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February 26, 2021

VIA EMAIL

Mr. Kevin Baldwin
Illinois Department of Insurance
State of Illinois
320 W. Washington St., 4th Floor
Springfield, Illinois 62767-000 1

Ms. Laura Lyon Slaymaker
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Via email to Jane Koenigsman, NAIC

Re: Amendments to Model 440

Dear Mr. Baldwin and Ms Slaymaker:

I write on behalf of a coalition of health insurance companies, including Anthem, Cigna, CVS Health and UnitedHealth Group, who thank you for the opportunity to provide comments regarding the revised amendments to the Insurance Holding Company System Regulatory Act ("Model 440") that the Receivership Law Working Group ("Working Group") recently exposed. As noted in our earlier comment letters, the coalition members agree that it is important to protect consumers in the event of a rehabilitation or receivership. We recognize the challenges receivers face in these instances and support amendments that would bolster a receiver's ability to protect the public. It is important, however, that these amendments do not, at the same time, harm consumers who are members of financially stable, ongoing concerns. Unfortunately, the revised language regarding bonding requirements do exactly that.

As we noted in greater detail in our letter dated January 29, 2021 (attached) imposing bonding requirements on stable, solvent health insurance groups places unnecessary financial burdens on the insurers and their members through increased premiums to finance these unnecessary bonding requirements. The provisions of the latest draft, which grant the state the unfettered discretion to impose any bond requirement at any time, in any amount, for any reason or for no reason, are unwise for a number of reasons. First, they do not recognize that the environment in the health insurance arena has long been toward health and wellness integration. Allowing the state to impose a bond requirement on internally integrated health care systems creates a perverse incentive for carriers to unwind their integration and avoid the potentially extreme bond cost requirements. This is, in effect, a regulatory tax on integration in the health care system.

Second, the bond requirement is unknown and unknowable, and bears no relation to the importance of the services to the operation, the riskiness of the business or the insurer, and ultimately, for the vast majority of insurers subject to these provisions, provides no benefits to policyholders or consumers. It will, however, create layers of costs that will ultimately be borne by those policyholders. As the U.S. regulatory system attempts to move toward a more risk-based solvency oversight system, it makes no sense to create a potentially massive financial requirement that has no rational basis in the risk posed by an enterprise. In addition, leaving the requirement completely to the discretion of insurance commissioners will necessarily result in uneven application and politicize the bonding requirements. Finally, the proposed amendment does not address the central issue of how to ensure that there are proper tools in place for receivers to address concerns with financially distress companies.

To the extent that bonding requirements remain in Model 440, we believe that the discretion to impose these requirements should be based on solvency triggers. The use of a solvency trigger ensures that the bonding requirements are only imposed on those insurers where additional protections are needed. Additionally, the use of solvency triggers also ensures that the bonding requirements are imposed at the point in time when additional protections are warranted. We recommend the following language as a better alternative as to when bonding requirements should be implemented:

> (g) If an insurer subject to this Act is deemed to be in a hazardous financial condition as defined by [*insert citation for Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition*] or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, then the Commissioner may require the insurer or the affiliated person(s) to obtain and maintain a bond for the protection of the insurer for the duration of the contract(s) or agreement(s). The bond amount should be no less than the amount specified by the commissioner;

We also recommend that the NAIC amend the proposed draft noting at page 440-17 regarding the bonding requirements as follows:

> **Drafting Note:** ~~The bond requirement is at the discretion of the commissioner.~~ The intent of the bond is to ensure the affiliated services provided under the contract(s) are fulfilled, which may be referred to as a "performance bond". In determining appropriate circumstances when a commissioner may require a bond and <u>in</u> specifying an amount, the

commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action including supervision, conservation, or a delinquency proceeding. If it is, the bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. ~~their review of the contract and the affiliated person, analysis of the holding company system, and examination or investigation of the insurer to determine whether concerns exist currently or prospectively that warrant such a bond. For example, the commissioner may consider whether concerns exists with respect to the affiliated person's ability to fulfil the contract or agreement if the insurer is placed into liquidation.~~

The commissioner also has discretion to determine if a bond ~~is necessary and if so, if it~~ should be required for a single contract, multiple contracts, or contracts with a specific affiliated person rather than requiring bonds for each contract or agreement. Note that bonds under Section 5A(g) may not be needed in states that already require bonds for licensure of third-party administrators.

We thank you for the opportunity to provide our comments and look forward to continued discussions with the Working Group.

Sincerely,

Chris Petersen
Arbor Strategies, LLC

cc: Jane Koenigsman

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January 29, 2021

Mr. Kevin Baldwin
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Ms. Laura Lyon Slaymaker
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1326 Strawberry Square
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Via email to Jane Koenigsman, NAIC

Re: Amendments to Models ##440/450

Dear Mr. Baldwin and Ms. Slaymaker:

I write on behalf of a coalition of health insurance companies, including Anthem, Cigna, CVS Health and UnitedHealth Group, who thank you for the opportunity to provide additional comments regarding the continuation of essential services through affiliated intercompany agreements for insurers in receivership. As we noted in our earlier comment letter of September 24, 2020, the coalition members agree that it is important to protect consumers in the event of a rehabilitation or receivership. We recognize the challenges that face receivers in these instances and support amendments that would bolster a receiver's ability to protect the public. It is important, however, that these amendments do not, at the same time, harm consumers who are members of financially stable, ongoing concerns.

The proposed amendments to Model #440, the *Insurance Holding Company System Regulatory Act,* will make far-reaching changes to the operations of holding companies, far beyond the receivership or rehabilitation arena. Every holding company, whether it is deemed to be at risk or not, will be required to post a bond for *all* affiliate contracts or agreements of an unknown, and unknowable, amount (Sec. 5.A.(a)(g)), they will be required to maintain separate accounts under certain circumstances (Sec. 5.A.(a)(i)), and are required to subject themselves to a potentially unknown and unknowable state court jurisdiction.

We suggest that these provisions, in particular the bonding requirement, are unwise for a number of reasons. First, in the health insurance arena, the environmental trend has long been toward health and wellness integration. Health insurers of any size that are part of a holding company system have and will continue to move toward a more integrated business model that provides not only better health and wellness but also synergies and centralized functions. Centralized functions not only provide policyholders, clients and owners a benefit of scale but streamline insurer operations. Suggesting that every affiliate contract, regardless whether it is material, whether it is critical to the continued operations of the legal entity, or whether it is more or less likely to be necessary to the operations of a receiver, be subject to a bond is a blunt instrument that creates barriers for health carriers to provide services to their members and policyholders, and raises costs and complexity. Health carriers by their very nature have multiple subsidiaries and affiliates. There is a very real chilling effect that the financial burden of a potentially unlimited bonding requirement will have on health insurance operations. Simply the cost of monitoring and maintaining appropriate bonding requirements is a significant cost to companies for very little return and will provide no health or wellness benefits to our consumers to justify such a significant operational cost.

Second, the bonding requirement is unknown and unknowable, and bears no relation to the importance of the services to the operation, the riskiness of the business or the insurer, and ultimately, provides no benefits to policyholders or consumers. There is no reason to place this potentially unlimited and burdensome requirement on a solvent, ongoing operation and the consumers that it serves. Receivers have access to many tools during the course of an insolvency. This one is overly draconian and unnecessary. If a bond is necessary, then it should be necessary for *all* contracts, not just those with affiliates. We suggest that non-affiliate, third -party contracts are significantly more risky than those within an insurance holding company system.

Third, the requirement that every affiliate contract be subject to a bond is, in effect, an economic tax on integration. A regulatory scheme that favors non-integrated, free-standing licenses that outsource all relevant operations to external contracts is misguided. Those non-integrated services provided by non-integrated contracts are more, not less risky to the operations of an enterprise, yet this provision penalizes insurers for developing the more rational, safe business model. If a health insurer uses an affiliate to provide payment integrity services, there is less, not more risk to the insurer and its consumers than if those services were provided by an outside contractor with no affiliation to the holding company system. The purpose of creating integrated groups is precisely to have better control, and better economics for the enterprise. There is no reason the regulatory community should attempt to disincentivize these operations that provide significant savings and benefits to members and policyholders.

In addition to objections to the bonding requirements, we question the language in Sec. 5.A.(1)(i) that "premiums or other funds belonging to the insurer" in the hands of an affiliate may not be commingled. It is unclear what "other funds belonging to the insurer" may include. While we agree that premiums collected by a third party, whether affiliated or not, should be clearly identified as belonging to the insurer on whose behalf they are collected, we request clarification about what other "funds" are included in this provision. We also suggest that Section 5 already requires that "the books, accounts and records of each party…shall be so maintained as to clearly and accurately disclosure the nature and details of the transactions…" We question whether this new language in paragraph (i) is necessary.

We thank you for the opportunity to provide our comments on these amendments and look forward to continued discussions with the Working Group.

Sincerely yours,

Chris Petersen
Arbor Strategies, LLC

Cc: Jane Koenigsman