INTERNATIONAL ASSOCIATION OF INSURANCE RECEIVERS
PROMOTING PROFESSIONALISM AND ETHICS

# THE INSURANCE RECEIVER

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## PRESIDENT'S MESSAGE

*Donna Wilson –CIR-MIL*

Spring has sprung and rolled into the lazy-hazy-crazy days of summer but the work of the IAIR Board and committees continues!

In April, at the NAIC National Meeting in Denver, the Society of Financial Examiners (SOFE) and IAIR hosted a breakfast which featured a role-playing presentation on Long Term Care Insurance. Several committees met including the Receivers & Guaranty Funds Committee which received an update on developments in the CastlePoint National Insurance Company Receivership and updates regarding health insurance receiverships. Also, IAIR hosted an Issues Forum with panels discussing legislative updates on the Affordable Care Act, risk retention litigation, multistate guaranty association management, and an introduction of IAIR's proposed designation program.

After the NAIC National Meeting, IAIR exposed documentation for the proposed designation program for comment. Thank you to those who submitted comments. The Ethics Committee has reviewed and discussed the comments received and will recommend modifications to the Board at the upcoming NAIC National Meeting in Philadelphia.

IAIR submitted comments to the NAIC Receivership Model Law Working Group on the working group's recommendation regarding stays and reciprocity as well as the working group's proposal on receivership provision in management, service, and cost-sharing agreements. In addition, IAIR submitted comments to the International Association of Insurance Supervisors (IAIS) on the consultation on ICP 12 and ComFrame material integrated with ICP 12. The comments are posted on the IAIR's website (www.iair.org/news).

The Audit, Finance, Governance and Membership and Promotion Committees continue to work on matters that may not be immediately visible to membership but are important to IAIR's future.

The Education Committee is preparing for a joint Issues Forum with AIRROC during the upcoming NAIC National Meeting in Philadelphia and a presentation to the Midwest Zone Guaranty Funds during their meeting **October 4-6** in Oklahoma City.

The Co-Chairs for the 2018 Insurance Resolution Workshop are preparing a program packed full of insightful panels. Mark your calendar now to be in Scottsdale **February 7-9, 2018**!

So how can you be involved?

- Join a committee. Every committee can use your help!
- Assist in drafting responses to NAIC , IAIS, or other groups asking for comments on matters of interest to IAIR.

- Submit comments to IAIR - two matters have been exposed to membership for comment. Further information can be found at iair.org. Comments will be discussed during the IAIR Board meeting on **August 8.** Please submit comments by **July 28** to nancy@iair.org regarding:
  - o New retired membership category; and
  - o Proposed revised mission statement.
- Write an article for the newsletter. Contact Jenny Jeffers at jennan@earthlink.net with your newsletter proposal.
- Participate in Board Meetings – Board meetings are open to membership either in person or via conference call.
- Run for the Board of Directors – See additional information in this newsletter. Nominations due **September 15, 2017.**

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# SHOULD YOU WORRY ABOUT RANSOMWARE?

**By Michael Morrisey**

Seeing all the recent publicity about WannaCry and other recent ransomware attacks, you might think, "OK, but It probably won't happen to me." It can happen to anyone or any organization. So, yes, you should be worried--and prepared.

Ransomware refers to any malware that locks up a computer or data until the victim pays a ransom fee to the anonymous hackers. The hackers can be based anywhere in the world, and the ransom can range from a few hundred to several thousand dollars.

Ransomware is usually transmitted via email—those "phishing" messages we all get, encouraging you to click on a hyperlink in the message. In other cases, business networks are compromised through websites or weak firewalls, allowing hackers to gain control of the business file systems to install an encryption tool. After the files are encrypted, the business receives a message requesting the ransom payment.

Ransomware phishing attacks start with an email message containing an attractive marketing offer, a credit card alert, an invoice, or a postal delivery notice. These messages are increasingly deceptive by design, employing logos and letterheads of popular businesses--like Amazon or FedEx. Due to the pervasive theft of personal data, some of which can be part of the attack, the phishing email may contain enough personal information to convince the recipient of its legitimacy. For example, it may refer to a specific credit card or merchant used by the victim. Or, it might contain a colleague's name or email address. Initially, clicking the link may have no obvious effect, but in the background, the malicious software is downloaded and installed, giving the hackers control of the computer, and triggering a scan for data to be encrypted. Ransomware encryption may extend beyond the local computer to mapped network drives or connected storage devices. One compromised PC can lead to the paralysis of an entire organization.

Some early ransomware versions simply installed a virus which locked the computer, presenting a warning or threat, and instructions for the ransom payment. Payment can be via PayPal or some other bank transfer. More sophisticated ransomware requires the victim to pay in bitcoin digital currency, purchased through legitimate on-line sites, like any other currency exchange. The victim then transfers the bitcoin token (a data file containing a long string of numbers) to the hacker. Bitcoin transactions are essentially untraceable. As of June 2017, the cost of one Bitcoin is approximately $3,000 but they are available in fractional amounts. In exchange for the paid ransom, and assuming the data is properly encrypted, the hacker sends a program and encryption key to decrypt and restore the data. If the hacker is lacking in expertise or ethics, the payment is lost along with the data.

There are hundreds and perhaps thousands of ransomware variants today. Since they behave differently in the level of encryption, means of attack, and the latency (time between infection and notification), it's difficult to identify the attack and nearly impossible to decrypt the data. Cybersecurity engineers have produced decryption tools for a few types of ransomware, but decryption is seldom an option.

Ransomware is the culmination of years of hacking research and the monetization of our data. Data is worth money, but so are business operations. By design, the ransom fees correspond to the inconvenience of downtime, which is expensive to large businesses. And ransomware attacks on healthcare facilities can mean the loss of life. Sophisticated virus technology and exploits of popular operating systems are at the disposal of the data kidnappers. The WannaCry hackers used a Microsoft vulnerability exploit (attack software) originally developed by the US National Security Agency which was leaked and subsequently published.

One of the first ransomware attacks came in 2013 when a hacker named Slavik developed Cryptolocker. Cryptolocker encrypted the data on the victim's computer with a powerful encryption scheme and infected half a million PCs, generating $27 million in bitcoin payments during the first six months. Victims included hospitals, businesses, and even a Massachusetts police station--which paid the ransom. Security analysts estimate that globally, ransomware generated a billion US dollars in 2016. Cyber insurance policies may offer ransomware coverage, and some provide assistance in forensic investigations and data recovery. Law enforcement agencies advise against paying ransom except where downtime is critical, as has happened in some hospitals. Unfortunately, more ransomware attacks in the US lead to payment as compared with other countries, making US businesses more desirable targets.

Protection from ransomware is not simple. However, it's not difficult to reduce the likelihood and mitigate the effects of an attack. First, make sure that patches to operating systems and applications are applied as they become available because most hacking tools depend on security flaws in operating systems and applications. Good, up-to-date antivirus tools are also vital since viruses are one way that ransomware infections occur. Above all, you, your family, and your co-workers must know how to recognize suspicious email. Training videos and programs are available, and some are bundled with phishing tests, which simulate the dangerous email and score each employee to indicate who needs further

training. The ever-changing cyber-threat landscape makes annual security awareness training inadequate.

The best way to reduce downtime and avoid dealing with cyber criminals is to have well-designed incident response plans and strong backup systems. Historically, backup and recovery plans addressed disasters. However, disasters are rare while cyber attacks are common. A 4 or 12-hour recovery time may be too long in a ransomware situation. Backup media may be overwritten periodically--an acceptable solution for disaster planning. But if the ransomware encryption program was active for a several days or weeks, then the backups will contain encrypted data. So, backup schedules should be modified to address ransomware attacks. Having "snapshot" backups permit restoration to a given date and time. Snapshot backups drastically reduce recovery time although they require larger storage systems. Individuals should have recovery images of their PCs, and back up data frequently to multiple locations. Some cloud-based storage sites, such as Microsoft OneDrive and Citrix ShareFile, offer a viable option: "versioning" whereby copies are retained every time a file changes. Regardless of the backup solution, timely recovery is dependent on a thoroughly tested recovery plan.

Ransomware attacks will continue to evolve. While we cannot prevent them, we can reduce the likelihood and impact with awareness, better IT management practices, and carefully designed incident response plans. Knowing how to recover your data without appeasing hackers is one less thing to worry about.

Michael Morrisey, AMCM, CISSP, CISA, AES, is president of Morrissey Consultants, LLC

Sources: Symantec Internet Security Threat Report, April 2017; Wired: What is Ransomware? A Guide to the Latest Global Attack; NIST Special Publication 800-184 - Guide for Cybersecurity Event Recovery; Health IT Security: How Ransomware Affects Hospital Data Security; Kaspersky Lab: Ransomware-All LockedUp and No Place to Go.

# LONG-TERM CARE INSURANCE – A LONG TERM PROBLEM

**By Wayne Johnson, Tricia Matson, Jan Moenck, and Andy Rarus**



The average life expectancy in the United States in 1970 was 70.8 years, just over a one year increase from the average life expectancy in 1960 (1). It is against that backdrop that Long-Term Care Insurance (LTCI) was originally conceived and marketed in the 1970's. At the time the product was developed, interest rates were high and assumptions regarding investment income were made based upon the thought that interest rates would remain at high levels. However, past performance is no guarantee of future results, and interest rates have been at historical lows since 2008. LTCI gained popularity in the late 1980's and the early 1990's, while at the same time the average life expectancy grew steadily and at rate that far outpaced the decade of the 1960's. By 2013, the average life expectancy in the United States had ballooned to 78.8 years. Today, financial planners continue to suggest LTCI as an essential element of a retirement plan.

A closer look at LTCI beyond average life expectancy and interest rates reveals other stresses to the pricing of this product. The frequency and severity of LTCI claims is increasing; a 2014 study performed by AON indicated that frequency was increasing 3% annually and severity was increasing 2% annually (2). The lapse rate for these policies has also been lower than expected. The same AON study showed that the overall loss ratio was expected to grow 5% annually. This perfect storm has caused long-term care insurance to be a long term problem for insurers, regulators, and policyholders.

According to an S&P Global Market Intelligence analysis of statutory filings, the insurers with the largest LTCI reserves at December 31, 2016 included the following chart (3):

As can be seen on the chart, several insurers had significant adverse development in their reserves during 2016. MetLife Inc., CNA Financial Corp., Unum Group and Prudential Financial, Inc. all stopped writing LTCI years ago, and Manulife Financial Corp. stopped writing these policies in 2016 (4). Genworth Financial Inc. continues to be a leader in writing LTCI, but realized that it will require additional capitalization to turn its business around and is in the midst of being acquired by a private investor to gain additional capitalization (5).

Many of these insurers are actively working to file rate increases. In 2016, Northwestern Mutual initiated rate increases for the first time, obtaining approval for rate increases that would affect over 43,000 policyholders and result in approximately $23 million in calculated premium increases. Genworth Financial Inc. is aggressively working to obtain rate increases, and the MetLife Inc. group of companies had the most filings approved in 2016, with 33 filings approved (6).

There are only about 15 companies that continue to write LTCI (4). Many insurers have changed their product structure in efforts to return to profitability. One new product structure includes riders providing for accelerated benefits clauses on life insurance products. The NAIC is also looking into new

**Reserve development at US long-term care writers with largest reserves**

For year ended Dec. 31, 2016

| Top-tier entity | Reported reserves on individual and group policies ($M) 2016 | Development based on present value of incurred claims ($M) 1-year |
|---|---|---|
| Genworth Financial Inc. | 17,524.9 | 361.5 |
| Manulife Financial Corp. | 16,038.7 | 240.1 |
| MetLife Inc. | 14,192.5 | 101.5 |
| CNA Financial Corp. | 9,442.7 | (58.6) |
| Unum Group | 8,020.2 | 41.4 |
| AEGON NV | 4,947.3 | (47.0) |
| Prudential Financial Inc. | 4,840.7 | (68.4) |
| Thrivent Financial for Lutherans | 4,438.0 | (51.3) |
| Ameriprise Financial Inc. | 3,727.7 | (385.8) |
| CNO Financial Group Inc. | 3,216.0 | 385.6 |

Data compiled April 17, 2017.
Rank based on total reported reserves as of year-end 2016. Top 10 entities shown.
Based on data reported in the supplemental sections of annual statements filed with the NAIC. U.S. filers only. Data on the reported policy reserves is taken from the Long-Term Care Experience Reporting Form 2, and the amounts shown are a summation of individual and group policy reserves. The development data is sources from the Long-Term Care Experience Reporting Form 3, Part 4.
Positive amounts of reserve development indicate reserve strengthening. SNL Financial calculated the 1-year reserve development by summing the reserves recorded in 2016 for incurred years 2015 and prior, then subtracting the amounts recorded in 2015 for those same incurred years.
SNL's top-tier designation reflects the consolidation of data, based on SNL-defined group structures, from individual P&C, life, health and fraternal filers.
Source: SNL Financial, an offering of S&P Global Market Intelligence

structures such as shorter duration products, annuity hybrid products, and the potential for favorable tax credit on LTCI savings accounts or purchases of LTCI from retirement plans (7).

Although very well capitalized, and with a diversified book of products, Thrivent Financial for Lutherans poses another challenge. As a Fraternal, it is not covered by guaranty associations. In the very unlikely event it were to fail, it would need to either assess its members or the policyholders would suffer significant losses.

The Penn Treaty group of companies, which has recently had significant press with its insolvency, is not listed on the chart above. It is estimated to have a net liability of almost $2.7 billion (7). The responsibility to provide funds for the benefits to the Penn Treaty policyholders now rests with the life and health insurance guaranty associations. The Penn Treaty insolvency is having a major impact on life and health guaranty associations across the country, which have assessed their members to cover the cost of the insolvency. As pointed out above, only a limited number of companies have written business in the LTCI market, leaving many companies that never wrote these types of policies with an assessment obligation to cover the cost. If another major insolvency of a long-term care insurer were to occur, it could have a devastating impact on the market.

Given the risks present in the industry, the regulator is challenged with whether to limit rate increases to allow the policyholders to retain coverage at a reasonable price or to allow the increases to mitigate solvency issues.

### Trends in rating practices

Insurers have aggressive and specific targets for rate increases, often with a goal of 100% or lower lifetime loss ratio. To achieve this goal, double-digit rate increases have been common. These increases often have the potential for cross-block and cross-state subsidies, since some states approve only small increases and others approval much larger ones. There have also been offers of reduced benefits when rate increases have been high, in an effort to retain coverage for those who cannot afford such high rate increases.

### Trends in reserving practices

In an effort to reign in rate increases, insurers have taken measures such as including morbidity improvement assumptions in assessing reserve adequacy. They have also taken a more aggressive stance in including future non-approved rate increases and increases in investment income (based on a more illiquid or lower quality investment mix) in cash flow testing. Although in most cases state regulators have allowed some reflection of approved (but not implemented) rate increases, the amount by which regulators allow reflection of future non-approved rate increases varies greatly by state. Companies base these assumptions on state specific historical experience, which contains a significant level of uncertainty. Given this, and given the long term model used to project LTCI reserves, companies should include significant margins in their assumptions and should reflect those unapproved increases at the state level, if possible. As noted below, the NAIC is scheduled to adopt a new actuarial guideline (effective 12/31/2017) to specify how companies are required to perform their asset adequacy testing for long-term care business.

As new industry morbidity experience emerges, companies must decide whether or not to reflect this new experience and how to do so. They must consider to what degree the experience in the study is applicable to the Company's own business mix. For example, does the experience from the industry study apply to how a company's specific business is marketed and underwritten? Does the study provide experience based on product features that align with those features at the company? How well or poorly the study data fits the company's business, will impact the level of credibility used when the Company blends its own experience with the new industry table. These are important considerations for one of the key assumptions used in LTCI reserving.

### Other strategies which could increase risk

Due to the continued low interest rate environment, some insurers have been investing in riskier assets in an effort to increase investment return to better support their liabilities. This could make the company more susceptible to market risk and volatility in investment markets, potentially resulting in increased losses in a significant or sustained market downturn.

### Consumer issues

Consumers are caught in the middle of the long-term care battle. When they bought a policy and thought that they understood what the premiums and benefits would be, they likely made it an element of their retirement planning. The reality today is that the premiums are either increasing or the

benefits are being reduced. Furthermore, they are finding that the way the benefits were stated in the policy doesn't meet current needs or preferred methods of care, resulting in the policy not providing the needed coverage.

Further complicating the problem for consumers, if the insurer becomes insolvent most state guaranty associations have a limit of $300,000, and a nursing home can cost upwards of $90,000 per year (7).

*Consumers are caught in the middle of the long-term care battle. When they bought a policy and thought that they understood what the premiums and benefits would be, they likely made it an element of their retirement planning.*

**Areas the regulator should look at when evaluating rate increases**

We believe that areas that regulators may want to focus on when reviewing requests for increased rates include:

- Determining if there were appropriate assumption margins based on the level of uncertainty for each assumption.
- Evaluating the extent to which the insurer may be trying to recoup past losses.
- Evaluating the lifetime expected loss ratio on the business if the increase is approved.
- Ensuring that sensitivities to test the materiality of each assumption have been provided in the actuarial memorandum and reviewing those sensitivities.
- Requesting a dynamic validation of the projection model to ensure that the historical pattern of claims and premium is reasonably aligned with the projected pattern of premiums and claims.
- Checking for consistency of assumptions between those used in the premium rate request and those used in the asset adequacy analysis.
- Determining the materiality of the projected results at the tail end of the projection by requesting an alternate projection which excludes the last five to ten years of the projection.
- Requesting an external review of the actuarial memo supporting the requested premium increase.

**NAIC Groups Addressing LTCI**

Long-Term Care has been gathering a considerable amount of regulatory attention, and several NAIC working groups are looking into ways to address increasing problems and risks associated with LTCI. Some of the key current NAIC activities are listed below.

**Long-Term Care Innovation (B) Subgroup**

The Long-Term Care Innovation (B) Subgroup has been focusing on approaches to financing LTCI and has developed a list of federal policy changes that could help to increase private long-term care financing options for consumers. As of the writing of this article, these options still require approval by the NAIC's Government Relations Leadership Council before they are presented to Congress. The options include (8):

- Option 1: Permit retirement plan participants to make a distribution from 401(k), 403(b) or Individual Retirement Account (IRA) to purchase LTCI with no early withdrawal tax penalty.
- Option 2: Allow creation of LTC Savings Accounts, similar to Health Savings Accounts (HSAs) and/or Enhance use of HSAs for LTC Expenses and Premiums.
- Option 3: Remove the HIPAA requirement to offer 5% compound inflation with LTCI policies and remove the requirement that DRA Partnership policies include inflation protection and allow the States to determine the percentage of inflation protection.
- Option 4: Allow flexible premium structure and/or cash value beyond return of premium (HIPAA and DRA).
- Option 5: Allow products that combine LTC coverage with various insurance products (including products that "morph" into LTCI).
- Option 6: Support innovation by improving alignment between federal law and NAIC models (HIPAA and DRA).
- Option 7: Create a more appropriate regulatory environment for Group LTCI and worksite coverage (HIPAA and DRA).
- Option 8: Establish more generous federal tax incentives.
- Option 9: Explore adding a home care benefit to Medicare or Medicare Supplement and/or Medicare Advantage plans.
- Option 10: Federal education campaign around retirement security and the importance of planning for potential LTC needs.

**Long-Term Care Actuarial (B) Working Group**

The Long-Term Care Actuarial (B) Working Group's broad charges are to provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model rules for appropriate LTCI rates, rating practices, and rate changes.

**Long-Term Care (B) Valuation Subgroup:**

Currently there is a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTCI reserves. The Health Insurance Reserves Model Regulation (#010) and the NAIC Valuation Manual (VM-25) contain requirements for the calculation of LTCI reserves. The Model Regulation states, "a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts"; BUT some apply at contract level while others do this at the major block level (and everywhere in between).

The NAIC (B Committee) Long-Term Care Valuation Working

Group has been working on a draft LTCI guideline to address how LTCI carriers perform Asset Adequacy testing. The draft LTCI Guideline is called "The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves". The draft was exposed in February, 2017 and was expected to go into effect December 31, 2017. However, outstanding questions relating to whether this will be a new guideline or incorporated into existing regulations may result in a delayed effective date.

The Draft Guideline establishes the following uniform guidelines and limits to certain assumptions to be used in Asset Adequacy Testing (AAT):

- Requires asset adequacy analysis (AAA) if LTCI business falls within scope of guideline
- Specifies form of AAA as either Gross Premium Valuation (GPV) or Cash Flow Testing (CFT) and points to Actuarial Standard of Practice No. 22 (ASOP 22, Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers)
- Specifies a process and timeframe by which additional reserves are established due to reserve inadequacy
- Uniform approach for future rate increase assumptions
- Assumption documentation requirements for key risks
- Standalone AAT results documentation requirements
- Phase In guidelines if additional AAT reserves are required

The scope of the guideline includes any insurer with long-term care insurance contracts with over 10,000 inforce lives as of the valuation date, both direct and assumed; and excludes accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity.

**Long-Term Care Pricing (B) Subgroup:**

The Long-Term Care Pricing (B) Subgroup has been charged with providing recommendations to address long-term care rates, rating practices and rate changes. One issue that has been a significant topic of discussion whether to allow recoupment of past losses in implementing rate increases. What has generally been determined is that past losses should not be recouped; however, projected future losses can be addressed by premium increases.

The Subgroup has been evaluating how to categorize into "buckets" the sources of past LTCI premium deficiencies and sources for recouping those past deficiencies. The Subgroup's primary goal is to create a resource document that would indicate how states would treat each of these "buckets". This has been led largely by Texas and Minnesota. States could use this resource document to help them in their review of LTCI rate increases depending on how they view the acceptability of recouping past losses and how these past losses are recouped (i.e., which policyholders, if any, should bear the burden of paying for these past losses and which ones). The Subgroup's discussion highlights the problems with lifetime loss ratios especially as they may be applied to shrinking blocks of LTCI policies if the company is allowed to recoup all of the past losses from persisting active policyholders.

**Receivership Model Law (E) Working Group**

Applicable charges of the Receivership Model Law Working Group include 1) to evaluate and consider the changing marketplace of LTCI products and the potential impacts on guaranty funds; and 2) evaluate the needs for amendments to the Life and Health Insurance Guaranty Association Model Act (#520) to address issues arising in connection with the insolvency of long-term care insurers.

**Conclusion**

Long-term care insurance is being carefully watched by both regulators and insurers, and both are working to find feasible means to shore up reserves on legacy business. There continues to be a need for this type of product in the marketplace, and regulators and insurers are also working closely on how the need can be met with a product that is designed and priced to achieve profitability. In the meantime, regulators are closely watching the impact that losses and reserve strengthening are having on the capitalization and solvency of insurers with legacy business on their books since another major insolvency could have a devastating impact on the market.

Wayne Johnson is a Senior Director of Troubled Company and Receivership Services with Risk & Regulatory Consulting ("RRC"), Jan Moenck and Tricia Matson are Partners with RRC, and Andy Rarus is a Consulting Actuary at RRC.

Sources:

(1) https://blogs.cdc.gov/nchs-data-visualization/deaths-in-the-us/

(2) AON 2014 Long Term Care General Liability and Professional Liability Analysis, November 2014

(3) Jason Woleben, "3 long-term care writers strengthened reserves by $200 million or more in 2016", SNL Financial, May 2, 2017

(4) Jason Woleben, "Insurers turn to accelerated life benefits to replace individual long-term care", SNL Financial, April 21, 2017

(5) Howard Gleckman, "Genworth's CEO On The Future Of Long-Term Care Insurance, Public Coverage, And Going Private", Forbes, November 30, 2016

(6) Jason Woleben, "Northwestern Mutual led the way in long term care rate increases in Q1", SNL Financial, May 8, 2017

(7) Elizabeth Festa, "LTC industry underfunded and problems mounting, worried stakeholders say", SNL Financial, April 12, 2017

(8) www.naic.org/documents/government_relations_ltc_fed policy_opt.pdf

# UNFULFILLED PROMISES: THE FEDERAL GOVERNMENT'S LIABILITY UNDER THE ACA'S RISK CORRIDOR PROGRAM

**By Greg Mitchell & Jason Halligan**

The Patient Protection and Affordable Care Act (ACA) promises to reimburse Qualified Health Plans (QHPs) for a portion of their unexpected costs through the temporary risk corridor program. After three years of the program, the federal government has still not paid $8 billion in risk corridor claims. This Article explores the history of the risk corridor program and its impact on the Consumer Operated and Oriented Plans (CO-OPs) and hospitals who relied on the program's promises.

**Overview of CO-OPs and Risk Corridors**

The ACA provided loans to kickstart nonprofit health insurance companies, known as CO-OPs, which provided coverage for individuals and small businesses.[1] In an effort to correct potential volatility following its reforms, the ACA created three risk mitigation programs known as the "3Rs": Reinsurance, Risk Adjustment, and Risk Corridors. The three-year risk corridor program is intended to stabilize health insurance premiums and "[p]rotect[] against inaccurate rate-setting by sharing risk." [2] The program requires all QHPs to report their target costs and actual allowable costs to the Centers for Medicare and Medicaid Services (CMS). Insurers whose allowable costs are below their target costs pay a portion of their savings to CMS and CMS reimburses those insurers whose allowable costs are above their target costs for a portion of their losses. In essence, the program helps shield insurers from market uncertainties by redistributing savings and correcting pricing miscalculations. Twenty-three CO-OPs formed, organized their finances, and subsequently began offering health insurance plans on January 1, 2014, in part based on the promise of risk corridor payments.

**HHS changed its interpretation of risk corridor payments after insurers had sold health insurance plans.**

The ACA does not explicitly limit funding for the risk corridor payments to the amount of risk corridor collections.[3] In fact, when the Department for Health and Human Services (HHS) was implementing its final rule on its Notice of Benefit and Payment Parameters for 2014, it announced, "The risk corridors program is not statutorily required to be budget neutral.

Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." [4]

However, in April 2014, three months after CO-OPs began offering coverage, CMS announced it would reduce its risk corridor payments in proportion to its collections and use the following year's collections to cover any previous year's shortfalls.[5] CMS repeated that it projected risk corridor collections would be sufficient to pay for all risk corridor payments.[6] CMS also promised future guidance or rulemaking to address how it would calculate payments if total collections over the three years were insufficient to pay all risk corridor reimbursement claims.[7]

In the meantime, new patients enrolled in insurance plans and sought medical treatment. Many of these previously uninsured patients predictably had greater medical needs than previously insured patients. And these previously uninsured patients were more likely to purchase CO-OP plans.[8] Hospitals provided necessary medical treatment and submitted their bills to insurance companies with the expectation of reimbursement. Unfortunately for hospitals, not all insurers could pay their bills.

**CMS paid only 12.6% of all risk corridor reimbursement claims in 2014, leaving insurers on the hook for $2.5 billion.**

A combination of higher than expected medical expenses, oversubscription of underpriced plans, undersubscription of appropriately-priced plans, and mismanagement caused significant financial strain for insurers.[9] In fact, twenty-one of the twenty-three CO-OPs incurred net losses in their first year.[10] Despite its budget-neutral projections, CMS received $2.87 billion in risk corridor reimbursement requests and only collected $362 million in payments.[11] CMS could only issue risk corridor payments at a prorated rate of 12.6%.[12]

Non-CO-OP insurers were in a better position to absorb this blow. Some established insurers viewed risk corridor payments with such uncertainty they did not even account for the payments in their 2014 accounting.[13] On the other hand, CO-OPs were particularly vulnerable and dependent on the risk corridor payments. For instance, Health Republic of New York's risk corridor claim represented almost half of its capital, Common Ground Healthcare Cooperative of Wisconsin's claim represented 69% of its capital, and Kentucky Health CO-OP's claim was 117% of its capital.[14]

**Congress blocked HHS from using appropriated funds for risk corridor payments.**

In early 2014, at the request of then-Senator Jeff Sessions and Representative Fred Upton, the U.S. Government Accountability Office (GAO) investigated risk corridor payment options and found that HHS could have used its FY2014 CMS Program Management (PM) appropriations for the payments.[15] If Congress wanted to preserve this payment option in FY2015,

then it would need to mirror the FY2014 appropriations language.[16] Congress subsequently changed the FY2015 appropriations language and blocked HHS from using any appropriated funds toward risk corridor payments.[17] The FY2016 appropriations bill maintained this funding block.[18]

**CMS has not paid $8 billion in claims, causing eighteen of the twenty-three CO-OPs to become insolvent.**

As a result of Congress's funding block, CMS could only use its risk corridor collections to make its risk corridor payments, effectively unraveling this risk mitigation program. Health insurers fared even worse in 2015 and CMS only collected $95 million and received over $5.8 billion in risk corridor reimbursement claims in 2015.[19] CMS applied its 2015 collections toward paying its 2014 claims,[20] leaving $8 billion in unreimbursed claims. [21] Unsurprisingly, most CO-OPs became insolvent. As of the writing of this Article, eighteen of the twenty-three CO-OPs are insolvent and most of the remaining CO-OPs are under enhanced scrutiny by regulators.

**Insurers filed suit against the United States to seek payment with mixed results.**

With little hope of receiving the promised payments from HHS or Congress, CO-OPs turned to the courts for help. There are now twenty-three court cases before the U.S. Court of Federal Claims and the court has issued inconsistent decisions thus far. The cases have similar fact patterns and issues of law and mostly address (1) whether HHS owes annual payments, (2) whether HHS owes 100% of risk corridor payments, and (3) whether the risk corridor program must be budget-neutral. If Congress intended the program to be budget-neutral, then insurers may only expect to receive a share of risk corridor collections as opposed to receiving the total amount of their reimbursement claims. The government won the first round in *Land of Lincoln*, in which the U.S. Court of Federal Claims decided that HHS's interpretation that the ACA did not require full annual risk corridor payments was reasonable and that HHS did not have a contractual obligation to make the risk corridor payments. [22]

Shortly thereafter, the U.S. Court of Federal Claims ruled in favor of Moda Health Plan, finding that HHS is required to make annual risk corridor payments, Congress did not intend the risk corridor program to be budget-neutral, later Congressional appropriations did not make the program budget-neutral, the government entered into a contract with health insurers supported by consideration, and that Moda met its condition precedent for payment.[23] The court decided "the Government made a promise in the risk corridors program that it has yet to fulfill. Today, the Court directs the Government to fulfill that promise." [24] Both *Land of Lincoln* and *Moda* are currently pending before the Court of Appeals for the Federal Circuit, which has decided the appeals are companion cases and will be heard by the same appellate panel. [25]

**CMS invited insurers to negotiate settlements, prompting Congressional backlash.**

During the waning days of the Obama Administration and around the time *Land of Lincoln* was decided, CMS raised eyebrows on Capitol Hill by issuing a memo stating:

> We know that a number of issuers have sued in federal court seeking to obtain the risk corridors amounts that have not been paid to date. As in any lawsuit, the Department of Justice is vigorously defending those claims on behalf of the United States. However, as in all cases where there is litigation risk, we are open to discussing resolution of those claims. We are willing to begin such discussions at any time. [26]

Congressional Republicans responded by introducing the "HHS Slush Fund Elimination Act" in November 2016 to prohibit courts using the Judgment Fund [27] to pay a "final judgment, award, or compromise settlement related to [risk corridors payments]." [28] The House also requested and was granted leave to file an amicus brief in the *Land of Lincoln* appeal addressing the same complaint. The House argues the "Appellant's attempt to obtain unappropriated payments through the Judgment Fund" elicits separation of powers concerns.[29] CMS under the Trump Administration is less likely to invite insurers to sue and settle than the Obama Administration, nevertheless, there could still be an interesting separation of powers struggle between Congress and federal courts over whether the Judgment Fund may be used to satisfy these claims.

*With little hope of receiving the promised payments from HHS or Congress, CO-OPs turned to the courts for help. There are now twenty-three court cases before the U.S. Court of Federal Claims and the court has issued inconsistent decisions thus far.*

Notwithstanding the *Moda* and *Land of Lincoln* companion cases, the U.S. Court of Federal Claims continues to issue conflicting decisions. In March 2017, Molina Healthcare of California filed suit against the United States seeking its risk corridor payment, relying heavily on *Moda*. Despite the similarities between the claims in *Molina* and *Moda*, the court declined to issue a stay of proceedings or a limit on the contents of the briefs. [30] Yet, on June 7, 2017, the U.S. Court of Federal Claims stayed *Farmer v. United States* pending the outcome of the *Land of Lincoln* and *Moda* appeals.

**Conclusion: Hospitals are left footing the bill until Congress or the courts intervene.**

As the funding and separation of powers debates rage in courts of law and public opinion, the true victims remain the hospitals and patients. Hospitals have fulfilled their part of the bargain and have treated patients while relying on a reasonable expectation of payment for services rendered. The ACA was passed in part to alleviate the burden of uncompensated care and to expand health insurance coverage. Yet, insurers cannot

pay what they owe and are failing while hospitals continue to experience even greater levels of uncompensated care. [31] How can we expect our cash-strapped hospitals to function if they are increasingly not reimbursed for the care they provide? Failing to pay for care will result in rising healthcare costs and hospitals closing their doors. Whether through Congress or the courts, hospitals must be paid or we will have even less access to affordable healthcare than before the ACA. Judge Wheeler's conclusion in *Moda* is just as relevant to hospitals as it is to health insurers:

> There is no genuine dispute that the Government is liable to [health insurers]. Whether under statute or contract, the Court finds that the Government made a promise in the risk corridors program that it has yet to fulfill. Today, the Court directs the Government to fulfill that promise. After all, "to say to [insurers], 'The joke is on you. You shouldn't have trusted us,' is hardly worthy of our great government." [32]

Greg Mitchell is a Member of Frost Brown Todd LLC and heads the firm's insurance regulatory practice group.

Jason Halligan is a Summer Associate at Frost Brown Todd LLC and a rising 3L at Harvard Law School.

Sources:

[1] See Dep't Of Health And Hum. Serv., Off. Of Inspector Gen., A-05-14-00055, Actual Enrollment And Profitability Was Lower Than Projections 5 (2015).

[2] HHS, Centers For Medicaid And Medicare Serv., *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule*, 11 (Mar. 2012).

[3] See 42 U.S.C.A. § 18062 (West).

[4] HHS Notice of Benefit and Payment Parameters, 78 Fed. Reg. 15409, 15473 (Mar. 11, 2013).

[5] See HHS, CMS, RISK CORRIDORS AND BUDGET NEUTRALITY (Apr. 11, 2014).

[6] Id.

[7] Id.

[8] For instance, 75% of customers on Kentucky's Exchange purchased a Kentucky Health Cooperative plan. See Kentucky Health Cooperative, *Kentucky Health Cooperative Not Offering Plans in 2016* (Oct. 9, 2015).

[9] See HHS, OFF. OF INSPECTOR GEN., supra note 1, at ii; Sabrina Corlette et al, *The Affordable Care Act CO-OP Program: Facing Both Barriers and Opportunities for More Competitive Health Insurance Markets,* The Commonwealth Fund (Mar. 12, 2015).

[10] See HHS, OFF. OF INSPECTOR GEN., *supra* note 1, at 5.

[11] See Anna Wilde Matthews & Stephanie Armour, *Health Law's Program to Ease Insurers' Risks Has Shortfall*, WALL STREET J. (Oct. 1, 2015).

[12] See HHS, CMS, RISK CORRIDORS PAYMENT PRORATION RATE FOR 2014 (Oct. 1, 2015).

[13] See Matthews & Armour, *supra* note 11.

[14] See Anthony Brino, *Hospital-owned Insurers Face Pinch from Obamacare Risk Corridor Program* (May 12, 2015).

[15] See U.S. GOV'T ACCOUNTABILITY OFF., B-325630, DEPARTMENT OF HEALTH AND HUMAN SERVICES – RISK CORRIDORS PROGRAM 4 (2014).

[16] Id.

[17] See Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014).

[18] See Consolidated Appropriations Act, 2016, Pub. L. No. 114 113, § 225, 129 Stat. 2624, 2624 (2015).

[19] See HHS, CMS, RISK CORRIDORS PAYMENT AND CHARGE AMOUNTS FOR THE 2015 BENEFIT YEAR (Nov. 18, 2016).

[20] See HHS, CMS, RISK CORRIDORS PAYMENTS FOR 2015 1 (Sept. 9, 2016).

[21] See Brian Blase, *A Taxpayer Bailout of ObamaCare Insurers Just Got a Lot More Expensive*, Forbes (Nov. 21, 2016).

[22] See *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 108, 114 (2016).

[23] See *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 451 (2017).

[24] *Id.* at 466.

[25] *See Land of Lincoln Mut. Health Ins. Co. v. United States*, No. 17-1224 (Fed. Cir. May 30, 2017) (order granting motion to consider *Land of Lincoln* and *Moda* appeals companion cases and assigned to the same merits panel).

To monitor the companion cases see *Land of Lincoln Mut. Health Ins. Co. v. United States* Case Details; *Moda Health Plan, Inc. v. United States* Case Details.

[26] HHS, CMS, RISK CORRIDORS PAYMENTS FOR 2015, supra note 20, at 2.

[27] For more information on the Judgment Fund, see U.S. Department of the Treasury, Bureau of the Fiscal Service, *Judgement Fund*.

[28] HHS Slush Fund Elimination Act, S. 3481, 114th Cong. (2016).

[29] *Land of Lincoln Mut. Health Ins. Co. v. United States*, No. 17-1224 (Fed. Cir. May 1, 2017) (motion of U.S. House of Representatives for leave to file amicus brief).

[30] See *Molina Healthcare of California, Inc. v. United States*, 131 Fed. Cl. 160, 161 (2017).

[31] The insolvent Kentucky Health CO-OP still owes Kentucky hospitals over $57 million.

[32] Moda Health Plan, Inc. v. United States, 130 Fed. Cl. 436, 466 (2017) (quoting Brandt v. Hickel, 427 F.2d 53, 57 (9th Cir. 1970)).

# THE PERFECT RECEIVER: NUMBER 15 - YADADAMEAN

The 8th installment of this column was ostentatiously named "The Numbers." In the same vein this one might be named "The Words." In our little receivership world, as in many others, effective communication is indispensable. Our efforts in that endeavor are too often undone by shortcomings in our verbal skills. With incredible audacity, therefore, I take this opportunity to mount my well-worn soap box and expound eloquently (at least to my unbiased ears) on the importance of using our language properly. If I have not already put you to sleep you are no doubt asking yourself "Doesn't this fool know that there are many excellent books on proper writing skills and habits and that he is wholly unqualified to address the matter at all?" In a word, YES. The problem is that YOU (not you, the guy behind you) ARE NOT READING THEM! The world can be overrun completely with brilliant books about communication skills but they do no good at all unless actually opened and read. So I hope that in the limited space provided here I can impart a few useful hints until you bother to take the time to read a book on the subject penned by someone actually qualified to discuss it.

First, the title of this column: in bay area slang it means "know what I mean." I leave to you to discern why I chose it as my title. I will instead provide some thoughts on effective communication. I begin with a distinction. My comments here are guided mostly by widely accepted *descriptive* grammatical principles (more attentive to popular uses of the language) rather than the narrower set of *prescriptive* rules that strive to channel the language toward "established" rules. Although our language is governed by a set of rules accepted widely among grammarians, teachers, dictionary editors, and "educated" people, in the U.S. there is not actually an authority to promulgate and maintain such rules, as there is for example in France, where L'Académié française is viewed as holding that exalted status (though mostly by tradition and convention). Arguably, this makes our language more rapidly responsive to cultural evolution but simultaneously less predictable. Think for example about how the expression *"that is not my bag man!"* would have been interpreted in the 1920s vs. the 1970s. More recently, "*you rock!*" has become a widely accepted compliment. What would it have meant to a 19th century listener? Note that both of these expressions use words that were very common in both relevant periods. Their interpretive change is not attributable to the evolution of new words like "phishing" or "nuke," but rather to cultural adaptation.

If we have any hope of communicating effectively it begins with the unspoken but universally assumed principle that when we say a particular thing we generally intend it to convey a particular concept, and that our listener (or reader) will take it to mean just that. Imagine the chaos that would ensue if I simply chose to routinely use the word "dog" to mean my portable telephone while you routinely chose to use the word "cat" to mean the trunk of your car, in each case finding the shorter word more convenient than the longer widely accepted term.

The responsibility for this desired symmetry of interpretation lies with both parties: the communicant and the recipient. The communicant must refrain from using expressions incorrectly. The most common reason that this principle is violated is simple ignorance: we use words or expressions without a sufficient understanding of how they are most commonly interpreted.[1] Conversely, recipients must eliminate doubt by seeking clarification when the message is less than fully clear. We must overcome our fear that by seeking clarification we may appear less brilliant. [2] Were we to adhere universally to these two simple suggestions (use only words we know and ask when we don't understand), most mis-communications (and many fights) would be avoided altogether.

Perhaps just as important is the value of avoiding unnecessary complexity. Far too tempted are most of us to strive to sound brilliant by using long sentences with complicated words. How much more brilliant are we, however, if every time we communicate our recipient grasps immediately and without mental trauma exactly what we mean to convey? It is a sad aspect of our humanity that as we progress from student to professional (or equivalents) we tend to show-off our accomplishments by rolling out all the neat new words ad phrases we have learned, typically all in the same sentence. Only as we approach our waning years do we truly grasp the much greater merit of clarity. It serves us well to accept that if understanding us requires effort, our message will miss the target far too often. Those to whom we address ourselves are very often distracted by simultaneous endeavors [3] and devote only a small portion of their intellect to grasping what we strive to convey. We do best when we fashion our message in a way that requires no more than that small portion of the intellect to grasp completely. [4]

Since my goal here is not to prepare a complete writing guide, but rather to offer just a few digestible suggestions, I add only a few tips that are self-explanatory but which when observed pay handsome returns.

1. ORGANIZE! When writing something of any length, consider beginning with an outline. That will organize your thoughts in a logical and persuasive progression. Then fill in the outline with the developed thoughts, striving always to maintain an effortless flow. Well-organized pieces are much easier and more entertaining to read than stream-of consciousness dumps of

technical knowledge.

2. AVOID SILLY MISTAKES. Make sure subject and predicate agree as to number, that tenses are consistent within a sentence, and that punctuation follows conventional rules, not the ones you just invented. Brilliant arguments are undermined by poor grammar or writing style much as a cool car is rendered ordinary by dirt and dents.
3. NEVER, NEVER, EVER confuse "its" and "it's," "affect" and "effect," "their" and "there," "your" and "you're," "principle" and "principal," or so may other frequently confused homophones. At best, such mistakes may create an impression of ignorance. At worst they may lead to easily avoidable confusion.
4. AVOID LONG SENTENCES AND CONFUSING PARAGRAPHS. Go to the store, buy a big box of periods, commas and semicolons, and use them with wild abandon.
5. STRIVE TO AVOID UNNECESSARY REPETITION. There is no question that lengthy writing (such as a legal brief) often benefits from some repetition. Indeed, many a critic has observed that effective communication sometimes require that you tell the reader what you are going to tell him, then actually tell him, then tell him what you have told him. But excessive repetition can have the opposite effect and border on boredom or lack of organization.

When I was young, my father taught me to play bridge. He explained that it is a game governed by many complicated rules. However, the good player is the one who masters when to make exceptions. I suggest that the same is true of effective and elegant communication. Once we have learned to dominate the principles I describe above, we can fill our canvas with the fascinating and mesmerizing turns of phrase, double-entendres and other literary devices that separate us mere mortals from the giants of the spoken and written word. We must remember always that our first duty is to communicate effectively. Dazzling, impressing, and rendering speechless are goals we should pursue only if that first duty is met.

Patrick Cantilo is the Managing Partner of Cantilo & Bennett, LLP.

*[1] Sometimes we have no clue whatsoever as to what an expression actually means when we use it; but it just sounds so cool ...*

*[2] "What do you mean your dog can't get a signal? I guess you might as well throw it in your cat?"*

*[3] For example musing as you speak: "What could possibly have led him to believe that that tie goes with that shirt?"*

*[4] I tell young lawyers in my firm: "Remember, no judge will ever devote nearly as much attention to reading your brief as you did to writing it. Keep it simple!"*

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# AN OVERVIEW OF OWN RISK AND SOLVENCY ASSESSMENT (ORSA) AND ITS RELEVANCE TO IDENTIFYING POTENTIAL TROUBLED COMPANIES

**By Steve Hazelbaker**

**Overview and Purpose of ORSA Requirements:** The NAIC Own Risk and Solvency Assessment (ORSA) is a relatively new tool for regulators to use in monitoring enterprise risk management (ERM) and solvency considerations for insurance groups and individual companies. The ORSA has two primary goals: 1) to foster an effective level of ERM at insurers; and 2) to provide a group-level perspective on risk and capital, as a supplement to the legal entity view.

Regulators and the industry, primarily through the North American Chief Risk Officers (CRO) Council, were involved in drafting the NAIC ORSA Guidance Manual. The Guidance Manual and Model Law #505 were adopted in 2012 with the expectation that all jurisdictions would adopt risk management and ORSA requirements into state law prior to 2015. The pace of adoption fell somewhat short of that target. A majority of states have now adopted the Model Law, with all remaining states expected to adopt it by year-end 2017. This becomes an Accreditation Standard in 2018.

There are important size criteria to the ORSA requirements. An insurer is exempt from maintaining a risk management framework, conducting an ORSA, and filing an ORSA Summary Report, if: a) the individual insurer's annual direct written and unaffiliated assumed premium is less than $500 million; and b) if the insurer is a member of an insurance group and all insurance legal entities within the group have annual direct written and unaffiliated assumed premium less than $1 billion. It is estimated that there will be approximately 300 ORSA Summary Reports filed annually, with 200 at group levels and 100 at single-entity levels. Many states started receiving their first ORSA reports in 2015.

**Key ORSA and ERM Components:** The ORSA Summary Report should discuss three major areas, which the Guidance Manual refers to in the following three sections:

- Section 1 – Description of the Insurer's Risk Management Framework
- Section 2 – Insurer's Assessment of Risk Exposure
- Section 3 – Group Assessment of Risk Capital and Prospective Solvency Assessment

When developing the ORSA Summary Report, the content should be consistent with the ERM information that is reported to senior management and the board of directors. The content should be based on the insurer's internal reporting of its ERM information.

An effective ERM framework should incorporate the following key principles:

- Risk culture and governance
- Risk identification and prioritization
- Risk appetite, tolerances, and limits
- Risk management and controls
- Risk reporting and communication

Many insurers have long had these elements as part of their approach to ERM. ORSA has tended to enhance the formality, quality of documentation, and degree of internal discussion regarding ERM matters. Many insurers are also finding that ORSA has contributed to increasing the awareness and the involvement of senior management and board members with certain enterprise risk management topics and considerations.

Section 1 of the ORSA Summary Report should provide a high-level summary of the above elements of the insurer's ERM framework. Strengths or weaknesses noted by regulators may have relevance to the ongoing supervision of the insurer.

*ORSA has tended to enhance the formality, quality of documentation, and degree of internal discussion regarding ERM matters.*

**Stress Testing Risk Exposures:** An insurer's stress testing of its material and relevant risks can yield meaningful insights. Section 2 of the ORSA Summary Report should provide a high-level summary of the quantitative and/or qualitative assessments of risk exposure in both normal and stressed environments. Companies will approach this exercise in a variety of ways. Critical factors include the selection of risk exposures to stress, the approach taken to assess such risks, and the stress conditions chosen for testing.

There is no standard or required selection of risks which must be assessed for purposes of the ORSA. Companies should address their reasonably foreseeable and material relevant risks. Examples of such risks may include: credit (investment and non-investment), legal, liquidity, market, operational, pricing/underwriting, reputation, reserving, strategic, and a

variety of other risks. As a practical matter, the nature of the company's business will strongly influence the risks assessed. For example, it is common for property and casualty companies to address certain stresses on their investment portfolios, reserves, and property catastrophe exposures, among the risks quantified for ORSA. Companies should also consider stresses which may be somewhat unique to their own circumstances, such as risks emanating from their corporate structure, their market niches, use of technology, etc.

The assessment of each risk will depend on its specific characteristics. The likelihood of occurrence and the potential impact should a risk event occur are commonly used assessment criteria. Companies also commonly consider a risk's velocity, or speed of onset, as a risk assessment criteria. The speed of onset, for example, may strongly influence the sense of urgency and approach an insurer uses in managing the risk. A number of insurance company risks lend themselves to quantification using deterministic stress tests or more complex stochastic modeling. Other risks, such as certain operational or reputational risks, may have less well established quantitative methods. A qualitative assessment may be more commonly used to address such risks. Each insurer should use assessment techniques applicable to its risk profile.

*Since stress events do not happen in a vacuum, it is important for an insurer's ORSA to consider the possibility that concurrent stresses will occur.*

There is also no standard set of stress conditions that each insurer must test under ORSA. The insurer selection of the stressed environments for assessment is a critical factor in determining the usefulness of the ORSA. Useful stresses are rigorous and challenging. Insurers often involve their subject matter experts to provide input into stress scenarios. Stress selections should consider previous stress events experienced by the insurer, as well as by others in its industry. The stress environments assessed in the insurer's ORSA may provide regulators with insights into the availability of financial resources to cover the insurer's key risks. Insights may also be gained regarding the type of stress events which could cause severe strain on the capital and financial resources of the insurer.

Since stress events do not happen in a vacuum, it is important for an insurer's ORSA to consider the possibility that concurrent stresses will occur. Just as diversification should be considered since all stress events are unlikely to occur within the same time frame, correlation between stresses should be considered. Recent history provides examples of the occurrence of concurrent stresses. We do not have to go back many years, for example, to find incidents of property catastrophe events and declines in the market value of investments occurring within the same year. It is not uncommon for other concurrent stress events to have been experienced by insurers. Regulators are keenly interested in the ability of insurers' capital and financial resources to withstand concurrent stress events.

Many troubled insurance company situations have the common characteristic of strain on liquidity. Although this is not always done in practice, it may be advisable for insurance companies to include liquidity as a risk stressed in its ORSA. Insurers may find that concurrent stresses work in combination to strain liquidity. Preparing in advance to meet such strains may be beneficial to an insurer's management of its capital, cash, and other financial resources.

**Assessment of Risk Capital and Prospective Solvency:** Section 3 of the ORSA Summary Report should combine elements of the insurer's risk management policy with its risk exposures to determine the level of financial resources it needs to manage its business. The insurer should compare its available capital against the various risks that may adversely affect the organization. Such a comparison should provide regulators with insight regarding the likely sufficiency of capital to cover foreseeable risks.

The insurer's capital assessment process should be tied to its business planning. As the insurer looks ahead to assess its prospective solvency, it is important that consideration be given to anticipated changes to its internal operations and strategies, as well as to the external business environment. The outcome of the prospective solvency assessment should either demonstrate that the insurer has the financial resources available to meet its multi-year business plan, or else it should describe the management actions that the insurer has taken or will take to effectively address its capital adequacy concerns.

Such management actions may include potential changes to the business plan or the identification and pursuit of additional capital resources. Business plan changes could involve revisions to areas such as growth and market objectives, pricing, investment portfolio management, use of reinsurance, and a variety of other operational or strategic considerations. Capital management actions could also involve use of reinsurance, and may include public company access to capital, various funding sources, etc., even leading to potential business combinations involving the company.

Regulators should not expect to see a high degree of detailed granularity when reviewing and evaluating ORSA Summary Reports. Companies do not have crystal balls and will be unable to say exactly which management actions would be taken when certain stress events are actually encountered. However, serious thought should have taken place at high levels of the organization. Discussions between senior management and the board of directors may be beneficial to consider what potential actions may be needed in response to risks causing significant deviations from the insurer's business planning.

**Walking the ERM Talk:** Both insurance companies and regulators should derive meaningful insights and value from ORSA. To provide such benefits, ORSA must be representative of the insurer's ERM framework and reflect information that is used in its management and risk-based decision-making, as well as its board oversight. ORSA should reflect dynamic process and reporting. It should not be merely an academic

process performed for regulatory compliance.

A number of positive indicators can provide perspectives on the usefulness of ORSA. Meaningful involvement of senior management and awareness of the board of directors are important for ORSA to have value internally and for regulatory purposes. A strong ORSA process has likely involved a number of subject matter experts within the insurer. Examples of risk-based decision making can provide useful illustrations of how ERM functions in practice, as can response to the breach or near-breach of risk tolerances. As ERM is inherently a dynamic process, companies will likely have examples of ERM success stories, as well as lessons learned and areas earmarked for improvement. Insurers with strong ERM will also be looking ahead to identify and address prospective risks.

Conversely, negative indicators may cast doubt on the usefulness of information provided by ORSA. The limited involvement of an insurer's key personnel may be detrimental, as is minimal evidence of senior management and board awareness of ORSA. Failing to operationalize risk tolerances can be a sign of ineffective ERM. In other words, risk appetites, tolerances and other metrics may exist on paper, but not be used operationally for risk monitoring and decision-making. An absence of ERM enhancements and the lack of consideration of emerging risks may also be indicators of ERM shortfalls.

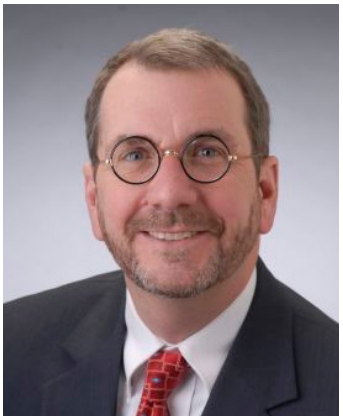
**Reaping Benefits from ORSA:** When done well, ORSA yields a number of benefits to the industry and regulators. Insurance companies derive benefit when ORSA is "real to the business" and not just a compliance exercise. Worthwhile insights can be provided from stress testing. Risk management may be enhanced and the linkage between business planning and capital management can be strengthened. The quality of risk communication and dialogue between senior management and the board may improve.

The ORSA contains much information of value to regulatory examiners and analysts. Information regarding the assessment of key risks and the prospective solvency assessment can aid understanding and provide worthwhile insights into the supervision process.

Steve Hazelbaker, CPA, FLMI is a Vice President with Noble Consulting Services.

# SAVING MONEY, SAVING LIVES: WGFS PROGRAM ADDRESSES EXCESSIVE OPIOID USE AND COSTS

**By Nick Crews**



Tom Kanan was putting the finishing touches on a presentation for the 2015 National Conference of Insurance Guaranty Funds (NCIGF) Fall Workshop on medical marijuana when a thought came to him.

"While I was looking at medical marijuana use, I found some research that showed in places where people are using medical marijuana, there is a reduction of the use of opioids," said Kanan, a claims manager for Western Guaranty Fund Services (WGFS). "In the last couple years there has been an incredible increase of people dying of opioid abuse, which usually starts with prescribed opioids."

The realization that there were effective, less dangerous opioid alternatives in part led Kanan in the following months to sign WGFS on to an innovative program, one that would allow it to control costs related to excessive opioid use by some of its Workers' Compensation claimants while encouraging less patient reliance on opioids.

A year later, the program, which is administered by a cost containment firm, had cut excessive opioid use among some of the WGFS program's 12 "test case" claimants, annually saving the organization an estimated $41,659. WGFS puts projected lifetime savings for the group of claimants at $1,226,902.

Most important, as Kanan points out, the program helped about half the selected claimants reduce dependence on the drug, and possibly even saved lives.

Kanan drew on some anecdotal evidence as his thoughts about opioid alternatives began to take shape. "My wife used to work with Veterans Administration patients who suffer from chronic pain and PTSD," said Kanan. Some were being prescribed opioids. Almost to a man patients told her that for pain treatment, marijuana was far more effective [than opioids]. For a lot of them, marijuana is what they'd prefer to everything else the doctors were prescribing for them…. I realized a lot of people will use marijuana for pain relief; and, unlike opioids, marijuana itself cannot kill you."

*Most important, the program helped about half the selected claimants reduce dependence on the drug, and possibly even saved lives.*

As Kanan sees it, excessive opioid dependence increases when the drug is used by those suffering from chronic pain. The goal of the program was to ascertain if a reduction of excessive opioid use in claimants with chronic pain – and of

related costs – could be achieved, while still helping those claimants appropriately manage pain.

Begun in 2015 and running through 2016, the project involved 12 of WGFS's injured Workers' Compensation claimants who suffered from a variety of disabling conditions – and who had a history of excessive opioid use as defined under the terms of Colorado's Department of Labor and Employment Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines. All the project participants were using opium-based medications well over recommended maximum limits, frequently without regular medical monitoring.

In time, WGFS would demonstrate that it could deliver benefits on four fronts: a decrease of opioid use and the related costs, a lessening of user dependency on the drug, and the substitution of other reasonable alternative medications, all while improving the functional lives of the injured workers.

The Colorado Guidelines gave WGFS a good framework for understanding the concept of "excessive use" of opioids from the perspective of accepted medical practice.

The Guidelines state: "Opioids are the most powerful analgesics. Their use in acute pain and moderate-to-severe cancer pain is well accepted. Their use in chronic, nonmalignant pain, however, is fraught with controversy and lack of scientific research."

Elsewhere the Guidelines assign generally acceptable levels of opioid use: "Doses of opioids in excess of 120 mg morphine equivalent have been observed to be associated with increased duration of disability, even when adjusted for injury severity in injured workers with acute low back pain – and thus any use above 120 mg should be very closely monitored. Doses in excess of 200 mg should be avoided."

With these dosages as a benchmark, WGFS selected its claimants for the program.

*"Opioids are the most powerful analgesics. Their use in acute pain and moderate-to-severe cancer pain is well accepted. Their use in chronic, nonmalignant pain, however, is fraught with controversy and lack of scientific research."*

"The cut-off we used for our claimants was 200 mg of morphine equivalent dose. We used that to identify our patient category," said Kanan.

Colorado Division of Workers' Compensation has established administrative guidelines for reasonable medical treatment, using evidence-based medical objectives in diagnosis and treatment. The basic idea behind the Guidelines is determining what's medically reasonable?"

"Our cost containment company's pharmacology expert reviewed the patients' drug prescriptions and billing histories for two years," Kanan said. "Based on that review, the company developed suggestions for doctors on alternative medications that can reduce the cost – and the use – of dangerous prescriptions, or prescriptions used where other medications would be less potentially harmful."

As a first step, a case manager from the cost containment company drafted and sent introductory letters to the attending physicians of the 12 identified patients, along with a report that documents current opioid usage levels and recommends prescription alternatives. The cost containment company then arranged meetings between its case manager and the treating doctors to discuss medications and medication levels to see if the cost containment firm could enter into a written agreement with doctors to implement possible changes to prescriptions. Following that, the cost containment company held follow-up conferences with the physicians to try to ensure they adhered to revised prescription plans.

As the program got underway, WGFS began to see results.

"The population [of claimants] we were looking at were ones we identified as people who are probably addicted to opioids and using them inappropriately," said George Fairbanks, a claims adjuster for WGFS. Fairbanks performed a detailed analysis of the program's cost savings.

"[One claimant] was taking a 400 mg morphine equivalent dosage, with the doctor continuing to increase it. We had a doctor discuss it with him; we pointed out to the doctor he was prescribing very dangerous levels of opioids to his patient.… Just by investigating and trying to look at these things, you can actually accomplish good for some people – either to stop their possible trade in drugs, or usage levels that will kill them."

No prescription savings was realized for five of the program's patients due to factors such as doctors' reluctance to work with the cost containment firm, medical failure to follow through on revised treatment plans, refusal to change medications or prescription levels, or the patient's unwillingness to allow the doctor to work with the cost containment company.

"So, in about half the selected cases, the program didn't accomplish anything," said Kanan. "But in the other half they did save us about $1,000,000 over the projected lifetime reserves, with an annual savings of somewhere between $41,000 and $72,000 depending on how you look at the cases. More fundamentally, about half of the selected patients are now using much safer techniques of pain control, with reduced risk of dangerous overdoses."

Kanan says that over-prescribed or improperly prescribed opioids – apart from the health risks they pose for users – can exact a high financial toll on Workers' Compensation carriers.

"When a doctor is not monitoring his or her patient, and not making sure the patient is using the drugs appropriately, it may create an aggravation of the Workers' Compensation claim, for which the Workers' Compensation carrier is potentially liable.… Opioids are not something that someone with chronic pain should be regularly taking, especially at high levels. The idea of this program was to reduce dosages over time so claimants

acclimated to receiving doses less likely to be harmful. This also reduces the costs."

The program's results show that WGFS, said Kanan, "was able to reduce some dangerous and excessive prescriptions to more safe levels for at least some of our claimants, without the need of litigation to challenge unreasonable or unnecessary types and levels of prescriptions." Litigation of issues relating to reasonableness of medical care is almost never cost-effective, he added.

WGFS's President Chad Anderson says the benefit of the program has been two-fold.

"While one initial goal of the program was to cut back on the out-of-control pharmacy costs, another obvious benefit of this has been to get some claimants' opioid use reduced," he said.

Kanan said that WGFS is not in the business of being doctors; it is in the business of making sure people are getting reasonable and necessary medical treatment.

"What we're seeing is there are many doctors who are giving unreasonable and unnecessary medical treatment. From our perspective, in chronic pain maintenance treatment, we consider a dosage above a 200 mg morphine equivalent to be unnecessary, as a matter of course, and most probably unreasonable – because it's dangerous."

"The idea of the program was to see if it would work for us," said Kanan. "Although it did not succeed in all cases, it was able to accomplish very good results in some cases, both in cost savings and by helping people achieve a more reasonable use of opiates."

Nick Crews is Vice President, Guaranty Fund Services and Communications for the National Conference of Insurance Guaranty Funds (NCIGF).

# RISK OF HEALTH INSURERS IN RECEIVERSHIPS AND BANKRUPTCIES

**By Lewis D. Bivona, Jr.**

While receivers are quite familiar with current risks that plague insurers, we are not always on top of what emerging or pre-emergent risks are in the marketplace. Like fraudsters, receivers must think of how a situation may present an opportunity for abuse and what the potential impacts might be. While fraudsters do jail time if they are caught, receivers that fail to assess emerging risks can be permanently tainted by failing to consider financial implications that they did not address under state ordered actions. There have been so many changes to healthcare under the Affordable Care Act, (ACA), that opportunities for fraud or "gaming the system" will impact all lines of insurance, but primarily healthcare and P&C insurers.

The Office of Inspector General (OIG) has announced in its workplans, from 2015 through the present, that it will be focusing on managed care and Medicare Advantage plans sold under the ACA. While it is obvious by reading any industry or daily periodical that the government is going after unethical and abusive provider billing practices, it may not be so clear that insurers have a contractual obligation to ferret out fraud as a provider of benefits under government programs or those subject to federal laws (Writers Note - virtually everything!). In 2016, the federal government recovered over $3.3 billion dollars in fraudulent payments under the guidance of the Health Care Fraud and Abuse Control (HCFAC) Program. Since the inception of the program the government reports that it has recovered $7.70 for every dollar it has invested in fraud detection and investigation; not a bad return on investment!

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One of the most specific citations in the OIG workplan is the concern over inflation of risk scores that drive reimbursement levels to Medicare Advantage plans and to Managed Medicaid plan enrollees. While both of the aforementioned plans are slightly different in how the money gets to the insurers, the risk adjustment methodology is strikingly similar. If an insured has multiple chronic conditions, the reimbursement to the insurer is increased to cover the higher expected costs of treating the individual. A person who has no obvious health issues would be paid a capitation rate lower than average Medicare cost per patient since the average includes moderate to very sick individuals; conversely, a very ill individual would quality for a higher monthly Medicare Advantage capitation since they are by definition a higher cost patient than the average patient.

The whole methodology is anchored by Hierarchical Condition Categories (HCCs, category of medical conditions that map to a corresponding group of ICD-9 or ICD-10 diagnosis codes). There is generally a base rate for an age/demographic group that is modified for additional reported disease/condition states.

Although familiar with coding, I am not a coding expert, so I borrowed an example from Anthem (see http://www.anthem.com/ca/shared/f2/s2/t4/pw_e181334.pdf) prepared to demonstrate coding and price differentials. For example, an 85 year old female with diabetes and a urinary tract infection (UTI) would be coded to yield a weighing of .602 which when multiplied by the applicable base rate would yield a plan payment of $481.60; basically, this is a healthy 85 year old with diabetes under control and a mild UTI. The same individual with a slightly more complicated health status including diabetic neuropathy (nerve pain caused by diabetes), chronic stage 3 kidney disease (also acerbated by diabetes, causing fluid buildup in the body and accumulation of toxins in the blood, just shy of needing dialysis), a below the knee amputation (another side effect of diabetes disease progression), a history of a heart attack and malnutrition would be scored at a 3.09 with a monthly payment amount of $2,475. This increased payment level encompasses the fact that this woman will probably have to be hospitalized in the coming year, if not already, and requires intensive testing and follow-up by her physicians.

As you can see, the payment differentials for the same woman can vary dramatically. But let us suppose that her fluid retention really has nothing to do with her kidney function but more to do with an improper pharmaceutical regimen to maintain her post-heart attack condition. This would drop her rating by .368 and lower her monthly amount by $294 per month. Now you can see how a minor coding change can reduce payments by over 10% to the health plan. Couple that with electronic billing, coding optimization software (used by hospitals, physicians, nursing homes and others) and millions of new insureds being added by the ACA, and you have a recipe for financial disaster. The health plans are not entirely at fault since they rely on the accuracy of the data being submitted by their care providers (who have a financial incentive to code as high as possible); however, insurers are responsible as fiscal intermediaries for the government payors to rout out aggressive, if not outright fraudulent, billing practices.

*Insurers are responsible as fiscal intermediaries for the government payors to rout out aggressive, if not outright fraudulent, billing practices.*

Prior OIG findings seem to indicate that medical documentation does not always support the treatments provided, tests ordered or procedures on patients. The Centers for Medicare and Medicaid Services (CMS) is considering dropping adjusters for disease states to lower the propensity to "upcode" patients and/or overprovide certain treatments when more conservative care/treatments would be medically indicated. The ACA established a review for treatment best practices which have been slow to evolve to this point but are expected to pick up in 2017. In addition, the "sustained growth rate" (SGR) was a key factor in passing the ACA because it was supposed to reduce reimbursements to certain physicians for overcompensated procedures to fund the addition of millions of new insureds expected under the ACA. The SGR, which was supposed to take effect when the ACA passed, only recently was implemented and physicians are screaming to the heavens that they cannot afford to see Medicare patients; noise is already being made in Washington to repeal the SGR reductions due to this outcry. What is important to note is that Medicare payment rates have become the de facto litmus test for insurer payments; many insurers use Medicare plus a mark-up to derive their reimbursement rates to providers. No matter how you look at the situation, providers of medical services will look for ways to game the system to preserve their current economic lifestyles which, in turn, will put additional pressure on insurers to make sure they are not being duped.

I know some of you reading this article are saying "Lew, aren't you crying wolf, the government shouldn't go after insurers first, they should go after the people responsible for miscoding." Well, you are right, but pragmatically, it is easier to go after big targets first to get the most money back into the Treasury and to create a "sentinel effect" by driving home the point that insurers are required, at a fiduciary level, to make sure that funds are not just flowing through the insurer, that adequate safeguards are in place and that they are at least taking some measures to assure that providers are not pulling the wool over their eyes.

Case in point, the OIG has already gone after several large insurers (remember big fish first, medium fish second, smaller fish last) but no insurer will escape scrutiny in the long term. The Department of Justice (DOJ) has requested information from Humana and most recently from UnitedHealthcare regarding risk adjustments assigned to Medicare Advantage beneficiaries, according to an annual report Humana filed with the Securities and Exchange Commission (SEC).

The report offers a look at how the feds are following up on criticisms levied against the Louisville, Kentucky-based insurance giant, and Medicare Advantage plans in general, in an investigative series published by the *Center for Public Integrity.* The issue was reinvigorated following charges against a South Florida physician who allegedly overcharged Medicare Advantage plans. The physician was charged on eight counts of healthcare fraud involving upcoded risk scores associated with Medicare Advantage patients, which led to $2.1 million in allegedly fraudulent payments. Humana provided the Medicare Advantage plan, but was not implicated in the charges.

Humana's SEC filing indicated that the DOJ has requested information concerning the company's risk adjustment practices and compliance procedures. *Fierce Healthcare* recently reported that "whistleblower cases involving Humana that

have been dismissed, but federal investigators are looking for information pertaining to Humana's 'oversight and submission of risk adjustment data' assigned by providers within the Medicare Advantage network." What is clear is that Humana will obviously take a financial hit from this investigation as well as a reputational hit, two key risks outlined in Risk Focused Examinationguidance. One doctor cited in this case allegedly overbilled Humana for $12M in excess charges which raises the specter of inadequate compliance practices at the insurer.

So as Receivers/Liquidators, what questions should you be asking and what trends would be worrisome to note? While not all inclusive, here are some issues I would consider:

- Does the insurer have a due diligence process when signing up new providers?
    - o Are the owners/providers American citizens? There is a high correlation between fraud and foreign ownership.
    - o How long have they been in business in your service area? Have they done business in any other states where actions were brought against them?
    - o A physical visit to site to determine existence of the provider. Consider their employees' qualities and review their medical record documentation.
    - o Review of degrees, licenses and insurance coverages.
- Coding reviews are extremely important as part of a compliance program. Many providers know they should test their medical records at least annually (best practice is quarterly) to detect and remedy billing inaccuracies. For HCCs there is a great deal of information that must be correct or the health plan may be in danger of running afoul of the properly coding federal risk adjusters according to *Top 10 Medicare Risk Adjustment Coding Errors By Carol Olson, CPC, CPC-H, CPC-I, CEMC, CCS, CCS-P, CCDS* (modified with explanations by Lewis Bivona), including:
    - o The medical record does not contain a legible signature with the credential of the provider who performed the service.
    - o The electronic health record (EHR) was unauthenticated (not electronically signed) which makes the record of work done invalid for billing purposes. Also, was the provider in the office or present at time of service?
    - o The highest degree of specificity was not assigned the most precise ICD-9-CM code (soon to be ICD-10) to fully explain the narrative description of the symptom or diagnosis in the medical chart.
    - o A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record. The diagnosis code and the description should mirror each other.
    - o Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT). If past conditions are not being treated or complicating current treatment, then they should not affect the coding.
    - o Status of cancer is unclear and treatment is not documented. Remember if cancer is in remission, it should not be effecting coding.
    - o Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
    - o Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
    - o Chronic conditions or status codes are not documented in the medical record at least once per year.
    - o A link or causal relationship is missing for a diabetic complication(s), or there is a failure to report a mandatory manifestation code.
    - o Does the insurer's contract with the provider require annual coding reviews by an external party or does the insurer reserve the right to audit the provider's medical records?
- Lack of data mining at the insurer level. Aberrant utilization and billing trends can be ferreted out by comparing the insurer's provider billing data to other providers in the same classification. For example, is one cancer doctor's treatment cost for the same type of cancer significantly higher than all others? Are there statistical variations in the cost per patient from one provider to the next?
- What type of security is deployed to safeguard protected health information (PHI)? Not a day goes by without seeing another article about patient data being stolen from providers and insurers; this data can be used to bill for services that are fraudulent, which makes the case for heightened sensitivity to firewalls/intrusion detection fortifications and a good cybersecurity insurance policy.

If history is any indicator, we can expect that the federal government will pursue overpayments directly from the party with the fiduciary duty to protect the federal coffers (i.e.: the insurers) from unnecessary payments. Remember, government obligations are generally not dismissed in any receivership or liquidation without acquiescence by the government. Yes, insurers will have the right of offset and recoupment against their providers for overpayment but what happens if they close up business or are bankrupt? You guessed it, the insurers are holding the wrong end of the stick! If you are sitting there reading this article and think it only affects health insurers and not P&C companies, beware! Tightening of reimbursement criteria on health insurers is forcing providers to look where they can increase fees and that includes indemnity billings (automobile accidents, property liability, and workers compensation to name a few) in areas that are not as aggressively reviewed.

Lewis D. Bivona, Jr., CPA, HFE is an Insurance Examiner for the INS Companies

# IAIR BOARD OF DIRECTORS NOMINATIONS AND ELECTIONS 2017 FOR A THREE-YEAR TERM BEGINNING 01/01/2018

## (THERE ARE FIVE AVAILABLE POSITIONS ON THE BOARD)

It's again time for us to request nominations of candidates for the Board of Directors of the International Association of Insurance Receivers ("IAIR"). These candidate nominations will be used to prepare the advance mail-in ballots for the election during IAIR's Annual Meeting.

If you are interested in submitting a candidate nomination, here is the current information:

1. **Qualifications** - You or the recommended candidate must be a current, fully paid member in good standing of IAIR.
2. **Confirmation of Commitment** - The qualified candidate must agree to attend Board of Directors meetings throughout the three-year term of Board membership. Currently there are at least four in- person Board meetings annually (one at each of the current NAIC meetings (3), and one at the IAIR education seminar (1) in February), plus additional meetings by teleconference throughout the year. Confirmation of this commitment should be sent to the elections subcommittee Chair at the e-mail below.
3. **What you need to do:**
    - Send an e-mail with the following items to the Chair of the Elections Subcommittee c/o Nancy Margolis (nancy@iair.org).

      (a) A picture of you to be published with the IAIR ballot (jpg format),

      (b) A statement, not to exceed one page, outlining why you should be elected, and/or what you believe you can do to promote or further IAIR's activities, and

      (c) A statement of your, or another candidate's interest, qualifications and attendance commitment (as described in items 1 and 2).

**SEND TO:** Nancy Margolis (nancy@iair.org).

## THE DEADLINE FOR NOMINATIONS IS SEPTEMBER 15, 2017