a nursing home. At this rate, some care costs are outpacing the U.S. inflation rate of 2.1% by almost double.

Category	2004 Cost	2018 Cost	Total Increase ($)	Average Annual Increase ($)	Total Increase (%)	Average Annual Increase (%)
Private Room Nursing Home[1]	$65,185	$100,375	$35,190	$2513.57	54%	3.16%
Assisted Living Facility[4]	$28,800	$48,000	$19,200	$1371.43	67%	3.81%
Home Care Home Health Aide[5]	$42,168	$50,336	$8,168	$583.44	19%	1.51%
Home Care Homemaker[5]	$38,095	$48,048	$9,953	$710.91	26%	1.70%

*Represents average cost through 2008, switched to median in 2009. Genworth Cost of Care Survey 2004-2018, Conducted by CareScout®
** United States Department of Labor, Bureau of Labor Statistics, Accessed 10/03/18.

See how much long term care could cost in 15 years.

policies held in financially troubled blocks. At least some of those are likely to end up in rehabilitation or liquidation.

Taking care of old people is expensive and getting more expensive:

The industry will no doubt respond with a less generous, more expensive products that will overcome the current challenges. Look for annual rate increases just like your health insurance, more management of care, and fewer bells and whistles. Look also for the proliferation of more affordable but less desirable ALFs to fill the gap between staying at home and unaffordable retirement communities.

In the meantime, we have all those legacy blocks to play with. Bottom line, you are here just in time to witness, and perhaps participate in, some fundamental changes in this segment of the insurance industry.[14]

As usual, the opinions expressed in this article are not those of anyone other than the author. If there is something in this piece with which you disagree, please write it on the back of a one hundred dollar bill (or as it many as it takes to vent your frustration) and mail it to the publisher with instruction to remit it to the author.

Patrick Cantilo is a very old Texas receiver who once was president of IAIR and served on its board of directors for ten years until he showed up at a meeting and they promptly booted him out! He practices law with Cantilo & Bennett, L.L.P. in Austin. Over the decades he has represented or worked for about half the states in various insurance insolvency or regulatory projects.

[14] Oh yeah, I promised to tell you about "morbidity improvement" before your next cocktail party. It refers to a trend of people getting healthier and therefore having fewer claims than had been projected. When modeled in the process of setting LTC reserves, morbidity improvement can make a very big difference, especially if projected to last for a while. Many companies had forecast annual morbidity improvement in excess if 1% for ten, fifteen and more years, enabling them to reduce their reserves materially. More recently the industry has been challenged in demonstrating that improvement in actual claims data so many, but not all, companies have been reducing their morbidity improvement assumptions. For purposes of your cocktail party, when you see a handsome but suspicious guy making goo-goo- eyes at the girl of your fancy, you need only whisper in her ear "That jerk includes a 2.5%annual morbidity improvement assumption for fifteen years in his reserves!" She will never look at him the same way again!

MANUFACTURING PREDICTABILITY AND STABILITY FOR INSURANCE BUSINESS TRANSFERS IN OKLAHOMA

By Oklahoma Insurance Commissioner Glen Mulready

During this time of the year, Americans celebrate our independence with fireworks that light up a dark sky. And while we still watch in amazement, we do so without fear of harm because we know the manufacturers of those fireworks have created a consistent process to safely bring us the explosions we crave. Through experience we expect them to work properly every time. Thoughtful planning, thorough collaboration, and well-executed implementation of successful events are what create predictability and stability—both of which are essential to functioning insurance markets. Right now, Oklahoma is manufacturing the first of many successful insurance business transfers (IBTs) with a focus on creating the right process.

There is a buzz among regulators and industry participants about Oklahoma's IBT law. Many eyes are fixed on the Sooner State, especially as we attempt to finalize the first successful IBT transaction in the United States. As regulators, we understand this additional scrutiny and are approaching our review with the utmost care. By manufacturing a product that can be replicated with predictability and stability, we are seeking to make IBTs in Oklahoma a long-term solution.

In many instances, an IBT will be utilized by financially strong companies to engage in mutually beneficial transactions, all while holding the consumer materially harmless. In other instances, companies that are ready to move on from a closed block of business that is absorbing

company resources and draining useful capital could transfer the business to a company that specializes in running off that particular product line. Both companies win, as one exits a line of business it no longer desires to administer while the other, through experience and scale, is able to profit from the business in a way the former company could not. This is all accomplished while ensuring that the policyholders are not materially adversely affected. In fact, policyholders may often reap the benefits of the assuming company's stronger financial position.

Certainly, new laws require a level of thoughtfulness and expertise to minimize or avoid unintended consequences. That's why Oklahoma is co-chairing the NAIC Restructuring Mechanisms Working Group and actively participating in the associated subgroup. These groups have already attracted some of the best and brightest in the industry to analyze the need for these restructuring tools across the country, address legal issues with cross jurisdictional applications, review possible changes to the Guaranty Association Model Acts that will retain current protections for policyholders after restructuring, and develop financial solvency and reporting requirements that are tailored to ensure successful transactions remain at the forefront of everyone's mind. Significant input from interested parties will help make the groups' end products as comprehensive and helpful as possible.

The success of similar transactions in Europe has undoubtedly helped some companies avoid insolvency. Staying out of receivership is just one of the many benefits these transactions could present to U.S. insurers and the work Oklahoma and others are doing with the NAIC Restructuring Mechanisms Working Group is invaluable to achieve that goal. The group will be publishing a white paper by the end of this year with the intent of clarifying the issues surrounding these types of restructuring tools, ensuring that consumers are protected, outlining the role of guaranty funds in the process, and maintaining a focus on the importance of long-term company solvency.

Challenges will arise as we begin to manufacture a stable and predictable process for IBTs. But as long as our focus remains on protecting consumers while also promoting a free market within which companies can compete, we'll see the night sky light up with colors that will continue for many years to come.

GLEN MULREADY

Glen Mulready became the 13th Oklahoma insurance commissioner after receiving 62 percent of the vote. He was sworn into office on January 14, 2019.

Glen is a recognized leader and champion in the insurance industry. Starting as a broker in 1984, Glen rose to serve at the executive level of the two largest health insurance companies in Oklahoma. In 2007, he joined Benefit Plan Strategies, a company helping businesses provide employee benefits and health insurance to their employees.

Glen has served as President of both the Tulsa and Oklahoma State Health Underwriters Associations and has been named State Health Underwriter of the Year.

In 2010, Glen successfully ran for state representative and quickly became the point person for the House of Representatives on insurance issues and was appointed chairman of the Insurance Committee after the 2014 elections. In this role, Glen passed legislation which resulted in more insurance companies offering service in the state, and he reformed the state employee insurance program to save Oklahoma millions of dollars a year while also saving thousands of dollars for those families. These successes led to Glen being tapped for the leadership position of Majority Floor Leader in 2017.

Glen and Sally, his wife of 31 years, are the proud parents of three teenage sons, Sam, Jake and Will. In 2008, Glen and Sally were the recipients of Leadership Tulsa's Paragon Award for their work with Big Brothers Big Sisters. Glen is very active in the community having served on numerous boards and committees including Big Brothers Big Sisters, the Juvenile Diabetes Research Fund, March of Dimes, Shepherds Fold Ranch Christian Summer Camp, Crime Commission and Tulsa Tough.

LIST OF BOARD MEMBERS/OFFICERS

OFFICERS

President
James Kennedy, Esq. – 2019

1st Vice President
Kathleen McCain, Esq., AIR – 2021

2nd Vice President
Bruce Gilbert, AIR – 2019

Treasurer
Kevin Tullier – 2021

Corporate Secretary
Wayne Johnson, CIR-MIL – 2020

Immediate Past President
Donna Wilson, CIR-ML – 2017

DIRECTORS

Chad Anderson – 2021
Evan Bennett – 2020
Mark Bennett – 2021
John Doak - 2021
Patrick Hughes, Esq. – 2019
Jenny Jeffers – 2020
Jan Moenck – 2020
John Murphy, JD - 2020
Don Roof – 2019
Douglas Schmidt, Esq. – 2019

THANK YOU TO OUR CORPORATE SPONSORS

THANK YOU TO OUR CORPORATE SPONSORS

Platinum Sponsor

rrc risk&regulatory CONSULTING

Gold Sponsor

RLR Management Services, Inc.
Resources Results Leadership

Silver Sponsors

Faegre Baker Daniels

FitzGibbons and Company, Inc.

Locke Lord LLP

Noble Consulting Services, Inc

Stradley Ronon Attorneys at Law

veris

Become a Corporate Sponsor Today! Corporate Sponsor Information