

SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force November 30, 2021, Minutes

Senior Issues (B) Task Force October 6, 2021, Minutes (Attachment One)

Senior Issues (B) Task Force Proposed 2022 Charges (Attachment One-A)

Long-Term Care Insurance Model Update (B) Subgroup November 3, 2021, Minutes (Attachment Two)

Long-Term Care Insurance Model Update (B) Subgroup October 13, 2021, Minutes (Attachment Two-A)

Senior Issues (B) Task Force
Virtual Meeting (*in lieu of meeting at the 2021 Fall National Meeting*)
November 30, 2021

The Senior Issues (B) Task Force met Nov. 30, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Dozier (AL); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey represented by Garlinda Taylor (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning and Laura Arp (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Jonathan T. Pike (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Jennifer Stegall (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Sara Stanberry (IL); Kay Warrington (MS); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Patrick Smock (RI); Andrew Dvorine (SC); Isabelle Keiser (VT); and Mavis Earnshaw (WY).

1. Adopted its Oct. 6 Minutes

The Task Force met Oct. 6 and took the following action: 1) adopted its 2022 proposed charges; and 2) heard a presentation on the WA Cares Fund.

Ms. Karnis made a motion, seconded by Director Wing-Heier, to adopt the Task Force's Oct. 6 minutes (attachment One). The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Insurance Model Update (B) Subgroup

The Long-Term Care Insurance Model Update (B) Subgroup met Nov. 3 and Oct. 13. During its Nov. 3 meeting, the Subgroup continued its cursory review of Section 7 through Section 12 of the *Long-Term Care Insurance Model Regulation* (#641). During its Oct. 13 meeting, the Subgroup began its cursory review Model #641, beginning with Section 1 through Section 6. The Subgroup plans to meet Dec. 1 to continue its cursory review of Section 13 through Section 19.

Director Wing-Heier made a motion, seconded by Ms. Kruger, to adopt the report of the Long-Term Care Insurance Model Update (B) Subgroup (Attachment). The motion passed unanimously.

3. Discussed DME, Medicare Supplement, and Excess Charges

Ms. Arp began the discussion by noting there appears to be a loophole being exploited by durable medical equipment (DME) suppliers. She said it may not be fraud, but it is certainly waste. She referred to the slide deck, pointing out that the slide refers to the same patient and the same DME provider for a nasal prosthesis. She pointed out that the charges jumped from \$4,850 to \$91,274 in a span of five years.

Ms. Arp cited another example involving scooters and power wheelchairs. She said, for example, in 2019, Medicare was billed \$43,485.10 for a power wheelchair and Medicare approved \$4,702, leaving the insurer to pay the balance of \$38,783.10. She cited another example where Medicare was billed \$44,422.83 for a power wheelchair and Medicare approved \$4,706.58, leaving the insurer to pay the balance of \$39,716.25. She said in another example from 2021, Medicare was billed \$10,841.04 for a hospital bed and Medicare approved a monthly rental charge only, which left the insurer to pay the balance after the approved charge of \$10,767.18. She said a call was made on this claim, and the insurer was told that the scooter store billed for the cost of the bed, and they billed it again as not assigned, and they will bill Medicare the monthly rental of the bed. She said that the most costly scooters are at around \$13,000, according to these suppliers' websites, but the charged amounts went as high as \$31,500. She said these are the amounts they are charging when it is found out a beneficiary has Medigap Plan F or Plan G. She said they know the insurer is on the hook for the excess charges.

Ms. Arp said the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) states in the excess charges section, have coverage for either 80% or 100%, depending on the plan of excess charges, and it is not to exceed any charge limitation established by the Medicare program or state law. She said Plan F and Plan F High Deductible shall include 100% of the excess charges, and Plan G shall include 80% of the excess charges. She said the next step is to look at what limitations exist. She said in the relevant sections of the federal Social Security Act (SSA), a person is not liable for payment of amounts billed for the service in excess of the limiting charge. She said that is a kind of balance billing protection built into this framework. She said the limiting charge is defined in the same relevant section as "115% of the recognized payment amount for non-participating physicians, or non-participating suppliers, or other persons."

Ms. Arp said if one looks back at the limitation on beneficiary liability in the SSA, it states, "In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply" She said the rules are the limiting charge, and the insured is not liable for any difference, so it begs the question: If this 115% limitation is applicable to physician billing, why does it say "... nonparticipating physicians, or nonparticipating suppliers, or other persons"? Ms. Arp said providers are operating on the assumption that 115% only applies to physicians and that they are free to charge whatever they want.

Ms. Arp said there are options to address this. She said state laws could be changed. She said eight states have done this already. She said Medigap regulations could be changed. She said the other option is to provide some kind of interpretation or bulletin that explains that the term physician service can be read to include the physician service of writing the prescription for the DME for which the supplier fills, and that would make more sense with the limiting charge language that includes both nonparticipating physician and nonparticipating suppliers or other persons.

Commissioner Caride asked if there are any comments from Task Force members. Director Wing-Heier said she appreciates this being discussed and dislikes price gouging. She said when people take advantage of a loophole, it destroys the system. She said issues like this are the reasons consumers pay what they are paying. Commissioner Caride agreed.

Meghan Stringer (America's Health Insurance Plans—AHIP) presented her slides and said some of AHIP's Medigap members brought this to her team's attention. She said there are other DME items, other than scooters, that are subject to these excess charges, such as dental devices for sleep apnea and knee therapy devices. She said there is an issue with advertisements where the ads state if you have a Medigap plan, these items are no cost to the consumer. She said some of the carriers think there is misleading information in these advertisements. She said on the scooters in particular, the supplier website will indicate that standard parts are included, but items that one would think are standard, like wheels or batteries, are billed separately. She said AHIP's members are seeing reports across the country in nearly every state. She said in some instances, if the Medigap plan tries to push back, the supplier then says it will balance bill the beneficiary, which cannot happen, so the plan eats the costs.

4. Heard a Federal Update

David Torian (NAIC) provided the Task Force with a federal update. He said funding for the State Health Insurance Assistance Program (SHIP) is operating under fiscal year (FY) 2021 levels, and SHIP funding is at \$55 million. He said the U.S. House of Representatives (House) did pass its FY 2022 Labor, Health and Human Services, Education and Related Agencies funding bill on July 29, and it included an increase to SHIP to a level of \$57,115,000. He said the U.S. Senate (Senate) has not acted on its appropriation bills. He said the U.S. Congress is looking at doing a short continuing resolution (CR) to keep the government funded through December.

Mr. Torian said the House passed the reconciliation bill on Nov. 19, which included language to provide for coverage of hearing aids under Medicare Part B for individuals with severe or profound hearing loss in one or both ears, once every five years and if furnished through a written order by a physician, qualified audiologist, hearing aid professional, physician assistant, nurse practitioner, or clinical nurse specialist qualified to write such order by the state. He said it is unclear when the Senate will consider this measure and if any of the hearing provisions may be changed.

Mr. Torian discussed an issue brought to the attention of the NAIC regarding delays with Medicare cards. He said the Social Security Administration (SSA) mails out (usually initiated by a phone call) the application and receives and processes the application. It then sends it to the federal Centers for Medicare & Medicaid Services (CMS) to send the Medicare card to the enrollee. He said since many SSA field offices have been closed due to the pandemic, almost all applications are being mailed to seniors, and then they must mail the application and supporting materials back to the SSA. He said the CMS and the SSA have found that serious mail delays (three to four weeks for each mailing) have resulted in significant delays in the final application being received by the SSA. He said the mail delivery and the slow down at the U.S. Postal Service (USPS) seems to be the main issue. The CMS and the SSA are looking at ways to address this, but this may take some time to resolve. He said the NAIC continues to monitor the matter and is in communication with the SSA and the CMS.

Having no further business, the Senior Issues (B) Task Force adjourned.

Draft: 10/8/21

Senior Issues (B) Task Force
Virtual Meeting
October 6, 2021

The Senior Issues (B) Task Force met Oct. 6, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Anthony L. Williams (AL); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Michael Ross (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Teresa Winer (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Shannon Lloyd (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Sherri Mortensen-Brown (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Shannen Logue (PA); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Jonathan T. Pike represented by Jaakob Sundberg (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Eric Anderson (IL); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Andrew Dvorine (SC); Mary Block (VT); and Mavis Earnshaw (WY).

3. Adopted its 2022 Proposed Charges

Director Wing-Heier raised last minute language proposed by Birny Birnbaum (Center for Economic Justice—CEJ) to be added to the 2022 Proposed Charges. The language Mr. Birnbaum proposed would add a subsection to the 2022 Proposed Charges that reads, “[e]xamine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.”

Mr. Birnbaum said he notes that the mission of the Task Force is to consider policy issues on insurance issues affecting older Americans. He said two of the most prominent policy issues affecting the insurance industry today are the effects of structural racism and the pandemic on access, affordability, and outcomes for insurance consumers, particularly insurance consumers in communities of color. He said he does not see any mention of these policy issues in the charges, so he suggests either adding to existing charges or creating a new charge to examine the impacts of structural racism and the pandemic on the specific subject matter of the Task Force, namely the impacts on older insurance consumers.

Ms. Miller asked if structural racism and the COVID-19 pandemic in terms of the new charge are to be considered in conjunction with each other or separate issues. Mr. Birnbaum said the intent of the charge is that there are two separate policy issues for consideration on their impact on older insurance consumers, and there is likely to be some overlap given that the pandemic has disproportionately affected communities of color. Mr. Lombardo said he wanted to make sure the new language is placed in the proper location and spot.

Director Wing-Heier made a motion, seconded by Ms. Nollette, to add Mr. Birnbaum's proposed added language to the 2022 Proposed Charges and label it as Subsection H (Attachment One-A). The motion passed unanimously.

Bonnie Burns (California Health Advocates—CHA) offered language to include complimentary language about the Task Force being a clearing house for Medicare Supplement (Medigap), as well as Medicare Advantage. She said the last sentence in Subsection B in the Task Force charges states, “[a]ssists the states and serve as a clearinghouse for information on Medicare Advantage plan activity.” She said there should be a similar line for Medigap.

Mr. Trexler said he did not see the need for such language, as Medicare Advantage and Medigap are different in structure. He said the states administer Medigap, whereas Medicare Advantage is run by the federal Centers for Medicare and Medicaid Services (CMS); therefore, coordination between the CMS and the Task Force is necessary. Peggy Camerino (United American Insurance Company) said she agreed with Mr. Trexler, as the information on innovative benefits are already on the Task Force web page. Director Wing-Heier and Ms. Karnis also expressed that the 2022 Proposed Charges are sufficient without the additional language.

Ms. Mortensen-Brown made a motion, seconded by Director Wing-Heier, to adopt the 2022 Proposed Charges, as amended (Attachment One). The motion passed unanimously.

4. Heard a Presentation on the WA Cares Fund

Todd Dixon, Washington Deputy Commissioner for Consumer Protection, said the WA Cares Fund is struggling. He said the Washington Office of the Insurance Commissioner (WAOIC) is not part of the WA Cares Fund in terms of administration or implementation. He said the WAOIC is only involved because of the provision in the WA Cares Fund law that allows persons to be exempted from the law.

Mr. Dixon said the WA Cares Fund is run by the Aging and Long-Term Support Administration of the Washington State Department of Social and Health Services (DSHS). He said the WA Cares Fund is a universal long-term care (LTC) program. He said it is an earned benefit; i.e., only those who contribute are eligible. He said it is self-funded from worker contributions, reducing the need to raise taxes to pay for Medicaid Long-Term Services and Supports (LTSS) costs associated with the coming age wave. He said there is a lifetime maximum benefit of \$36,500; contributions begin Jan. 1, 2022, and benefits begin Jan. 1, 2025.

Mr. Dixon said workers contribute 0.58% of their wages, and premiums go into a dedicated trust fund that can only be used for this program. He said if a person has private long-term care insurance (LTCI), that person can either keep it and use it to supplement the WA Cares Fund \$36,500 benefit or apply to permanently withdraw from the WA Cares Fund Oct. 1, 2021, through Dec. 31, 2022. He said employers collect premiums from employee wages beginning Jan. 1, 2022. He said employers do not contribute to the WA Cares Fund. He said if an employee has LTCI and does not want additional coverage through the WA Cares Fund, the employee can opt out by applying through the Washington State Employment Security Department (ESD). He said employers do not process the opt-out applications; the ESD processes them. He said self-employed earners may opt into the WA Cares Fund through the ESD.

Mr. Dixon explained the vesting criteria for the WA Cares Fund. He said an individual must have earned their WA Cares Fund benefit by working and contributing: 1) at least 10 years at any point in their life without a break of five or more years; or 2) three of the last six years. They must also have worked and contributed at least 500 hours per year during those years. Mr. Dixon said to be eligible for benefits, the individual must require assistance with at least three activities of daily living (ADLs). He said the benefit is flexible; i.e., a person can: 1) spend up to \$36,500 on a combination of services and supports; 2) choose how they want to use it; and 3) hire a home-care aide, pay a family member, make home modifications, etc.

Mr. Dixon said federal employees are not included, the self-employed can opt in beginning Jan. 1, 2022, and the tribes have the option to opt in at any time. He said there are circumstances where certain people may be unable to claim benefits. He said under the current statute, people who live in border states and work in Washington will pay in but cannot access benefits unless they reside in Washington when they need care. He said people who will retire before they permanently vest will be unable to claim if they need care beyond three years of retiring, and people who move

out of state will not be able to access benefits unless they return. He said the LTSS Trust Commission Benefit Eligibility Workgroup is considering policy options to address these issues.

Mr. Dixon said the WAOIC is not an administering agency for the WA Cares Fund by statute. He said the WAOIC acts as a partner as the official regulator for LTCI in Washington and acts as a partner to the WA Cares Fund by providing consumer protection. He said the main involvement of the WAOIC involves those seeking exemptions. He said workers who have their own private LTCI may apply for an exemption, and exemptions are permanent. If an exemption is approved, the worker will not have premiums assessed, and they forfeit their right to the benefit for life. He said workers seeking an exemption must apply themselves through the ESD; employers cannot apply on behalf of an employee. He said policies must meet the definition for LTCI in law for an exemption. He said under Washington law, LTCI is an insurance policy, contract, or rider that provides coverage for at least 12 consecutive months to an insured person if they experience a debilitating prolonged illness or disability. He said employees who apply for an exemption must attest that they have purchased LTCI before Nov. 1, 2021, and must provide notification of exemption to all current and future employers, and the only acceptable notification is a copy of the employee's approved exemption letter from the ESD.

5. Discussed Other Matters

Commissioner Caride asked if there are any other matters or issues to be raised before the Task Force. None were heard.

Having no further business, the Senior Issues (B) Task Force adjourned.

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2022 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products or Services

1. The **Senior Issues (B) Task Force** will:

- A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
- B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist the states, as necessary, with regulatory issues. Maintain a dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist the states and serve as a clearinghouse for information on Medicare Advantage plan activity.
- C. Provide the perspective of state insurance regulators to the U.S. Congress (Congress), as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
- D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
- E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state- approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
- F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Review the existing *Long-Term Care Insurance Model Act* (#640), the *Long-Term Care Insurance Model Regulation* (#641), the *Limited Long-Term Care Insurance Model Act* (#642), and the *Limited Long-Term Care Insurance Model Regulation* (#643) to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving LTCI marketplace. Work with federal agencies, as appropriate.
- G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
- H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.

2. The **Long-Term Care Insurance (LTCI) Model Update (B) Subgroup** will:
 - A. Review and update Model #640 and Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.
 - B. Update Model #642 and Model #643 to correlate with Model #640 and Model #641.
 - C. Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

NAIC Support Staff: David Torian

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Draft: 11/4/21

Long-Term Care Insurance Model Update (B) Subgroup
Virtual Meeting
November 3, 2021

The Long-Term Care Insurance Model Update (B) Subgroup of the Senior Issues (B) Task Force met Nov. 3, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Sarah Bailey (AK); Emily Smith (CA); Roni Karnis (NH); Jill Kruger (SD); Tomasz Serbinowski and Jaakob Sundberg (UT); Bob Grissom (VA); and MaryKay Schaefer (WA). Also participating were: Willard Smith (AL); Eric Unger (CO); Paul Lombardo (CT); Susan Jennette (DE); Teresa Winer (GA); Jason Asaeda (HI); Cynthia Banks Radke (IA); Kristen Finau (ID); Eric Anderson (IL); Mary Ann Williams (IN); Tate Flott (KS); Ron Kreiter (KY); Jeff Ji (MD); Sherry Ingalls (ME); Renee Campbell (MI); Fred Andersen (MN); Michelle Vickers (MO); Bob Williams (MS); Ashley Perez (MT); Ted Hamby (NC); Yuri Venjohn (ND); Bogdanka Kurahovic (NM); Jack Childress (NV); Martin Wojcik (NY); Tynesia Dorsey (OH); Cuc Nguyen (OK); Colette Hittner (OR); Jim Laverty (PA); Matt Gendron (RI); Andrew Dvorine (SC); Vickie Trice (TN); Mary Block (VT); Julie Walsh (WI); and Mavis Earnshaw (WY).

6. Adopted its Oct. 13 Minutes

The Subgroup met Oct. 13 and heard presentations on the current long-term care insurance (LTCI) marketplace and what products are being seen, filed, and produced in the marketplace.

Ms. Kruger made a motion, seconded by Ms. Karnis, to adopt the Subgroup's Oct 13 minutes (Attachment One). The motion passed unanimously.

7. Discussed Comments Received on Sections 7–12 of Model #641

Mr. Gennace asked Mr. Serbinowski to explain his comment to Section 7 of the *Long-Term Care Insurance Model Regulation* (#641). Mr. Serbinowski said additional guidance may be appropriate regarding the application of Section 7 to the long-term care (LTC) benefits provided through a policy or contract without specified premiums. He said when LTC benefits are provided through a universal life insurance policy, there is no required premium; and typically, by the time the policy enters the grace period, the premium required to continue the policy is prohibitive. He said at the time, life insurance and hybrid products were kind of an afterthought, but they are now a major piece of LTCI, and this may be more of an important issue than it was at the time. Bonnie Burns (California Health Advocates—CHA) said she is supportive of the comments. Birny Birnbaum (Center for Economic Justice—CEJ) said this is part of a broader set of issues as to what type of guidance is needed for hybrid products in general, and there is nothing really in the model that addresses that.

Mr. Gennace asked Ms. Burns to explain the NAIC Consumer Representatives' comment on Section 7A(1). Ms. Burns said insurers should be required to send any changes in their contact information to the third party as well as an insured. She said there have been instances when there was a change in address for an insurer, and consequently, past due premiums and notices of an impaired policyholder were returned to the third party, as they were mailed to an outdated address. She said adding a confirmation notice to be sent to the current third party every two years would be helpful, and insurers should be required to notify policyholders of the right to change a third party for notification of a lapse in premium payment. She said there is no current requirement that an insurer periodically confirm the current contact information for the third party who is to be notified of a pending lapse, and she knows of instances where a third party

has moved or died, or the notice went to an outdated or even wrong address. Mr. Birnbaum agreed with Ms. Burns and said there has been a lot of work done on plain language and user-friendly approaches to providing disclosures to consumers, and this example illustrates that there is a better way than simply calling it a notice of lapse or termination. He said the requirement to send first-class mail should be updated to include electronic delivery, particularly for the third party.

Mr. Gennace asked Ms. Burns to explain the NAIC Consumer Representatives' comment on Sections 8A(2) and 8E. Ms. Burns said policyholders often do not see the language about premium increases buried in the paragraph about guaranteed renewability, and a notice of the right to increase premiums should be in a separate paragraph from guaranteed renewability. She said there also should be a requirement for a clear notice of waiver of premium, and the notice should describe any benefits covered by a premium waiver; a clear notice of the benefits not covered by a premium waiver; and a clear notice of how and when the premium waiver will be credited or refunded. She said policy language generally describes that premium payment will be owed when benefits are no longer payable but may not clearly describe how and when waived premiums will be credited or returned. She said generally, a premium waiver is described in one place in a policy, while the return or credit of the waived premium is described separately.

Mr. Birnbaum said there should be a glossary or a table of contents to help consumers navigate the model, and the definition of class, as discussed on the last call, should be included in this part as well. He said the history of the company's rate increases, itemized and cumulative, should be included.

Mr. Gennace asked if this is something that has changed in the LTCI marketplace that would require or precipitate the need for these changes or something where the regulation could be improved. Ms. Burns said it is two-fold. She said these are experiences people have had with their policies, so improvements are needed; but going forward, it also illustrates how the marketplace needs to work better. Mr. Birnbaum said he agrees with Ms. Burns, the nature of the products have changed significantly, and significant advances have developed since the model was developed.

Ray Nelson (American Association of Health Insurance Plans—AHIP) said he understands Ms. Burns' concerns about rating practices, and Section 9 added a lot of rating practices notices and disclosures for consumers that are beyond what is just in the policy. He said, as Mr. Birnbaum noted, there are a lot of disclosure requirements already, and most of them are regarding the sales process, so many of the concerns are addressed, and any changes should be looked at in total.

Mr. Gennace asked Ms. Burns to explain the NAIC Consumer Representatives' comment on Section 9. Ms. Burns said life and annuity contracts that provide for LTC benefits have internal costs associated with the policy and the benefits paid by the policy, and there is no mention in this section of how those costs might change. She said, for instance, the cost of insurance charged in a policy might change, or the cost of LTCI might change, which could affect the earnings in a policy and the daily benefit amount paid for care, and while this is not a change in premium, changes in internal costs affect the benefit a policyholder will receive.

Mr. Serbinowski said it is not clear why in Section 9B(5)(a) the rate increase history is limited to 10 years when most prospective buyers will keep their policies for much longer than that. He said a cumulative rate increase for each policy form might be preferable to a long list of individual increases. He said for Section 9B(5)(d), one should consider if this provision allows some rate increases to not be reflected. He said if every company transferred business after the first increase, no company would be required to disclose more than one increase on a policy form.

Mr. Gennace asked Mr. Serbinowski to discuss his comments on Section 10. Mr. Serbinowski said one should consider adopting retention requirements for actuarial assumptions, similar to those in Section 10C of the *Limited Long-Term Care Insurance Regulation* (#643). He said it can create problems as to how much assumptions change and produce projections based upon prior filing assumptions. He said this is not a reason alone to open the model, but should the model be open for updating or editing, retention language would be a good addition.

Mr. Birnbaum said he had a comment on a part of Section 10. He said the section requires that insurers develop their best estimate of future claim costs under moderately adverse experience, then pad that estimate by at least 10%. He said the theory seems to be that insurers not only did not know what they were doing in the 1990s, but they have not learned anything given historically low interest rates, extensive lapse, and claims experiences. He said insurers are already using conservative values for estimating future claim costs, so it is unclear why this 10% padding is still needed, and there is no requirement for the insurers to return the excess profits resulting from the 10% padding. He said an insurer can raise rates of claimed costs that are worse than expected, but there is no requirement to lower rates of claim costs that are as good or better than expected before the 10% padding. He said Section 10 also provides for a margin greater than 10% if the company has less than credible experience to support its assumptions. He said eliminating this 10% margin is consistent with AHIP's justification for limiting rate increase history to 10 years.

Mr. Serbinowski said he disagrees with Mr. Birnbaum. He said perhaps if rate stability does not work, the Subgroup could rethink the model altogether and think of a different way to do LTC, but if there is an expectation that the Subgroup wants an actuary to certify that the rates are expected to be good for the lifetime of the product, then the Subgroup wants to have a margin.

Mr. Nelson asked Mr. Birnbaum if he believes the 10% margin is in addition to the moderately adverse experience because one has to certify that the rates are sufficient under moderately adverse experience, and this moderately adverse experience has to be at least 10% of lifetime claims unless the company can justify reasons to have lower margins; therefore, the 10% margin is not on top of the moderately adverse experience. Mr. Serbinowski and Mr. Gennace agrees with Mr. Nelson's reading of that section.

Mr. Gennace asked Ms. Burns to discuss the comments on Section 11C(1). She said insurers have begun to ask questions about family health history as part of the application process, and that could lead to misinformation or mistaken information that could be used later to rescind coverage. She said insurers and others have access to information and data from many sources that could contain erroneous information or information and data that are different from what the policyholder entered on the application. She said, for instance, an applicant might know anecdotally about the cause of death of a family member, but that might be inconsistent with the medical cause of death listed on a death certificate. She said some older family members might conceal a health condition from other family members, leading to an erroneous response on an application.

Mr. Birnbaum agreed with Ms. Burns and said the insurer should be required to provide evidence as to why there may have been a denial of benefits and disclosure any third-party databases used in that decision. Mr. Gennace asked whether there have been cases of this happening where a policy is rescinded or if this is more of a general concern. Ms. Burns said she had been involved with cases where answers on the application were challenged, but the use of third-party databases is a new area, and she could see this happening more frequently.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said there are cultural issues involved as well, especially with older relatives. She said in quite a few cultures, it is difficult to get information from relatives, especially older relatives, about how a family member may have died. She said she has experienced this personally, and in some cultures, how a death or serious illness has occurred or what occurred is just not spoken about. She said this could be a serious impact on certain groups of people.

Mr. Birnbaum said while the Fair Credit Reporting Act (FCRA) requires disclosures of sources, it does not cover third-party databases like social media; therefore, there is no opportunity for the consumer to address erroneous information found through these third-party databases.

Ms. Arp asked if big data should be part of this discussion. Mr. Birnbaum said in the last decade, insurers have been using third-party databases to not only obtain or verify information given by the consumer but to also speed up the application process. He said he raised this issue in this section, as it could hurt the consumer having a denial based upon information that is not true coming from these third-party data sources. Ms. Arp asked if language in this section needs to be changed or if it is a matter of keeping an eye on denials and cancellations of coverage based upon the

information insurers receive that was not available 20 or 30 years ago. Mr. Birnbaum said two things need to be addressed. He said the first is what it means to make an untrue statement that can result in a claim denial, and giving the consumer some examples of what an untrue statement would be that could cause a denial would be useful. He said the second is disclosure to a consumer that third-party sources are going to be used and providing the consumer with what those sources are in the event of a denial so that the consumer is on notice and can correct incorrect information found through a third-party data source.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 12. Ms. Burns said the dollar amount of \$25 should probably be increased, as a home health care benefit that provides \$25 a day would be illusory based on costs today. She said in addition, the drafting note seems to conflict with the language in Section 12B. Mr. Nelson said industry has typically been against having a minimum dollar amount because there are occasions where a policyholder buys a second or third policy to add to the previous policy, and they are sometimes buying \$25 worth to just add on. He said that would be the concern of putting in higher minimums, but the \$25 figure is small. Ms. Yee agreed and said the language in Section 12B is outdated, as making a distinction between home health and nursing home care and the language in the section stating “at least one-half of one year’s coverage” is in conflict.

Mr. Gennace asked if Mr. Serbinowski wished to further clarify his comments from the last meeting on Section 6D. Mr. Sundberg said Mr. Serbinowski had to get off the call, but he said Mr. Serbinowski believes there is a need to specify what is meant by “continue” in Section 6D. He said the plain reading of the section suggests that there ought to be a conversion policy on the group policies, and most policies do not include one. He said the concern is not that there is no conversion policy, but whenever these policies are reviewed and a group policy is seen without a conversion policy, then it is objected to even though the group policy continues, so Mr. Serbinowski believes there needs to be some clarity about what it means to continue the policy.

Ms. Burns asked if there were not a conversion and that group policy continues, whether the certificate holder who is no longer part of the group would be in danger of having their certificate terminated if the group policy is terminated. Mr. Sundberg said he has not dealt with enough group LTC to know, but he would be interested in a response from industry on this. Ms. Burns said it is her understanding that a conversion is required so that the person then has what constitutes an individual policy separate from whatever action the group policy takes later. Mr. Hamby agreed with Ms. Burns and said they would hold that continuation should be allowed for the individual person. Ms. Bailey said one of the things she has been seeing across all lines of business is portability, and it may be messy and not a good fit for LTC. She said the insurer creates a trust, and if the group policyholder terminates the plan, then they move the certificate holder to the portability trust and the portability certificate is issued to the consumer so that they can continue the same benefits that they previously had. Mr. Hamby said he has seen this arrangement as well.

Mr. Gennace said the next meeting will be Dec. 1, and the Subgroup will cover comments received on Section 13–19. He asked that comments be sent to David Torian (NAIC) by close of business on Nov. 23.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.

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Draft: 10/15/21

Long-Term Care Insurance Model Update (B) Subgroup
Virtual Meeting
October 13, 2021

The Long-Term Care Insurance Model Update (B) Subgroup of the Senior Issues (B) Task Force met Oct. 13, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Mayumi Gabor (AK); Tyler McKinney (CA); Roni Karnis (NH); Jill Kruger (SD); Tomasz Serbinowski (UT); and Elsie Andy (VA). Also participating were: William Rodgers (AL); Carroll Astin (AR); Erin Klug (AZ); Emily Smith (CA); Shirley Taylor (CO); Jared Kosky (CT); Susan Jennette (DE); Benjamin Ben (FL); Teresa Winer (GA); Jason Asaeda (HI); Andria Seip (IA); Kathy McGill (ID); Eric Anderson (IL); Scott Shover (IN); Craig VanAalst (KS); Ron Kreiter (KY); Fern Thomas (MD); Sherry Ingalls (ME); Karen Dennis (MI); Fred Andersen (MN); Amy Hoyt (MO); Bob Williams (MS); Ashley Perez (MT); Ted Hamby (NC); Yuri Venjohn (ND); Bogdanka Kurahovic (NM); Sean Becker (NY); Tynesia Dorsey (OH); Cuc Nguyen (OK); Jim Laverty (PA); Andrew Dvorine (SC); Vickie Trice (TN); Barbara Snyder (TX); Mary Block (VT); Julie Walsh (WI); Dena Wildman (WV); and Mavis Earnshaw (WY).

8. Adopted its July 15 Minutes

The Subgroup met July 15 and heard presentations on the current long-term care insurance (LTCI) marketplace and what products are being seen, filed, and produced in the marketplace.

Ms. Kruger made a motion, seconded by Ms. Karnis, to adopt the Subgroup's July 15 minutes. The motion passed unanimously.

9. Discussed Comments Received on Sections 1–6 of Model #641

Mr. Gennace asked Jan Graeber (American Council of Life Insurers—ACLI) to discuss the ACLI's comments on Sections 1–6 of the *Long-Term Care Insurance Model Regulation* (#641). Ms. Graeber said the ACLI believes the language currently contained in Sections 1–6 remains flexible and compatible with the current LTCI marketplace, and new language is unnecessary. She said as the Subgroup continues its review of the remaining sections of Model #641, the ACLI recognizes that changes needed to those sections could result in a need to reconsider their position regarding the opening of Sections 1–6.

Birny Birnbaum (Center for Economic Justice—CEJ) said Ms. Graeber should show evidence that Model #641 works and Sections 1–6 remain flexible and compatible with the current LTCI marketplace. Ms. Graeber said she has not seen anything in the marketplace being stifled by Sections 1–6. Mr. Serbinowski said it is difficult to prove a negative, and Sections 1–6 are mostly definitions.

Mr. Gennace asked if someone from California cares to explain their comment to Section 3. Ms. Smith said this section singles out one type of other product that may come within the scope of Model #641—disability income insurance with a benefit triggered by activities of daily living (ADLs)—but it does not address other types of products in the marketplace today that have triggers based on ADLs or confinement in a facility. She said inclusion or exclusion of these other products within the scope of Model #641 should be considered. Mr. Serbinowski said it would be helpful if the Subgroup could look at or see examples of these products that skate on the edge of being LTCI. Ms. Smith said she is unable to give specific examples at this time, but she could provide generic examples.

Mr. Gennace asked Bonnie Burns (California Health Advocates—CHA) to explain the NAIC Consumer Representatives' comment on Section 3. Ms. Burns said it is like California's comment in that this section should be reviewed to determine if any part of it should apply to newer products that trigger benefits on ADLs and cognitive impairment, not just DL. Ms. Graeber said it would be helpful to see what these products are so products that are not really LTCI are not pulled in. Mr. Gennace said should Model #641 be opened for editing, the Subgroup can take a deeper look into these products.

Mr. Gennace asked Ms. Burns if the NAIC Consumer Representatives' comment on Section 4 is like the previous section. Ms. Burns said it is similar, and she believes this section should be reviewed to determine if it covers newer products that provide benefits for long-term care (LTC) expenses.

Mr. Gennace asked Mr. Serbinowski to discuss his comment to Section 4B(1). Mr. Serbinowski said of the definition of the "exceptional increase," it incorporates requirements that go beyond defining the term, and Utah would move the requirements outside of the section that defines the term. He said he merely is making an observation and has no real concern.

Mr. Gennace asked Mr. Serbinowski to discuss his comment to Section 4F. Mr. Serbinowski asked if there is a reason to require membership in a specific organization rather than maybe an actuary that is subject to the American Academy of Actuaries' (Academy's) "Qualification Standards." He said the Academy does not recognize a status of "in good standing." Ms. Snyder said a qualified actuary could be defined as an actuary and is a member of the Academy and qualified under its qualification standards. She said the Academy has a particular document that defines the standards to be met. Mr. Serbinowski said it might be more useful to have alternative language, and that could be addressed should Model #641 be opened.

Mr. Gennace asked Ms. Burns to discuss the comment received on Section 5. Ms. Burns said the section should be reviewed to consider definitions for reduced benefit options (RBOs). She said the phrase is used often in NAIC discussions, but there is no definition, and a definition should be included if it is being used in Model #641 and elsewhere. Mr. Serbinowski said RBOs is not the exact term used. He said the language requires that a policy offers the option to reduce benefits. He said RBOs may be used by the NAIC, but it is not in Model #641. Ms. Burns said if the term is being used, it should have a definition, and she suggested the definition used by J.P. Wieske (Horizon Government Affairs). Mr. Serbinowski said it is hard to determine whether a definition is needed just based on Sections 1–6 and how it relates to any parts of Model #641 with respect to the options to reduce benefits. He said while the term RBOs is not used in Model #641, should it be opened, a determination of whether a definition is needed can be decided.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 5E. Ms. Burns said this section should be reviewed to consider changing the wording "safety awareness" to a more specific definition. She said it seems to be a very outdated term, and there must be a better way to describe it, so the definition should be revised. Ms. Karnis asked how changing the term safety awareness or using a different term would foster increased flexibility, as the goal of the Subgroup is to determine whether the language in Model #641 no longer remains flexible and compatible with the current LTCI marketplace. Ms. Burns said she did not know what "safety awareness" means. She said that terminology is more like a risk to oneself or others, but it does not make sense. Mr. Gennace said it seems like the issue is a matter of perhaps tightening up or increasing the clarity of the language, but he asked whether it is also a matter of just modernizing or if there is a need to address that as an improvement. Ms. Andy asked if this term could be a federally defined term, and if so, if it could even be adjusted. Ms. Burns said she is pretty sure it is not a federally defined term. Mr. Gennace asked Mr. Torian if he could find some history on the term "safety awareness."

Mr. Gennace said the Subgroup will look at Section 6, and he asked the NAIC Consumer Representatives to discuss their comment on Section 6A(4). Ms. Burns said the section refers to a "class" regarding rate increases, and there should be a definition of a class for the purpose of imposing a premium increase. Mr. Serbinowski said the Subgroup is not opposed to examining this, but defining class could be a very tricky issue. Mr. Gennace asked whether this has

been an issue, there have been problems, or if it is inadequate in some way. He said he could see why it may need to be defined, but he asked if there have been issues or concerns from it not being defined. Mr. Birnbaum said this issue has been a source of litigation.

Ms. Burns said her comment may not have been totally clear, and she has concerns about guaranteed renewable even though the section in question states the use of a class basis. She said on the front page of all policies is a visible guaranteed renewable section, but the right to raise premiums is buried in the section. She said policyholders do not see that and do not know it is there from her experience in counseling consumers. She said there should be two separate paragraphs that pertain to the right to raise premiums and the guaranteed renewability. Ms. Graeber said this is the standard definition of guaranteed renewable, and it starts to get problematic once defining class. She said the class concept would be covered under a state's anti-discrimination statutes because any kind of class that is developed must have an actuarial support for it. Ms. Burns said there are three entirely different issues at play. She said there is the language on guaranteed renewability; the language on the right to raise premiums, which is not clear to policyholders; and the language on what constitutes a class for the purposes of premium increases.

Mr. Birnbaum said an increase in premiums is based on class, and there should be some definition of class but also some requirement that the policy states what one's class is. Mr. Serbinowski asked, supposing that there is one class and then there is an increase for some people by 0.5% and some others by 200%, if the definition would prevent that. He also asked, supposing that the class are policyholders who are males, age 57, lifetime benefits, 3% inflation, 90-day elimination period, preferred underwriting, and there are 17 persons at that moment in that class, if that is what is being sought. Mr. Birnbaum said what the insurance company has used to determine the rate is the class the consumer is in. He said the insurance company must identify some rating class to issue a policy, so it should be made clear to the consumer what their class is. Mr. Serbinowski said the purpose of the term is to offer protection so a class cannot be people named Tomasz who speak Polish, because the narrower the class, the less protection exists.

Mr. Gennace asked Ms. Burns to discuss her comment on Section 6A(4) and level premium. Ms. Burns said level premium and the other terms discussed are confusing for consumers. She said consumers do not understand the terms and many times are unaware of what these terms mean for them. She said the term level premium needs more definition in the policy. She said all state insurance regulators encourage consumers to read their policies, but the main reason people do not read their policies is they do not understand what these terms mean.

Mr. Gennace summarized Mr. Serbinowski's comment on Section 6B(2). Mr. Gennace said the section allows exclusions or limitations based on "mental or nervous disorders," and it specifically disallows exclusion based on Alzheimer's disease. He said Mr. Serbinowski asked if there is a better definition since if someone Googles "nervous disorder," the search comes up with "nervous system disorders" that include things like Parkinson's or stroke. Mr. Gennace said the term may be problematic and not exactly clear, and should Model #641 be opened, the Subgroup may want to redefine this section. Ms. Burns said the section does not include other dementias, and this definition needs work.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 6B(4)(c). Ms. Burns said the section allows for an exclusion for conditions related to military service and discriminates against members of the military who may have been exposed to conditions that cause a disabling condition later in life. She said it is long past time to remove this discriminatory exclusion.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 6B(8). Ms. Burns said the drafting note contains language that is specific and should be added to Section 6B(8). She said the specific language in the drafting note is "...if the claim would be approved but for the licensing issue, the claim must be approved." Mr. Gennace said Mr. Serbinowski had a comment on Section 6B(8)(a) that the language "the state of policy issued" in the third line should be "the state of policy issue." Mr. Gennace asked Ms. Burns to discuss the comment on Section 6B(9). Ms. Burns said it was merely to point out that if there are changes made to the Long-Term Care Insurance Model Act (#640) regarding extraterritoriality, then changes must be made to the Model #641.

Mr. Sundberg spoke on behalf of Mr. Serbinowski's comment on Section 6D. He said the Subgroup should probably look at this section, as in practice, most group LTC policies do not have any formal "conversion" provision. He said the coverage under the same certificate continues when the person leaves the group or the group terminates as if the certificate was an individual policy, and the section should probably reflect what is happening in practice.

Ms. Graeber asked Mr. Sundberg if he means the conversion provision does not allow for a company to convert to an individual policy. Mr. Sundberg said if a person purchased a policy through their company and then retires, that person maintains the same policy. He said there is no real conversion from group to individual. He said they just maintain coverage with that same group. Ms. Graeber said some companies do that, and there may be instances where a conversion to an individual policy happens, but she asked if the current language would allow for both. Ray Nelson (TriPlus Services Inc.) said the language allows for either a conversion or a continuation. Ms. Graeber said she is not sure what sort of change is being envisioned for the language. She said there is not a lot of true group policies in the marketplace, but conversions exist. Mr. Sundberg said if there are conversions happening, then leaving the language as it is would not be an issue, but he said Mr. Serbinowski can clarify his comments at the next meeting.

Ms. Karnis said with an eye toward thinking about whether more flexibility is needed in Model #641 and whether adding something about portability in this section would be helpful. She said she does not know if that is practical, but perhaps getting some input from industry might be helpful. She said it may not be necessary if the majority of consumers remain on their former employers group policy, but it may be something to think about in terms of flexibility. Mr. Gennace said it could be helpful if Ms. Graeber or someone else from industry cares to provide some insight at the next meeting.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.

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