June 16, 2017

James Kennedy, Chairman
Receivership Model Law Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO  64108

RE:  Request for NAIC Model Law Development

Dear Chairman Kennedy:

The American Council of Life Insurers (“ACLI”)\(^1\) would like to provide some additional comments to the May 30, 2017 letter that we submitted to the Receivership Model Law (E) Working Group (“RMLWG”).

Our new comments specifically address the Request for NAIC Model Law Development and its scope as it relates to the RMLWG’s recently adopted charges, as listed below:

1. Evaluate and consider the changing marketplace of long-term care insurance products and the potential impact on guaranty funds; and

2. Evaluate the need 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.

We believe that the aforementioned charges are sufficiently broad enough that it would allow the RMLWG to consider including HMOs as “member insurers” in the Model. Any changes to the Model Act should be made in a holistic manner, taking into account the potential need to include a type of entity or organization that is currently not subject to the Model’s provisions. The specific merits of why HMOs should be included in the Model are mentioned in another, separate comment letter that we submitted today.

Accordingly, we urge the RMLWG to modify Item 3 in its draft Request for NAIC Model Law Development as follows (addition is underlined):

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1 The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with 290 member companies operating in the United States and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers’ products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 94 percent of industry assets, 93% of life insurance premiums and 97% of annuity consideration in the United States. Learn more at [www.acli.com](http://www.acli.com).
Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

Life and Health Insurance Guaranty Association Model Act (#520). Propose to revise the model to address guaranty association assessments and coverage issues identified specifically regarding long-term care insurer insolvencies. Such issues include the potential inclusion of HMOs as “member insurers” of a state guaranty association.

Sincerely,

Bruce Ferguson
Senior Vice President, State Relations

cc: Jane Koenigsman
June 16, 2017

James Kennedy, Chairman
Receivership Model Law Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

RE: Guaranty Association Issues Relating to Long-Term Care Insurance

Dear Chairman Kennedy:

The American Council of Life Insurers (“ACLI”)

appreciates this opportunity to provide comments to the Receivership Model Law (E) Working Group (“RMLWG”) on the various options for guaranty association assessments with regard to long-term care (“LTC”) insurance-related insolvencies that are contained in Attachment B of the Agenda for the June 21 conference call.

At the outset, we cannot emphasize enough how integral the guaranty association system is to our state-based framework and how instrumental it has been in protecting policyholder interests for over 25 years. This state-based framework has handled most insolencies seamlessly for policyholders and has helped maintain robust insurance marketplaces for those products that are covered.

With that principle in mind, we would like to first submit comments that envision an approach that is built on what we believe are the best elements of the four Options presented by the RMLWG, followed by comments on each of the individual Options.

**Approach That Combines Elements of all Four Options:**

ACLI has reviewed the four Options that were provided, and we believe that a combination of those Options could create a workable solution that may be equitable to all stakeholders. We respectfully recommend that the RMLWG consider the following elements as part of an appropriate framework on how to address LTC insurance-related assessments on a uniform national basis:

1. **Shift in LTC Insurance-Related Assessments Among Assessment Accounts**
   A shift in LTC insurance-related guaranty association assessment liabilities from the health assessment account to the life insurance and annuity assessment accounts should be consistent with the following:

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1 The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with 290 member companies operating in the United States and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers’ products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 94 percent of industry assets, 93% of life insurance premiums and 97% of annuity consideration in the United States. Learn more at [www.acli.com](http://www.acli.com).
a. Applies only to LTC insurance-related assessment liabilities.
b. Life insurers will become responsible for 50% of the LTC insurance-related assessment liabilities.
c. Percentage calculations shall be based on the assessable premiums specific to each individual state and not based on national averages or any other indices external to an individual state (see Appendix I for the formula for calculating the assessment shift for any state).
d. Calculations shall take into account the percentage of the health account currently borne by life insurers and the percentage of the life insurance and annuity accounts currently borne by health insurers.
e. Liabilities shifted to the life insurance and annuity accounts shall be allocated to those accounts on a pro rata basis.

2. **Treatment of Health Maintenance Organizations (“HMOs”)**

Amendments to the *Life and Health Insurance Guaranty Association Model Act* (“Model”) regarding the way in which LTC insurance-related assessments are handled must also provide that any HMO who does business in a state and writes major medical coverage (but excluding Medicare/Medicaid) must be a participating member of that state’s guaranty association. To ensure that HMOs are on strong financial footing, a drafting note should be placed in the Model stating that, should a state’s insurance regulator determine that the solvency oversight of HMOs in that state is inadequate for such organizations to be part of the guaranty association, companion legislation shall be introduced to provide for enhanced solvency oversight of HMOs that is substantially similar to that required of traditional health carriers.

3. **Hybrid LTC Insurance Products**

As the marketplace for LTC insurance products is changing, so should its treatment in the guaranty association system. With the advent of hybrid LTC insurance products, which consist of LTC insurance riders attached to life insurance policies and annuity contracts, ACLI believes that these products should be solely covered within the life or annuity accounts. Therefore, we propose that LTC insurance rider premiums be allocated to the underlying base policies and contracts for NAIC reporting purposes (e.g., Schedule T; Assessment Base Reconciliation Exhibit), and that related rider benefits be covered under the state guaranty association provisions that relate to the base contracts.

Of course, any changes to the LTC insurance-related guaranty association assessment mechanism should be prospective in nature only (it should only apply to insolvencies that have not yet occurred).

While outside the charges for the RMLWG, we would be remiss if we did not point out that there are some ancillary issues to the guaranty association assessment issue for LTC insurance. First and foremost, it is paramount that a national, comprehensive, uniform system of reviewing LTC insurance rate increase requests be developed, such that actuarially-justifiable rate increases are granted in a timely fashion. This will greatly reduce the likelihood of other LTC insurance-related insolvencies. Second, more attention must be paid to prompt corrective action and least cost resolution. Changes to the *Insurer Receivership Model Act* may be appropriate to more effectively advance these concepts in the resolutions of future insolvencies.

**The Four Options Provided by the RMLWG:**

While the approach outlined above combines elements of all four Options, we would have concerns if any of the Options were considered or adopted as individual solutions. These concerns are outlined below.
**Option 1** - Aggregate the life / annuity and health insurance accounts for the purpose of making Class B assessments with respect to LTC policies issued by an insolvent member insurer. Accounts remain separate for all other purposes.

ACLI is supportive of methodologies that provide the broadest assessment basis for LTC insurance-related insolvencies. While this Option provides a broader assessment base, it would also shift approximately two-thirds of the assessment burden to the life insurance industry, which is something that we cannot support. While it is true that the majority of LTC insurance has been written by life insurance companies, almost 80% of life insurance groups have never written LTC insurance. In addition, LTC insurance is regulated as health insurance and has been written by major medical insurers, and it is hard to predict what types of insurers will write LTC insurance in the future.

For these reasons, it makes sense for the product to be treated differently and for health insurers and life insurers to equally share the responsibility of funding these types of insolvencies. However, we believe that shifting two-thirds of the burden to the life insurance industry, as this Option would do, simply flip-flops the problem that we are trying to solve, which is the overburdening of companies that do not write LTC insurance.

**Option 2** – Eliminate separate accounts for life and health insurance and annuities entirely. Class B assessments with respect to any insolvent member insurer would be paid by all association members in accordance with the methodology provided by legislation.

A primary purpose of the guaranty association system is to ensure a robust marketplace for particular product lines (health insurance, life insurance, annuities). It is in the best interest of companies doing business in a particular marketplace to participate in a guaranty association system that maintains that robustness. The Model’s assessment mechanism has done, and continues to do, a very good job of holding companies that participate in a particular marketplace responsible for any insolvencies that occur within that marketplace. Using broad marketplace categories, the current three-account mechanism assures a general correlation with marketplace participation while at the same time assuring adequate assessment capacity.

LTC insurance is a unique product that blends characteristics of health insurance, life insurance and annuities, and requires a unique solution in terms of guaranty association coverage and assessments. However, we strongly oppose the concept of eliminating the existing three assessment accounts and holding all companies responsible for insolvencies regardless of the market in which they do business.

**Option 3** - Include HMOs as members of the guaranty association. HMOs would be a third account under Section 6 of the Model. However, Class B assessments with respect to LTC policies issued by an insolvent member insurer would be apportioned among all three accounts in accordance with the methodology provided by legislation. This option will require changes to the Model to provide for the payment of claims against HMOs.

ACLI supports the inclusion of HMOs as “member insurers” of a state’s life and health insurance guaranty association, to the extent a HMO does business in that state and writes major medical-type coverage (excluding Medicare and Medicaid). Again, it is in the HMOs’ best interest to have a robust health insurance market, and they should participate in the guaranty association system to ensure that such robustness is maintained.

However, we would oppose the creation of a separate assessment account for HMOs, as the businesses of HMOs and traditional major medical health insurers have become extremely similar, with little differences remaining between the insurance coverage provided. The current exclusion of
HMOs and managed care plans have evolved significantly since Congress enacted the Health Maintenance Organization Act of 1973. Today, HMOs and indemnity medical carriers have very similar business models, offering comparable major medical benefit products and services in the commercial market. Very simply stated, they are both essentially collections of provider networks.

Major medical carriers have told us that they can easily shift their businesses over to a HMO platform. If that were to happen, and major medical carriers were to exit the states’ life and health insurance guaranty associations, the related health accounts would be rendered so anemic that they may not have enough capacity to fund a major insolvency. This is a fundamental concern that policymakers need to address. To their credit, the health carriers have not yet changed their business models. Instead, they are addressing it head-on and working collaboratively with the life insurance industry and other stakeholders to achieve an equitable solution. However, if their concerns about competitive balance are not adequately addressed, there exists the real possibility that major medical carriers will see no solution other than to shift their businesses over to a HMO platform.

**Option 4** - Provide that Class B assessments with respect to LTC policies issued by an insolvent member insurer would be allocated among the life and health insurance accounts pursuant to a methodology and formula established by the Association, and approved by the Commissioner.

We strongly oppose any proposal that would encourage the states to develop their own LTC insurance-related assessment methodologies and formulas. The NAIC, state regulators, ACLI and others in the life insurance industry have continually promoted the uniform adoption of the assessment methodology contained in the Model. Amending the Model to provide each state the discretion to develop its own assessment mechanism for such insolvencies would create a disparate and complex maze of laws and assessment formulas. Furthermore, it does not solve the problem. Instead, it just shifts the problem to the individual states and sets up the potential for future conflicts between guaranty association board members that represent different industry segments. It is inevitable that these boards, based upon their composition at the time, would determine winners and losers after the insolvency has already occurred and the costs are known.

Depending upon how a state implements this Option, it could also result in placing undue burdens on certain companies which in turn could create solvency concerns. Current laws are built on the concepts of using broad assessment bases. Isolating specific products, such as LTC insurance, only serves to de-stabilize the product line’s viability in the event of an insolvency.

We realize that some differences among the states are inevitable, but to assure fair consumer protections and balanced marketplaces, policymakers should strive for the highest degree of uniformity, predictability and efficiency across the system. This Option does just the opposite, potentially creating some significant degree of instability, and variances in the system will lead to unequal results.

Thank you for the opportunity to provide comments on this very important matter. Feel free to contact me at 202-624-2385 or bruceferguson@acli.com if you have any questions.
Sincerely,

Bruce Ferguson
Senior Vice President, State Relations

cc: Jane Koenigsman
Appendix I

Formula for Determining Proportion of LTC Assessments to Shift to Life and Annuity Accounts for a 50%/50% Split Between the Life Insurance and Health Insurance Industries

Terms Used

X-factor – Represents the percent of LTC assessments assigned to the life and annuity accounts

HA – Guaranty Association Health Account

LIAA – Guaranty Association Life Insurance and Annuity Accounts

Generalized formula for life insurers’ share of LTC assessments

Life insurer share = (Life insurer share of HA x Health Account GA assessments for LTC) + (life insurer share of LIAA x Life & Annuity Account GA assessments for LTC);

Development of formula to set life insurers’ share of LTC assessments at 50%

Life insurer share = (Life insurer share of HA x (1 – X-factor)) + (life insurer share of LIAA x X-factor);

Setting the Life insurer share at 50%, we get:

.50 = Life insurer share of HA - Life insurer share of HA x (X-factor) + life insurer share of LIAA x (X-factor);

(.50 -Life insurer share of HA) = (life insurer share of LIAA - Life insurer share of HA) x (X-factor));

Therefore:

Formula for Determining Proportion of LTC Assessments to Shift to Life and Annuity Accounts

X-factor = \[ \frac{(.50 - \text{Life insurer share of HA})}{(\text{Life insurer share of LIAA} - \text{Life insurer share of HA})} \]
June 16, 2017

Mr. James Kennedy
Chair, Receivership Model Law Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Dear Chairman Kennedy:

I am writing on behalf of Aetna, Anthem, Cigna, HCSC and United, a coalition of national major medical health insurers who together provide major medical health insurance coverage to more than 227 million members world-wide and who offer a wide range of health insurance offerings including major medical coverage and HMO products. On behalf of those carriers, we urge the Receivership Model Law Working Group (“Working Group”) to amend the Life and Health Insurance Guaranty Association Model Act (#520) (“Model Act”) to expand the assessment base for future potential insolvencies including long-term care insurance insolvencies.

The Working Group Should Adopt an Approached Based on Option 3

We thank the working group for recognizing the need to amend the NAIC model in order to ensure the continued stability of the state-based guaranty fund system and the health insurance markets that fund the health accounts of those systems. In order to accomplish this, we urge the Working Group to adopt a solution based on Option 3 as set forth in the Working Group’s July 21, 2017 agenda. We believe the Working Group should have two goals, both of which can be addressed by an Option 3 approach, when addressing the funding of future insolvencies:

1. To more fairly distribute the cost of long term care insolvencies among companies writing life, health, annuity and HMO products; and

2. To amend the model to provide stability and fairness for the guaranty funds and for health insurance consumers.

To meet those two goals, the Model must be amended to a) spread future long-term care insurance assessments across not only health writers but also life and annuity writers and b)
include HMOs in the assessment formula.

We believe the revised Model should include HMOs as members of the guaranty association, as part of the health account. Under this approach Class B assessments with respect to long-term care insurance policies issued by an insolvent member insurer would be apportioned between the life/annuity and health account. Option 3 notes that the Model will need to develop a method to deal with claims against HMOs in states that have free-standing HMO guaranty association. Several state guaranty association already include HMOs in their guaranty fund systems, either as a free-standing fund or as part of the overall fund, so the Working Group can borrow from the experiences of these states when addressing the claims issue.

The lead-in paragraph to the four options presented to the Working Group provides that the “Working Group has identified the following options with respect to potential changes to Section 9 of the Model.” We believe that other sections of the Model Act will also need to be amended to implement any of the options presented to the Working Group. As a result, we recommended that the Working Group adopt language which makes it clear that the proposed changes to the Model Act are not limited to Section 9 and that the Working Group will make all amendments necessary to implement whichever option it adopts.

The existing assessment formula is not sustainable. There are clear differences in treatment between the life insurance industry and the major medical health insurance industry that must be considered when determining appropriate assessment bases for long-term care insolvencies. The Working Group needs to broaden and re-align the assessment base for long-term care insurance related insolvencies among life and health insurers to reflect the evolution of the long-term care insurance market. Any realignment must acknowledge the rapid growth of life insurance and annuity hybrid products, as such products account for approximately 24% of the current long-term care insurance market and 85% of new long-term care insurance sales.

**The Model Should be Revised to Ensure Continued Market Stability**

As we have seen in a number of states, the major medical health insurance industry cannot on its own absorb the cost of future long-term care insolvencies. Long-term care insurance, while classified as “health” policies, are not written by major medical insurers in any material way. Our industry has no more than 3% of the long-term care writings, yet is being asked to shoulder almost 75% of the cost of these insolvencies. The major medical health insurance industry cannot and should not be expected to bear such a disproportionate cost of these insolvencies. Given how very little of today’s long-term care insurance is being written by major medical carriers, passing along this tremendous cost to health care consumers is unfair and is unworkable.

The major medical industry writes very little of today’s long-term care insurance yet is being asked to fund the lion’s share of these insolvencies. This is unworkable in today’s marketplace. The American Council of Life Insurers (“ACLI”) recognizes these inequities and
working together in Colorado we developed a solution that spreads the cost across the entire health and life insurance industry. The ACLI and this coalition of health insurers recognizes the societal benefits of a functioning and fair safety net for customers of long term care insurance. We believe that the entire life, annuity, and health insurance industry, including HMOs, should participate in meeting this societal need.

The Model Should Reflect the Evolving Insurance Marketplace

Any new assessment formula must recognize, and make allowances for, how health insurance has evolved. There are new products and new competition. As presently drafted the model favors one type of health insurance coverage (HMOs) over other types of health insurance coverage. This creates an unjust and inequitable situation for consumers, who are denied the ability to purchase health insurance products in a robust and competitive market.

Excluding HMOs from the guaranty fund assessment system is an outdated concept. The health insurance market has changed dramatically over the decades since the NAIC originally excluded HMOs from the assessment base of guaranty assessment health accounts. The health insurance market and the HMO market have to a large extent converged, and it is critical that this convergence be considered in designing a properly functioning system to protect consumers in the event of insolvencies and to ensure the long-term stability not only of the guaranty fund system, but also of the health insurance marketplace.

Major medical health insurers and HMOs directly compete against each other and offer similar products. Yet despite this fact, in most states only the major medical writers are required to participate in the social safety net for insurer insolvencies. Despite directly competing with major medical health insurance plans, HMOs are not included in the assessments and therefore are not required to share in the consumer protection mechanism like all other health insurers.

The Model Should Protect Robust Health Insurance Markets

If changes are not made, and as assessments increase, the marketplace will react and will move more and more to an HMO product offering as customers seek cost savings wherever they can find them. Assuming this occurs, it will lower the assessment pool and will result in increased instability and uncertainty for guaranty associations. Companies that compete in the same market, such as the HMOs and major medical health insurers, should both be required to shoulder the responsibility of funding the guaranty fund association system. Failing to rationalize the assessment base in this way almost guarantees that markets will destabilize and that consumers will be harmed.

On a previous call, the Working Group heard the Colorado Department speak about their legislative proposal to address future insolvencies. The Colorado Department worked with the major medical health insurers and the ACLI to develop a proposal that recognizes that future long-term care insolvencies are an industry issue that must include participation by all segments of the life and health insurance industry including HMOs. We believe elements of the Colorado
proposal constitute a template for crafting a national solution to the perceived shortcomings of the current way in which assessments for long-term care insurance insolvencies are handled. We also believe that the Colorado proposal, in large part, is consistent with Option 3 which is included in the Working Group’s June 23, 2017 agenda materials.

The Working Group charges grant the Working Group the authority to amend the model to address future insolvencies. This is important because changes are needed to the guaranty fund assessment system and to the model act regulating this system and changes are needed now. It is also critical that these changes be made on a national basis. The needed changes will not work if each individual state is free to develop its own solution. Insurance insolvencies need a national solution. Additionally, any approach to a solution to long-term care insolvencies must examine the Model as whole and cannot limit its focus to a particular section or provision of the Model.

The national solution should be based on a broad-based approach to funding future long-term care insurance insolvencies. We believe Option 3 provides the broadest assessment base, and provides the greatest stability to guaranty funds, to the insurers participating in the guaranty funds and to the consumers protected by the funds. We also strongly support the reference in Option 3 to a more equitable apportionment of assessments among the life and annuity industry and health insurers, including HMOs. Finally, we believe Option 3 recognizes that all participants in the life and health insurance industry should help pay for the future viability of the state-based guarantee fund system.

We urge members of the Working Group to support an amended version of Option 3 that includes HMOs within the health insurance account.

Please feel free to call me at 703-847-3610 if you have any questions regarding our comments. Thank you.

Sincerely yours,

Chris Petersen
For Arbor Strategies, LLC
June 20, 2017

James Kennedy, Chairman
Receivership Model Law Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

RE: Guaranty Association Issues Relating to Long-Term Care ("LTC") Insurance

Dear Chairman Kennedy and Members of the Working Group:

The Alliance for Community Health Plans (ACHP) welcomes the opportunity to comment on the proposed changes to the Life and Health Insurance Guaranty Association Model Act (#520). Unfortunately I will not be able to attend the conference call on June 21, but we wanted to share these thoughts with you.

ACHP is a national organization bringing together innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are community-based, non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for more than 18 million Americans in 27 states in the commercial market and Marketplaces and for Medicare, Medicaid, and federal, state, and local public employees.

ACHP appreciates NAIC’s efforts to address issues related to the financial problems facing the long-term care (LTC) insurance industry. ACHP’s members have an interest not only in the well-being of our members, but in the well-being of the larger communities in which we operate. The policy holders of LTC insurance products should be protected from carrier insolvencies and receive the benefits for which they are due. Moreover, the potential for health insurers, who write only a tiny fraction of LTC insurance policies, to shoulder responsibility for a major portion of the state guaranty fund assessments of the Penn Treaty liquidation, and potentially others in the future, raises understandable concerns about equity and financial burden.

ACHP does not believe, however, that the Working Group’s Option 3, which would include HMOs as members of the same state guaranty associations called for by the Life and Health Insurance Guaranteed Association Model Act (#520), is an appropriate or fair approach to addressing this situation. Not only would this option break with long-established precedents relating to the regulation of HMOs, its adoption without addressing other NAIC model laws, e.g., the HMO Model Act and other model laws identified below, could undermine the integrity of state HMO regulations. *With these concerns in mind, we urge the Receivership Model Law Working Group not to include “Option 3” in its recommendations to the NAIC.*
Our specific concerns are as follows:

**HMOs are not Health Insurance.** HMOs have always provided health coverage and care that is different from traditional health insurance. HMOs retain the distinct characteristics that have been the basis for their separate treatment in NAIC model laws and HMO acts adopted by states, including:

- In-network benefit structure: An HMO’s in-network benefit structure remains at the heart of the HMO approach to coverage and care. HMOs have always had physicians and other providers who are affiliated with the plan through employment or contractual arrangements. And, while variations have evolved, HMO members receive their care only from physicians and other providers who are in the plan’s network, unless they have a referral from a plan provider.

- Delivery of care: Prepaid group practice organizations, including staff model and group model HMOs, directly provide services or arrange for the provision of services, as opposed to merely paying for health care services after the enrollee has chosen the provider and received the service.

- Risk-sharing with providers: HMOs are characterized by the presence of payment arrangements such as capitation or other mechanisms that place physicians and other providers at whole or partial financial risk for care provided.

- Preventive care: Given the imperative of operating within a fixed payment, HMOs have placed special emphasis on preventive care and often enlarge the scope of their efforts to address living arrangements and other social factors that affect health status.

**Long-term Care Insurance is not an HMO Line of Business.** HMOs do not sell long-term care insurance and, as a matter of most states’ licensure laws, HMOs are not able to offer such products under HMO state licenses.

**HMOs Must Meet HMO-Specific Solvency Requirements.** Because HMOs are not health insurers and are treated differently under NAIC model laws and the laws and regulations adopted by states, they are required to operate under different reserve and solvency.

- Under the NAIC’s Model HMO Act, adopted in part or whole by many states, hold harmless provisions obligate HMO-contracted providers to hold a member harmless for any money that may be owed by an HMO including non-payment by, or insolvency of that HMO (NAIC Model HMO Act, Section 19).

- An HMO must also make a special deposit with the state insurance commissioner in an amount equal to 120 percent of “uncovered expenditures” (expenditures not subject to hold harmless agreements, such as payments to non-contracted emergency physicians) whenever such expenditures exceed 10 percent of its total health care expenditures (NAIC HMO Model Act, Section 20).

- All HMOs also must participate in an open enrollment process to offer replacement coverage to the members of an insolvent HMO (NAIC HMO Model Act, Section 21).

These requirements, coupled with other insolvency prevention and protection measures in the NAIC Model HMO Act, eliminate any need for coverage for HMOs under state life and health insurance guaranty associations. This is further reinforced by the NAIC whose Life and Health Insurance Guaranty Association Model Act excludes HMOs from the definition of “member insurer” (NAIC Life and Health Insurance Association Model Act, Section 5.L.). The Model Act appropriately reflects the fundamental difference
between insurers and HMOs, i.e., that insurance carriers pay claims for covered services, while HMOs directly provide or arrange covered health care services.

The NAIC’s 2013 compendium of Health Maintenance Organization Coverage by Guaranty Associations underscores the distinct treatment of HMOs by states from other insuring entities, including LTC insurance carriers. Most states provide for a separate HMO guaranty fund; in the few states that HMOs are grouped under the state’s life and health insurance guaranty fund, with possibly two state exceptions, the HMO’s are assessed only for other HMO insolvencies.

**HMOs Do Not Benefit from State Life and Health Insurance Guaranty Associations.** Since HMOs do not write LTC insurance, they should not be included in state life and health insurance guaranty associations nor should they be included in the assessments for LTC insurance insolvencies. HMOs would derive no benefit from participation in state guaranty funds. Consequently, the effect on HMOs would thus be an adverse one, that is, to require payments of assessments, which would most likely be reflected in increased premiums, with no benefit to enrollees.

**More Appropriate and Equitable Options Exist for Addressing the Problem.** ACHP believes that the existing Life and Health Insurance Guaranty Association Model Act #520 already provides a state guaranty association with the tools to address the losses from LTC insurance carriers. For example, if the capacity of a state’s health insurance guaranty association is inadequate to fund the losses from a LTC carrier in one year, it can extend the assessments to future years (NAIC Life and Health Insurance Guaranty Association Model Act, Section 9.E. (c)). As the Working Group has identified, however, other options may be needed, particularly given the large sums of money associated with insolvencies of LTC insurers. One or more of the Working Group’s options numbered 1, 2 and 4 may therefore merit adoption.

If, however, the Working Group decides to advance Option 3 to the NAIC, ACHP strongly urges the Working Group to proceed cautiously and examine the implications of that recommendation, including the likely need to revise the other NAIC model acts that relate directly or indirectly to HMOs. These include: the NAIC HMO Model Law, the Model Regulation to Implement Rules Regarding Contracts and Services of HMOs, the Risk Based Capital for HMOs Model Act, Insurance Holding Company System Regulatory Act and the Unfair Trade Practices Model Act.

Thank you for your consideration of ACHP’s comments. If we can answer any questions or provide additional information, please contact me at hshapiro@achp.org.

Sincerely,

Howard B. Shapiro, PhD
Director of Public Policy
June 20, 2017

James Kennedy, Chairman
Receivership Model Law Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

RE: Guaranty Association Issues Relating to Long-Term Care (“LTC”) Insurance

Dear Chairman Kennedy and Members of the Working Group:

Kaiser Permanente appreciates the opportunity to provide comments on the proposed changes to the Life and Health Insurance Guaranty Association Model Act (#520).

We fully endorse and support the comments of the Alliance for Community Health Plans (ACHP). The Working Group should not further proceed with Option 3 of the four listed options because of the material and fundamental differences between HMOs and health insurers, including their regulatory structures, both in the states and in the NAIC models.

Kaiser Permanente (KP) serves 11.8 million members in eight states and the District of Columbia. KP comprises Kaiser Foundation Health Plan, Inc., the nation’s largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii, including the Kaiser Foundation Hospitals, which owns and operates 38 hospitals and over 670 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan, Inc. to meet the health needs of Kaiser Permanente’s members.

Our model fully integrates all aspects of health care into a coherent delivery system. Since our inception in 1945, we have been nationally recognized as an alternative to traditional health insurance.

Exclusive Relationship With Medical Groups
The dominant and indispensable characteristic of KP is the health plan’s relationship with the Permanente Medical Groups in each of our regions. PMGs are independent physician group practices. Kaiser Foundation Health Plan, Inc. contracts exclusively with them in each of our regions to meet the health needs of Kaiser Permanente’s members.

Our system was different from the start. It was not based on claims, but on the direct provision of medical care for a prepaid fee. That difference continues to distinguish HMOs from health insurers.
Kaiser Permanente Comments
NAIC Receivership Model Law Working Group

Care Management is at the Core of the KP Model
The organized integration of all parts of the delivery system is designed to make sure that we have a full line of sight into the care provided to our members. HealthConnect, our electronic medical record system, links care provided by our physicians, our clinicians, our pharmacists, and all other relevant, HIPAA-protected employees involved in any aspect of patient care. That closely managed system is designed to assure the highest quality of care to our members.

The results have been recognized nationally. In CMS’s 2017 Medicare star quality ratings, Kaiser Permanente’s Northern and Southern California, Colorado, Northwest and Mid-Atlantic States regions received 5 out of 5 stars each, the highest overall rating. Kaiser Permanente’s Georgia and Hawaii regions earned 4.5 out of 5 stars. According to CMS, out of the more than 1.6 million beneficiaries enrolled in all 5-star plans nationwide, 81 percent are Kaiser Permanente Medicare members.

NAIC Models treat insurance differently than HMOs
The NAIC has long recognized the differences between HMOs and health insurance. HMOs conspicuously are not defined as a form of insurance. While they provide insurance-like protection for their members, the core relationship between persons covered under an HMO and policyholders of a health insurance company is significantly different – a fact that pervades the HMO Model Act and other NAIC models and forms.

Nothing demonstrates the awkwardness of treating an HMO like an insurer more than the absence of the word “claim” in the NAIC HMO Model Act. Compare the absence of the term in the HMO Act to the Health Insurance Reserves Model Act (#10), where claims and claims reserves are found throughout.

As a consequence of that primary difference in the care delivery model, the HMO Model Act deals with solvency issues differently as well, beginning with explicit protections for covered persons. Section 19 (B) specifies that “All contracts among health maintenance organizations, risk bearing entities and participating providers shall include a hold harmless provision specifying protection for covered persons,” which may not be waived. Covered persons are to be notified that “YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION.”

Since covered persons will not incur any expenses (aside from their monthly payments) besides deductibles, copayments and coinsurance that they are individually responsible for under their contracts, any potential tail for incurred claims is nearly nonexistent for HMOs. In the worst-case scenario for an HMO covered person, Section 21 of the HMO Model provides that an insolvency of their HMO will lead to an open-enrollment period to purchase another guarantee issue health policy.

Further demonstrating the mismatch of the change contemplated in Option 3 are the other entities excluded in the definitions of Model #520, section (L) (1)-(8). In the current model, hospital or medical services organizations, fraternal benefit societies, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or “entities similar to the above” are all grouped with HMOs.
Kaiser Permanente Comments
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We do not mean to make a judgment on the health insurance model. Many consumers prefer that model. The point is that the two models are unambiguously and fundamentally different. That is why so many insurance departments supervise them under distinct regulatory structures.

Lumping HMOs in with health insurers for guaranty system assessment purposes would be a radical departure from the current regulatory state. We agree with ACHP that the other options under consideration are consistent with the differences in the regulatory models for insurance and managed care, as well as sound policy and the needs of the market.

We also note that, as the presentation by NOLHGA (posted at the Working Group’s website) demonstrates, there is already progress being made in the LTC market to address the overriding concern about the solvency of the industry. New products and increased regulatory oversight are making a difference.

CONCLUSION

We appreciate the opportunity to comment on this proposal. If you have questions or concerns, please contact me by phone or email at 510.271.5742 (email: david.f.link@kp.org).

Sincerely,

David Link
Senior Counsel, Government Relations
Kaiser Permanente
June 16, 2017

VIA EMAIL

Mr. James Kennedy
Texas Department of Insurance
Chair, Receivership Model Law (E) Working Group
c/o Jane Koenigsman
Sr. Manager, L/H Financial Analysis
National Association of Insurance Commissioners (NAIC)
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Re: Life and Health Insurance Guaranty Association Model Act (#520)

Dear Chairman:

On behalf of HealthPartners, we appreciate the thoughtful discussions that your committee has had to date on the issues related to Long-Term Care (LTC) insolvencies and Guaranty Association assessments. HealthPartners is an integrated health care system based in Bloomington, Minnesota, with a team of 22,500 people dedicated to a mission to improve the health of members, patients and the community. Since its founding in 1957, HealthPartners has grown to be one of the largest providers of health and dental insurance in Minnesota and western Wisconsin. This coverage is offered through two non-profit Health Maintenance Organizations (HMOs) as well as a for-profit insurance company and a third party administrator. As an organization that functions as an HMO and as an indemnity carrier, we are uniquely positioned to appreciate the different and challenging constructs at play in this issue.

The current insolvency of Penn Treaty as well as the potential of future LTC insolvencies places a tremendous strain on the organizations that participate in the Guaranty Associations. Through our insurance company, we are subject to some of these assessments, so we understand the desire to "broaden the pool". At the same time, HMOs have unique structures and solvency requirements that make adding them into the assessment challenging.

Health Maintenance Organizations are structured and regulated differently, particularly regarding solvency. HMOs are regulated under different constructs and rules than insurance companies. For example, in Minnesota, HMOs have historically been required to be non-profit. They are regulated not by the Department of Insurance, which also oversees the state Guaranty Association, but rather by the Department of Health. They have separate and distinct solvency requirements as required under the HMO model act as well as separate and unique investment rules and other financial requirements.
In Minnesota, HMOs are statutorily excluded from the state Guaranty Association. Given these very different requirements, **HMOs are not a good fit for inclusion in a state Guaranty Association.**

In addition, while any organization currently included in a state Guaranty Association is legally allowed to offer a long-term care policy if it follows appropriate regulatory requirements, HMOs are NOT allowed to offer long-term care coverage. Therefore, **HMOs should not be required to cover the insolvencies of a type of coverage from which they are specifically excluded from offering.**

First, we believe that a **consideration to include HMOs in LTC assessments through Guaranty Associations requires a comprehensive review of existing model acts** — Health Maintenance Organization, Risk Based Capital, ORSA and others — to identify conflicts with existing solvency standards for HMOs.

Second, The NAIC Model HMO Act has its own protections for HMO enrollees.

- **Hold Harmless:** A primary protection for HMO enrollees against the risk of an HMO insolvency is the requirement that all contracts between an HMO and a health care provider must include a “hold harmless” provision which obligates the provider to hold a member harmless for any money that may be owed by an HMO including non-payment by, or insolvency of, the HMO (NAIC HMO Model Act, Section 19).

- **Special Deposit:** An HMO must also make a special deposit with the state insurance commissioner in an amount equal to 120 percent of “uncovered expenditures” (expenditures not subject to hold harmless agreements, such as payments to non-contracted emergency physicians) whenever such expenditures exceed 10 percent of its total health care expenditures (NAIC HMO Model Act, Section 20).

- **Open Enrollment:** All carriers also participate in an open enrollment process to offer replacement coverage to the members of an insolvent HMO (NAIC HMO Model Act, Section 21).

These requirements, coupled with other insolvency prevention and protection measures in the NAIC Model Act, eliminate any need for guaranty fund coverage for HMOs. This is further reinforced by the NAIC whose Life and Health Insurance Guaranty Association Model Act excludes HMOs from the definition of “member insurer” (NAIC Life and Health Insurance Association Model Act, Section 5.L.). This reflects the fundamental difference between insurers and HMOs - insurance carriers pay claims for covered services, while HMOs directly provide or arrange for covered health care services.

**Non-profit vs. for-profit**

We also suggest that any discussion of HMOs in relation to Guaranty Associations consider the challenges inherent in requiring a non-profit to bear the weight of an assessment, particular for a for-profit insolvency. In Minnesota, all HMOs are currently and historically non-profit. While our state law just recently changed to allow for-profits HMOs, there are none in the state. Including non-profit HMOs in the state Guarantee Association would create significant financial challenges and undue burden on HMO reserves.
Making HMOs financially responsible for the insolvency of long-term care insurers would increase premiums, with no benefit to HMO enrollees.

The guaranty associations were formed to have companies writing similar lines of business cover the losses from an insolvent carrier in that line of business. HMOs are not in the insurance business and in Minnesota are not allowed to be in the LTC market. HMOs are subject to a unique set of insolvency protections which impose costs that are not applicable to health insurers. As noted above, the existing NAIC Life and Health Guaranty Association Model Act has excluded HMOs for many years; there is no evidence that this exclusion has had any negative impact on the competitiveness or growth of health insurers across the country. And there is also no evidence that this exclusion has put HMO enrollees at risk.

Not including HMOS in the Guarantee Association does not create a competitive advantage over health insurance carriers. While the assessment may increase premiums for insurers, HMOs also face unique cost challenges. In Minnesota, the individual market risk is now held largely by non-profit HMOs while the insurers have pulled out. The risk for the market place now lies with the HMOs.

**Guaranty Associations have options other than adding HMOs to the assessment base.**

If the capacity of a state’s health insurance guaranty association is not adequate to fund the losses from a LTC carrier in one year, the guaranty association can extend the assessments to future years (NAIC Life and Health Insurance Guaranty Association Model Act, Section 9.E. (c)). Further, if additional assessment capacity is needed, a state might consider adding to the LTC assessment pool other types of insurance companies whose products are similar to LTC coverage, such as life insurance carriers which issue annuities payable over the lifetime of the annuitant.

Thank you for the opportunity to comment on this issue. We appreciate how financially challenging LTC insolvencies are to the market and to states. We look forward to staying in conversation on the appropriate policy and fiscal solutions to this problem.

Sincerely,

David A. Dziuk
Senior Vice President and Chief Financial Officer
HealthPartners