To: Receivership Model Law (E) Working Group  
From: James Kennedy (TX), Chair  
Date: October 26, 2017  
Re: Proposed Revisions to Model 520, Life and Health Insurance Guaranty Association Model Act

On July 10, 2017, the Receivership Model Law (E) Working Group formed a drafting group to revise Model 520, contingent upon the approval of the Request for Model Law Development. The Executive (EX) Committee approved the request at the 2017 Summer National Meeting.

The drafting group held 12 conference calls during September and October 2017, and an interim meeting on October 12, 2017. Representatives of 12 state insurance departments and 35 interested parties participated in the calls and meeting. Interested parties included life & health insurance trade groups, life insurers, health insurers, health maintenance organizations, guaranty associations, receivers, consumer representatives, health care provider trade groups, and academics.

Comments and drafts from regulators, interested parties and NAIC staff were discussed during the conference calls and at the interim meeting. Attachment A contains written comments and edits considered by the drafting group and is attached for reference. At the conclusion of this process, the regulator members proposed revisions to Model 520. The material changes are described below:

<table>
<thead>
<tr>
<th>§2 Drafting Note</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>The purposes of the act include: (1) having sufficient assessment capacity for all insolvencies, and (2) assessing insurers in a fair and reasonable manner.</td>
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<thead>
<tr>
<th>§3.A.1</th>
<th>Coverage and Limitations, General</th>
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<td>Specifies that coverage under the Act applies to health care providers rendering services covered by a health insurance policy or certificate to which the Act applies.</td>
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<tr>
<th>§3.A.2</th>
<th>Coverage and Limitations, General</th>
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<td>Extends coverage to HMO enrollees.</td>
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<tr>
<th>§3.B.2.m</th>
<th>Coverage and Limitations, Medicaid</th>
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<tbody>
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<td>Excludes Medicaid from guaranty association coverage, similar to the current exclusion of Medicare.</td>
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<tr>
<th>§3.B.3 and Drafting Note</th>
<th>Coverage and Limitations, Moody’s Provision</th>
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<tr>
<td>Clarifies that the “Moody’s rollback” in §3.B.2.c is not intended to apply to any portion of a policy or contract (including a rider) that provides long-term care or any other health insurance benefits.</td>
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<tr>
<th>§3.C.2.a.ii, 3.C.2.d and Drafting Note</th>
<th>Coverage and Limitations of Health Insurance Benefits</th>
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<tr>
<td>• Clarifies that “disability insurance” is intended to mean disability income insurance, which is consistent with the historical interpretation. The change corrects the terminology.</td>
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<td>• Replaces “basic hospital, medical and surgical insurance or major medical insurance” with new definition of “health benefit plan” to encompass benefits provided by HMOs. (See Section 5.).</td>
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<th>§3.C.2.g</th>
<th>Coverage and Limitations of long-term care riders</th>
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<tr>
<td>Clarifies that LTC riders to life and annuity contracts are considered the same as the base policy or contract.</td>
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<th>§5.J</th>
<th>Definition of “Health Benefit Plan”</th>
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<tr>
<td>A new definition for “health benefit plan” was added, which includes health maintenance organization subscriber contracts. This definition is consistent with other similar NAIC model definitions. As “health benefit plan” is a subset of “health insurance”, exclusions are provided to the definition.</td>
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§5.M and Drafting Note | **Definition of “Member Insurer”**
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Added health maintenance organizations to the definition of “member insurer”, and removed the exclusion of HMOs from the Act. The drafting note is intended to alert states that license health care service corporations to address those entities in the Act.

§6.A | **Creation of the Association**
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Added a reference to health maintenance organization business.

§7.A and Drafting Note | **Board of Directors**
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The change increases the board membership to account for additional HMO member insurers. The drafting note gives states flexibility to address fair representation of membership on the board.

§8.B.2 | **Powers and Duties of the Association**
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- §8.B.2.a - Removes outdated language with regard to “identical … premium”.
- §8.B.2.d and §8.B.2.f - Requires that rates for substitute or reissued coverage be “actuarially justified”.
- §8.B.2.e - Deletes requirement for approval by the receivership court.

§8.L.9 | **Premium – Rate Increases**
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Clarifies that guaranty associations have the authority to file for actuarially justified rate or premium increases.

§9.C.1 | **Assessments – Class A Limitation**
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Eliminated the $300 limitation on Class A assessments, to give boards flexibility to address Class A assessments as appropriate in each state. It was noted that some states have deleted this limitation.

§9.C.2 | **Assessments – Class B**
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The former §9.C.1 was split into two paragraphs to differentiate between Class A and Class B assessments.

§9.C.2.a-b and Drafting Note | **Assessments – Class B Allocation for Long-Term Care Insurance**
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In the current model, the health account is assessed for LTC insurance insolvencies. Several alternative methodologies for Class B assessments for a long-term care insurance were considered. The proposed methodology provides that assessments for LTC insurance insolvencies be shared with the life account, so that all life and health insurers contribute to the assessment base. The proposed revision utilizes a 50%/50% split between the member insurers of the life/annuity and health accounts. This formula factors in that life and annuity member insurers will be subject to assessments from the health account, and health and HMO member insurers will be subject to assessment from the life account. The methodology would be included in the Plan of Operations. The approval by the commissioner in §9.C.2.b is intended to follow the existing approval process of the state.

§9. Drafting Note | **Assessments – Pre-Funding**
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The drafting note describes a pre-funding concept for health benefit plans. A provision was not included in the Model, as there was no consensus for a standard for pre-funding, and it may be appropriate only in certain states.

§13.B and Drafting Note | **Credits for Assessments Paid (Tax Offsets)-Optional**
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- The added subsection provides for recoupment of assessments via surcharges on premium where a member insurer is exempt from the tax liability in subsection A. Subsection A allows for a tax offsets.
- The drafting note addresses considerations for tax-exempt member insurers, such as some HMOs.

§Appendix | **Alternative Provisions**
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Revisions were made for consistency with other sections above.

**General Changes**
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Throughout the Model, revisions were made to insert terminology for “contract”, “enrollee”, “certificate”, “health maintenance organization”, “health benefit plan”, “reissue”, “health care providers”, etc. as applicable to address the addition of HMOs as member insurers.

**Other Matters**
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1. If the NAIC approves the proposed changes to Model 520, it will be necessary to review and update Annual Statement Supplemental Exhibits Supp. 2 and Supp. 4:
   - *Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit*
   - *Adjustments to the Life, Health & Annuity Guaranty Association Model Act*
2. The Drafting Group discussed other potential changes to Model 520, but determined that they required further study. It is suggested that the Working Group evaluate these proposals for consideration in future revisions of Model 520:

- Section 8D, allocation of premium - see language proposed by Patrick Cantilo, Cantilo & Bennett LLP (10/5/17 and 1/26/17 comment letters in Attachment A).
- Section 3C2, limitation of LTC benefit increases or adjustments - new provision recommended by Harold Horwich, Morgan Lewis & Bockius LLP (10/22/17 comment letter in Attachment A).

I would like to thank everyone who participated in the drafting process for their contributions. I especially appreciate the dedication of the NAIC staff, who worked tirelessly on this project.
• Pg. 1—American Council of Life Insurers (ACLI)
• Pg. 5—America's Health Insurance Plans (AHIP)
• Pg. 10—American Medical Association (AMA)
• Pg. 12—Arbor Strategies, LLC
• Pg. 22—Cantilo and Bennett, LLP
• Pg. 29—Kaiser Permanente
• Pg. 43—Morgan Lewis Brockius, LLP
• Pg. 51—National Organization of Life and Health Guaranty Associations (NOLHGA)
• Pg. 54—Colorado Division of Insurance
• Pg. 55—Maine Bureau of Insurance
• Pg. 63—Washington Office of the Insurance Commissioner
October 5, 2017

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

RE: Section 9 of the Life and Health Insurance Guaranty Association Model Act (Assessments)

Dear Chairman Kennedy and Members of the Drafting Group:

The American Council of Life Insurers (ACLI)\(^1\) appreciates this opportunity to provide comments to the Receivership Model Law (E) Working Group (RMLWG) as it considers options for broadening the assessment base for insolvencies of companies that have written long-term care insurance (LTCI).

Endeavoring to spread LTCI assessments to a broader base comes with a host of challenges. Most insurance companies and HMOs have never written LTCI. The LTCI market itself is small, and does not have capacity to handle an insolvency of any size. Therefore, it is inevitable that a change to the assessment base is going to cause consternation from those companies that do not have an LTCI assessment burden under today’s construct, but will pick up an assessment burden under a changed assessment base.

ACLI recognized this dynamic a little over a year ago, and brought together CEOs from member companies, both with and without LTCI business, to hammer out an agreement on how much of the assessment burden the life insurance industry was willing to take on. Our decision to take on additional LTC assessment liabilities is in keeping with the life insurance industry’s longstanding support of state-based regulation and its guaranty association system, the latter of which is an efficient and effective consumer safety net. After agreeing internally with our members, ACLI representatives met with representatives from the largest health carriers in the country to see if we could come to a similar agreement. Ultimately, the life insurance industry agreed to assume a total of 50% of future LTC assessment liabilities. No more. No less. Additionally, the life insurance industry agreed to make clarifying changes to the handling of hybrid LTCI products, ensuring that the life insurance and annuity accounts would be assessed for insolvencies involving those products. The process to reach agreement with all parties was not easy, and took about nine months.

\(^1\) 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.
ACLI recognizes that there are simpler formulations for allocating LTCI-based assessments, such as that proffered by Patrick Cantillo. However, no other formulation will allow for the exact outcome of the negotiated 50/50 split. ACLI will not be able to support any of the other formulations, either at the NAIC or in the states. We believe that our willingness to take on a significant, additional assessment burden should not be lost on regulators.

In the current economic environment, getting the ACLI Board of Directors to agree to a roughly 43% increase in assessments for LTCI beyond what current law requires was an extremely heavy lift. Getting our Board to go beyond that shift of liability is simply a non-starter and we would strongly oppose any effort by the NAIC or any state to do so. Further, ACLI has negotiated in good faith with major health insurers and agreed to pay 50% of LTCI-related assessments (including the portion of the health account already covered by life insurers). We urge the drafting group to strongly consider the importance of these agreements as it moves this updated Model Act forward through the NAIC and state legislatures.

Thank you for considering these recommendations.

Sincerely,

Paul S. Graham, III, FSA, MAAA
October 9, 2017

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

RE: Reporting and Guaranty Association Coverage of LTC Riders

Dear Chairman Kennedy:

As the Receivership Model Law Working Group reviews the Life and Health Insurance Guaranty Association Model Act to determine how long-term care (“LTC”) related insolvencies should be assessed, the American Council of Life Insurers (“ACLI”) would like to provide additional comments on hybrid products that contain LTC riders, specifically:

(1) How benefits provided by LTC riders should be covered under the state guaranty association system; and

(2) How premiums relating to LTC riders should be reported on an insurer’s annual Schedule T (Premiums and Annuity Considerations) and its Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit.

Hybrid products, particularly life insurance and annuity products with LTC riders attached to them, have been a rapidly growing segment of the life insurance industry. As the market for LTC hybrid products continues to expand, it is important that both regulators and industry strive to achieve consistency regarding how LTC rider benefits are covered and how LTC rider premiums are reported.

Guaranty Association Coverage of LTC Rider Benefits

ACLI believes that LTC rider benefits should be covered under the applicable state guaranty association provisions that relate to the underlying base contracts, and that the Model Act should be clarified accordingly.

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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 95 percent of industry assets, 93% of life insurance premiums and 98% of annuity consideration in the United States. Learn more at www.acli.com.
We, therefore, propose the following addition to Section 3.C.(2) of the Model Act for the Working Group’s consideration:

\[(g) \text{ For purposes of applying limitations under this subsection, benefits provided by a long term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.}\]

Reporting of LTC Rider Premiums

ACLI also believes that separately identified LTC rider premiums should be allocated to the base contracts (e.g., life insurance policies, annuity contracts) for both Schedule T reporting and guaranty association assessment base purposes.

During its Summer National Meeting this past August, the NAIC agreed to clarify its Instructions to Schedule T in order to convey that all rider premiums, not just those relating to LTC riders, should be allocated to their base contracts, so long as such riders do not act like separate policies and that their benefits are tied to the value or benefits of the underlying policies or contracts. The clarifying language reads as follows:

If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, and has benefits that are not tied to the value or benefits of the underlying contract, then it is to be recorded on the same line of business as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. Otherwise, the rider, endorsement or floater should be reported on the same line of business as the base policy.

Premiums and considerations that are reported on Schedule T, including those relating to LTC riders, automatically flow to the Life, Health & Annuity Insurance Guaranty Association Model Act Assessment Base Reconciliation Exhibit in the same way they are reported on Schedule T. Nonetheless, we intend to ask the Blanks (E) Working Group to clarify this treatment in its Instructions to the Reconciliation Exhibit.

Thank you for this opportunity to provide comments on this matter. Feel free to contact me at 202-624-2135 or at waynemehlman@acl.com if you have any questions.

Sincerely,

Wayne A. Mehlman
Senior Counsel, Insurance Regulation

cc: Jane Koenigsman
September 11, 2017

Mr. James Kennedy
Texas Department of Insurance
Chair, NAIC Receivership Model Law (E) Drafting Group

Mr. Douglas Hartz
Washington Office of the Insurance Commissioner
Vice-Chair, NAIC Receivership Model Law (E) Drafting Group

Re: Receivership Model Law Discussion related to Inclusion of Public Programs (Medicare Advantage and Medicaid Managed Care Plans)

Dear Chairman Kennedy and Vice-Chairman Hartz:

On behalf of America’s Health Insurance Plans (AHIP), I would like to thank you for the opportunity to provide our comments on the discussion occurring at the Receivership Model Law Drafting Group related to the inclusion of public programs (i.e. Medicare Advantage, Medicare Part D and Medicaid managed care) in a guaranty association structure.

AHIP is the national association of health insurance plans that provide coverage and health-related services that improve and protect the health and financial security of consumers, families, businesses, communities and the nation. AHIP and our members create and accelerate positive change and innovation across the health care system through market-based solutions and public-private partnerships that advance affordability, value, access and well-being. More than 60 of AHIP’s member health plans serve Medicaid enrollees, operating in 36 states, plus the District of Columbia and Puerto Rico. We also have over 80 member companies that offer Medicare Advantage plans, with 58 companies offering Medicare Part D plans across all 50 states.

AHIP objects to the inclusion of public programs in a guaranty association or any effort to bring such programs into the Model Law to be assessed for Long Term Care insurer insolvencies.

In relation to Medicare Advantage and Part D plans, the current Model Act, Section (3)(B)(2)(m) excludes “…benefits pursuant to…Medicare Part C & D”. As we stated in our letter to the NAIC Receivership and Solvency Task Force in 2008 (attached), we agree that Medicare Advantage (Part C) and Medicare Part D plans should continue to be exempt from the assessments. There is no sound policy reason to change that provision since the federal laws
and regulations\(^1\) expressly pre-empting such assessments have not changed since the Model was adopted in 2009.

If there is to be more dialogue to revise the exclusion, we can provide a thorough legal and policy explanation outlining why Medicare Advantage and Medicare Part D plans should continue to be excluded from the model. We have been disappointed in a few states that have not honored this exclusion as outlined in the current model, and instead have assessed Medicare Advantage and Part D plans over the Penn Treaty matter, requiring our member plans to challenge such assessments. We are hopeful that the drafting group, and subsequent discussions within the Working Group, will continue to support the exclusion of Medicare Advantage and Part D plans.

In regards to Medicaid we feel it is important to understand the uniqueness of the Medicaid program as it may relate to this matter. Medicaid is a shared program between the state and federal government that provides health care services to a set of defined beneficiaries through a federal entitlement. Medicaid is funded through a state and federal partnership where the federal share varies by state, but the federal government contributes from 50 to 75 percent of the total cost of each state’s programs. This funding structure, as well as the populations served by the Medicaid program is unique in each state, tailored to the needs, budgetary constraints, populations served and services provided in each state.

Medicaid managed care plans are the now the dominant approach to providing Medicaid benefits to beneficiaries, covering more than 70% of Medicaid enrollees (approximately 50 million Americans) across 39 states. Medicaid plans cover a diverse and often vulnerable population of Medicaid beneficiaries including children, people with physical or developmental disabilities, older adults with significant impairments, low-income working people without other coverage and people with serious mental illness.

Federal Medicaid regulations require rates paid by states to Medicaid managed care plans to be actuarially sound. If guaranty fund assessments are applied to Medicaid plans, federal actuarial soundness provisions would require a commensurate increase or gross-up of Medicaid rates that would be paid by states and the federal government. In an environment where many state budgets are already strained and the federal government is looking for ways to reduce its Medicaid expenditures, assessments on Medicaid plans could make it less likely for this model legislation to be passed in the states because it would place additional financial burden on states and the federal government. Further, applying guaranty fund assessments to Medicaid managed

\(^1\) Most notably outlined in 42 C.F.R. § 422.404, which states in relevant part “‘(a) Basic rule. No premium tax, fee, or other similar assessment may be imposed by any State,’ the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa, or any of their political subdivisions or other governmental authorities with respect to any payment CMS makes on behalf of MA enrollees under subpart G of this part, or with respect to any payment made to MA plans by beneficiaries, or payment to MA plans by a third party on a beneficiary’s behalf.” (emphasis added) For similar restrictions relating to Part D, see 42 C.F.R. § 423.440. See also 42 U.S.C. §§ 1395w-24 and 1395w-112.
Care plans would create an unlevel playing field, favoring states that still have Medicaid fee-for-service and disadvantaging states that have large Medicaid managed care programs, which would ultimately pay for these assessments.

Unlike enrollees who voluntarily purchase insurance products in good faith from commercial insurers for whom there is otherwise no financial guarantor, Medicaid is a federal entitlement program administered by states to provide safety net coverage to low income individuals. State Medicaid programs – backed by state and federal funds – are the ultimate guarantor of services and benefits to Medicaid beneficiaries. States, as purchasers, determine how to handle the providers in networks and the enrollees they cover. Since the guaranty association system will not be implicated, the premiums should not be assessed.

State Medicaid programs contract with Medicaid health plans to administer services and benefits and manage care for Medicaid beneficiaries in a highly regulated environment, including CMS-mandated contractual provisions designed to protect the low-income consumers served by Medicaid in the event of a plan insolvency. The state Medicaid agency has the primary oversight and regulatory role over Medicaid managed care plans. State Medicaid programs exercise extensive due diligence in contracting with managed care plans and ongoing oversight of fiscal and contract performance. Extending guaranty fund assessments to Medicaid plans would seem to complicate and undermine the regulatory role of state Medicaid agencies.

Applying guaranty fund assessments to Medicaid plans becomes even more complicated and inadvisable in the context of integrated plans that serve Medicare-Medicaid “dual eligible” beneficiaries. For example, there are several different types of programs such as Medicare-Medicaid plans (MMPs), Programs for All-Inclusive Care for the Elderly (PACE) and Dual-eligible Special Needs Plans (D-SNPs), one or more of which are offered in forty states. Application of guaranty assessments to these arrangements could place them in the extraordinary position of being assessed for an indeterminate part of their revenues. Such application could also have federal pre-emption implications. Further, if Medicare plans are excluded from guaranty assessments and Medicaid plans are not, such assessments would create a host of accounting and administrative issues for integrated plans that serve Medicare-Medicaid dual eligible beneficiaries.

This year’s debate over health care reform made clear that a wide range of stakeholders are concerned that Medicaid funding needs to be adequate to meet the healthcare and service needs of beneficiaries. More importantly, the debate demonstrated the keen interest of Governors and state Medicaid program directors over the financial strain that could be placed on state budgets if cuts to those programs were made. Guaranty fund assessments would be a direct yet non-controllable cost passed on to these programs, creating a financial burden harmful to these essential programs and states.

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In closing, AHIP and our member health plans appreciate the opportunity to provide comments and look forward to continued collaboration and dialogue with you as we work through revisions to the Receivership Model Law.

If you have any questions, please do not hesitate to contact me at LGassaway@ahip.org (202.861.6365) or Bob Ridgeway at Bridgeway@ahip.org (501.333.2621).

Sincerely,

Leanne D. Gassaway, MHA
Senior Vice President, State Affairs
America’s Health Insurance Plans

Enclosure

cc: Jane Koenigsman, Sr. Manager, L/H Financial Analyst, NAIC
Bob Ridgeway, State Affairs Senior Government Relations Counsel, AHIP
Mr. James Mumford
Chair, Receivership and Insolvency Task Force
Division of Insurance
State of Iowa
330 Maple Street
Des Moines, Iowa 50319-0065

Re: Life and Health Insurance Guaranty Association Model Act

Dear Mr. Mumford:

I write on behalf of America’s Health Insurance Plans (AHIP) to provide comments regarding the recent exposure of the Life and Health Insurance Guaranty Association Model Act. AHIP is the national trade association representing the private sector health insurance industry. AHIP’s nearly 1,300 member companies provide health, long-term care, dental, disability, and supplemental coverage to more than 200 million Americans. AHIP’s comments are limited to the amendment to sentence 3B.(2)(m) on page 5 of the Model Act. This language clarifies the fact that claims made under policies or contracts providing benefits through the Medicare Part C (Medicare Advantage) and Medicare Part D (prescription drug) plans are not covered by state guaranty funds.

We understand this also to mean that given the non-covered status of these policies or contracts, the premiums associated with them would not be included in state guaranty fund assessments. We agree that this is the correct understanding of the Medicare Parts C and D programs, and support the proposed amendment to the Model Act. As we noted in our earlier comments to the Receivership Model Act Revision Working Group, we believe that any state guaranty fund assessment that is based upon receipt of federal Medicare Part C and Part D premiums is preempted by federal law (42 U.S.C. 1395w-24 and 42 U.S.C. 1395w-112) and regulations. We also note that there is no policy rationale to support assessments of these federal premiums, given the extensive safety net of consumer protections already built into the Parts C and D programs in the Social Security Act and its implementing regulations. Congress and the Centers for Medicare & Medicaid Services (CMS) have ensured that beneficiaries will continue to receive services by providing for expeditious continuation of coverage, either by transitioning beneficiaries to another Medicare Part C or Part D plan or to original Medicare, depending on the beneficiaries’ preferences, and have protected consumers in the case of an insolvency of a Medicare Part C or Medicare Part D plan, by ensuring that the beneficiary is protected from liability for any outstanding claim that is the responsibility of those plans. (See, e.g, 42 U.S.C. 1395w-26; 42 CFR 422.504(g)(1), and 42 CFR §423.505(g)(1).

As noted in our earlier comments, because Congress has created a system under which beneficiaries in these programs will not need the protection afforded by a guaranty association, those state guaranty associations similarly need not assess Medicare Part C or Medicare Part D premiums. We commend the Task Force for amending the Model Act to clarify its scope in recognition of the application of the federal laws and regulations.

Thank you again for your consideration of this matter and please do not hesitate to contact me if I may be of any assistance or provide the Task Force with any further information regarding these programs.

Sincerely,

Randi Reichel
October 11, 2017

Mr. James Kennedy  
Chair  
Receivership Model Law (E) Working Group  
National Association of Insurance Commissioners  
444 North Capitol Street, NW, Suite 700  
Washington, DC  20001  

Re:  Life and Health Insurance Guaranty Association Model Act (#520)

Dear Chairman Kennedy:

On behalf of the American Medical Association (AMA) and our physician and student members, thank you for the opportunity to comment on possible revisions to the National Association of Insurance Commissioners’ (NAIC) Life and Health Insurance Guaranty Association Model Act (Model Act) being considered by the Receivership Model Law Working Group (Working Group). We appreciate the opportunity to urge the Working Group to ensure that the Model Act will protect patient access to health care through the continued financial viability of independent practicing physicians when an insurer or health maintenance organization (HMO) becomes insolvent.

Today, perhaps more than ever, it is vital to preserve the independent practice of medicine from insurer and HMO insolvencies. In 2016, most physicians (55.8%) in the U.S. worked in “independent” physician practices—practices that were wholly owned by physicians, and not some other entity (e.g., a hospital or health system).1 A thriving community of independent practicing physicians fosters competition. When the market for physician services is competitive, patients have more choices, and greater and timelier access to health care. Competition can lower health care costs for patients, employers, and other health care purchasers, and improve the quality of physician services. Subjecting independent practicing physicians to loss in the form of thousands, and perhaps even millions, of dollars in unpaid claims due to insufficient solvency protections undermines the financial viability of independent practices that are already under stress due to overly burdensome regulations, and is likely to reduce competition for physician services.

Failure to ensure that a robust guaranty fund will protect independent practicing physicians will also hinder the development of new payment and delivery reforms. Independent physician practices are already facing significant financial challenges due to regulatory burdens and the need to acquire new technologies, e.g., electronic health records. As the Working Group knows, our country is earnestly exploring ways to make the delivery of health care services more efficient and higher quality for patients.

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through value-based payment initiatives, such as accountable care organization/shared savings arrangements, capitated contracts, patient-centered medical homes, bundled payment programs, etc. Physicians must be able to adapt to and succeed in these new payment and delivery strategies if these strategies are, as a whole, to transform the U.S. health care payment and delivery system. Yet physician practices cannot succeed in these innovative practice arrangements unless they have sufficient financial resources to make the kinds of practice investments, e.g., purchase new technology or hire additional staff, which will enable the physicians to track, monitor, and otherwise manage the health status and outcomes of the patient populations or episodes of care assigned to them. Independent practices cannot absorb the kinds of losses they have incurred in the past due to unpaid claims because of inadequate insolvency protections and also make the kinds of investments that are essential to make health care payment and delivery reform a reality.

Accordingly, it is imperative that when insurers or HMOs become insolvent, physician practices can be made whole by a robust guaranty fund that is funded by insurers and HMOs. This will help to protect the financial viability of these practices and will allow them to continue providing health care to the patients they currently serve.

Thank you again for giving the AMA the opportunity to share its thoughts concerning the Working Group’s discussions concerning this Model Act. Please contact Wes Cleveland, Senior Attorney, Advocacy Resource Center, at (312) 464-4503 or wes.cleveland@ama-assn.org if you have any questions or comments.

Sincerely,

James L. Madara, MD
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 a Coalition\(^1\) of health insurers that represents some of the country’s largest major medical insurers and health maintenance organizations. This Coalition strongly supports the “50/50” assessment allocation that appears in the redlined version of the Life and Health Insurance Guaranty Association Model Act (#520) (“Model Act”). The coalition is opposed to any effort to make the assessment formula “proportional” as suggested on the Receivership Model Law Drafting Group’s (“Drafting Group”) October 3, 2017 conference call.

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 Drafting 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.

Recognizing that the existing assessment formula was not sustainable, the Coalition worked with the American Council of Life Insurers to develop a new assessment formula that could be supported on a national basis. The 50/50 assessment formula was carefully crafted by the industry after much negotiations as part, albeit a key part, of an overall proposal to address future long-term care insolvencies.

\(^1\) Aetna, Anthem, Cigna, HCSC and United, who together provide health insurance coverage to more than 227 million members world-wide, are the members of this Coalition.
We believe that the 50/50 assessment allocation works because it is practical, equitable and it recognizes the realities of the marketplace. It’s practical because preserving the long-term viability of the state-based insolvency safety net will require broad support from regulators and stakeholders to secure passage. The 50/50 assessment allocation has the support of the major segments of the life and health insurance industry. It is also equitable. All health and life insurers contribute towards the assessment base. It ensures that no individual company will over, or under, pay an assessment regardless of whether they are licensed as an accident and health insurer, a health maintenance organization or a life and annuity carrier. Finally, this approach recognizes the reality that there are significant cross-over sales among those life and annuity companies that sell accident and health lines and vice versa. This crossover necessitates the adoption of a methodology that acknowledges state-specific marketplace dynamics.

We are also concerned that the proportional allocation formula is not equitable in all cases. This approach fails to normalize for cross-over sales between life and annuity and accident and health companies resulting in a potentially unfair assessment mechanism. A proportional assessment approach harms health insurer nationally, as health insurers have higher premium values in most states. We also believe that this approach does not address the practical realities needed to secure passage of the amended Model Act at the state level. The potential failure to revise the Model Act jeopardizes the future of the state-based insolvency system safety net.

We urge members of the Drafting Working Group to support 50/50 assessment formula. 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
October 11, 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 a Coalition of health insurers and manage care organizations that represent some of the country’s largest major medical insurers and health maintenance organizations. The members of this Coalition, Aetna, Anthem, Cigna, HCSC and United, together provide health insurance coverage to more than 227 million members world-wide. We are writing to set forth our positions on several of the issues that will be discussed during the Receivership Model Law Drafting Group’s (“Drafting Group”) October 12, 2017 in person meeting.

Long-term Care Insurance Insolvency Assessment Formula

As discussed in our October 5, 2017 letter to the Drafting Group, the Coalition strongly supports the “50/50” assessment allocation formula that appears in the redlined version of the Life and Health Insurance Guaranty Association Model Act (#520) (“Model Act”). In support of that position, the Coalition has developed a brief presentation that explains how the formula works and sets forth the rationale in support of the 50/50 assessment formula. We request the opportunity for us, or our representatives to give this presentation to the Drafting Group, if not at the in-person meeting, then shortly thereafter. We suggest this will provide the Drafting Group with a better of understanding of how the assessment formula works.

The Coalition has also developed alternative Model Law language that we believe simplifies the 50/50 assessment formula statutory language. We provide the following concept language as an alternative to the more complex language in the existing draft for the Working Group’s consideration:
The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology in the Plan of Operation and approved by the Commissioner. The methodology shall ensure that 50% of the assessment is allocated to accident & health carriers and 50% is allocated to life and annuity carriers.

We suggest this language, which is significantly less complex, yet effectuates the split between health and life insurers and their respective accounts. We believe that this language meets the objectives of the “50/50” split by allowing the insolvency experts, i.e. Guaranty Associations and Insurance Commissioners, to apply the methodology in the existing draft Model Act and by allowing allows state legislatures to focus on adopting the broad public policy.

Allocation of Premiums between Guaranty Associations and Liquidators

The Coalition opposes the inclusion of a drafting note that suggests premiums may be allocated between the guaranty association and the liquidator. This drafting note is contrary to our interpretation of the Life and Health Guaranty Association Model Act (#520) (“Model Act”). We also believe that it is contrary to the historical interpretation and implementation of state laws based upon the Model Act.

We oppose this drafting note for several reasons. First, paying premiums to liquidators invariably puts the liquidator in the role of an insurer. With premium payments comes the obligation for the liquidator to pay claims on an on-going basis, to manage and invest those premiums, etc. In the case of a long-term care insurer insolvency the liquidator would be required to perform these obligations for the unforeseeable future. This is not the proper role for a liquidator. Additionally, sharing premiums with the liquidator would result in fewer premiums for the guaranty fund association, which in turn means greater losses for guaranty associations resulting in larger assessments to insurers. As a general rule, in the case of an insolvency, the premiums paid are insufficient to cover the losses. Allocating some of the premiums to the liquidator would only magnify this problem. Finally, making the proposed change would mark a significant public policy shift that should be properly vetted. Due to time constraints beyond anyone’s control, we do not believe that Drafting Group has sufficient time to discuss whether a change of this magnitude should be made to existing policy, and note that it is not necessary, at this time, to tackle this very limited-scope issue, in order to fulfil the Working Group’s charge. Tackling it now, however almost certainly guarantees that the Working Group will fail to meet its deadlines. We urge that this issue be tabled.

Guaranty Fund Payments to Capitated Providers

It was suggested during the October 10, 2017 conference call that guaranty fund payments should not be made to health maintenance organization (“HMO”) providers that are contracted and paid on a capitated-basis. At other times it has been suggested the guaranty fund should not make payments to HMO providers with hold harmless agreements. The Coalition opposes this idea and believe that providers should be treated the same regardless of whether they are under contract with an HMO, a PPO, an EPO or are under some other contractual
arrangement. Under existing Model Act provisions, providers contracted with a non-HMO health insurer are covered and paid by the guaranty fund regardless of whether the provider was subject to a hold harmless agreement or was paid on a capitated basis. The vast majority of non-HMO network contracts contain hold-harmless provisions. A significant number of non-HMO contracts have either full or partial capitation. They are, today, covered by the guaranty associations, and claims payments for providers with hold harmless provisions and capitated arrangements have already been handled, without difficulty, in cases of HMO and non-HMO insolvencies. Failure to pay those providers for services already provided, or for services to be provided post-insolvency will almost certainly ensure that the guaranty associations are unable to maintain their provider networks during the course of the insolvency, which certainly is a poor result for consumers. Guaranty associations have not faced difficulties addressing these two types of arrangements when confronted with health insurance insolvencies so we do not see any reason to include exceptions in the Model Act to exclude payments to providers for certain types of contractual arrangements.

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
October 17, 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 a Coalition of health insurers and manage care organizations that represent some of the country’s largest major medical insurers and health maintenance organizations. The members of this Coalition, Aetna, Anthem, Cigna, HCSC and United, together provide health insurance coverage to more than 227 million members world-wide. As noted in our earlier letters, the Coalition strongly supports the “50/50” assessment allocation formula.

As stated in our October 5, 2017 letter to the Drafting Group, we believe that that the 50/50 assessment allocation works because it is practical, equitable and it recognizes the realities of the marketplace. It’s practical because preserving the long-term viability of the state-based insolvency safety net will require broad support from regulators and stakeholders to secure passage. The 50/50 assessment allocation has the support of the major segments of the life and health insurance industry. It is also equitable. All health entities and life and annuity writers contribute towards the assessment base. It ensures that no individual company will over, or under, pay an assessment regardless of whether they are licensed as an accident and health insurer, a health maintenance organization or a life and annuity carrier. This approach recognizes the reality that there are significant cross-over sales among those life and annuity companies that sell accident and health lines and vice versa. This crossover necessitates the adoption of a methodology that acknowledges state-specific marketplace dynamics. Finally, this approach also provides uniformity and certainty to the marketplace.
For the reasons set forth above, the Coalition offers the following language to address the Section 9 assessment formula:

SECTION 9 – AMENDMENTS WITHOUT FORMULA EMBEDDED

Section 9. Assessments

A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at [insert amount] percent per annum on and after the due date.

B. There shall be two (2) classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.

C. (1) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments.

(2) (a) The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts, and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(b) The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan of Operation and approved by the Commissioner. The methodology shall provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to be allocated to life and annuity member insurers.

(c) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired) bears to premiums
received on business in this state for those calendar years by all assessed member insurers.

**Drafting Note:** The purpose of Subsection C(2)(b) is to allocate the responsibility for an insolvency of a long-term care member insurer evenly between member insurers in the health account and member insurers in the life and annuity industries. As it is likely that life and annuity member insurers will be subject to assessments from the health account, and health and HMO member insurers will be subject to assessment from the life account, the formula below should be utilized by guaranty associations so that member insurers in the health industry pay 50% of the assessment and member insurers in the life and annuity industries pay 50% of the assessment.

In determining the shares that shall be allocated pursuant to paragraph (2)(b) of this subsection, guaranty associations should use the following formula:

\[
X\text{-factor} = \frac{(.50 \times \text{Life insurer's share of HA})}{(\text{Life insurer's share of LIAA - Life insurer's share of HA})}
\]

in which the “X-factor” represents the percentage of LTC assessments assigned to the life and annuity account, HA represents the guaranty association Health Account and LIAA represents the guaranty association Life Insurance and Annuity Account.

(4) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

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

Thank you.

Sincerely yours,

Chris Petersen
Arbor Strategies, LLC
October 18, 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:

On behalf of the American Council of Life Insurers, Arbor Strategies, LLC (representing a coalition of national health insurers and health maintenance organizations) and the Blue Cross Blue Shield Association, we wish to thank the Receivership Model Law Drafting Group (“Drafting Group”) for the significant amount of effort spent last week to nearly complete its first round of proposed amendments to the NAIC Life and Health Insurance Guaranty Association Model Act (“Model Act”). Major progress was made towards reaching the Receivership Model Law Working Group’s (“Working Group”) charge, and we appreciate your ongoing commitment and collaboration to reforming the Model Act for the protection of long-term care consumers and the preservation of the state-based insolvency system. We submit the following comments in opposition to the amendment that would create a separate sub-account for assessments levied on health maintenance organizations (“HMOs”) within the health account.

We urge the Drafting Group to reject the amendment, and any corresponding drafting note. The concept of a sub-account within the health account subverts all the work that this Drafting Group has done to date.

The preservation of the state-based insurer solvency protection system requires a comprehensive approach to protecting consumers. This requires a recognition that we all bear the societal responsibility of preserving the guaranty association consumer safety nets when existing market conditions necessitate it. The undersigned, representing HMOs doing business in almost every state, health insurers, and life insurers understand this critical responsibility and have worked with the Drafting Group to achieve this end for many months. It would be regrettable if this Drafting Group included language in the Model Act, even as a drafting note, that suggests to states a path that would undermine its main purpose.

Specifically, it has been suggested that a drafting note be included in the Model Act to permit HMO assessments to be held in a separate account within the Guaranty Fund. This approach would raise questions about the responsibility of an HMO to pay for any future long-term care insolvencies, and would specifically ensure that HMOs do not participate in the Guaranty Fund system in the case of a health insurer insolvency. This proposal is intended to encourage states to bypass the entire purpose of the Model Act. It has long been acknowledged by this Drafting Group that the Guaranty Fund assessment base needs to be broadened to protect policy holders, by ensuring a broad and stable base for assessments. The inclusion of this
drafting note perpetuates the status quo and puts the priorities of policyholders behind the business objectives of a few HMOs.

In addition, this drafting note will have the unintended consequence of permitting health insurers with an “escape hatch” in the receivership system. Under the sub-account structure as proposed, insurers will have the option to move their business to an HMO platform, leaving the life insurers to bear the burden of these assessments and further destabilizing the state-based insolvency system. Because it perpetuates the unlevel playing field between HMO and non-HMO writers in the health insurance market, consumers will be faced with cost differentials that will drive the market to the HMO platform and health carriers will have no choice but to follow. We do not believe this to be the intent of the Drafting Group nor is it a sound public policy solution.

In the spirit of cooperation, a coalition representing the vast majority of life insurers, health insurers and HMOs from across the nation worked diligently to reach consensus on a legislative proposal that more equitably spreads guaranty association assessments for long-term care insurance. It was not an easy compromise to reach, but they were driven by the desire to preserve the state-based solvency protection system and consumer confidence in the guaranty association safety net. These stakeholders stand ready to commit their resources to support passage of legislation in the states.

Regulators and interested parties have devoted a significant amount of time to enhance the Model Act so that it meets the needs of policyholders, today and tomorrow. Adding a sub-account for HMOs and a corresponding drafting note would defeat the very purpose of this exercise and jeopardize the success of this entire initiative. For these reasons, we urge you to reject it.

Sincerely,

J. Bruce Ferguson, Senior Vice President, State Relations
American Council of Life Insurers

Chris Petersen for
Arbor Strategies, LLC

Paul S. Brown for
Blue Cross Blue Shield Association
Dear Mr. Kennedy:

During a call on October 3, 2017, you requested a proposed drafting note for the issue I raised regarding the allocation of premium between the “covered” and “uncovered” portions of implicated insurance contracts.

**SUGGESTED DRAFTING NOTE**

**Drafting Note:** There may be receiverships in which the coverage provided by the guaranty association does not extend to the full amount of benefits for which the insolvent insurer was contractually bound to policyholders under its policies or contracts and such policyholders are required to continue paying the full contractual premium after the entry of orders of liquidation. Debate has arisen as to the propriety of allocating such post-liquidation premiums between the guaranty associations and the liquidator in proportion to the part of the continuing coverage to which the policyholder is contractually entitled that is covered by the guaranty association. While it may be argued that the definition of “Premiums” in Section 5(Q) already calls for such allocation, some observers interpret this section as not calling for such allocation. States desiring to require such allocation and to avoid ambiguity may elect to clarify this matter by amending Section 8(D) as follows:

*Premiums due or received for coverage after entry of an order of liquidation of an insolvent insurer for the portions of policies or contracts for which coverage is provided under Section 3B shall belong to and be payable at the direction of the Association. The premiums due or received after the entry of an order of liquidation of an insolvent insurer for the portions of policies or contracts for which coverage is not provided under Section 3B shall be paid to the liquidator. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premium collected by the Association.*
Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

The methodology to be used in such allocation may differ depending on the type of coverage at issue. For example, in the case of long term care insurance such allocation may be made in proportion to the affected policies’ gross premium reserve bifurcated between the portion that does not exceed the applicable guaranty association limit and the balance (sometimes referred to as “over the limit benefits”).

DISCUSSION

Specifically, I suggested that consideration be given to clarifying that the premiums that belong to the guaranty association under Section 8.D. are those portions of the total premiums for relevant policies that correspond to the portions of the policies for which coverage is provided under Section 3.B.

As you know, Model Act, Section 5.Q. provides currently as follows:

"Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 3B except that assessable premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to one individual, one participant and one contract owner. "Premiums" shall not include:

(1) Premiums in excess of $5,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, or

(2) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

I will omit from this letter any argument in support of this language. Prior to sending it to this drafting group I did provide it to NOLHGA and counsel for the health insurers but we were unable to agree on a drafting note.

October 5, 2017 - Model 520 comments of Patrick Cantilo - page 2
As usual, the views I express are strictly my own and not offered on behalf of any client or organization. I would be happy to answer any questions about these matters. Thank you for your courtesy in considering my comments.

Very truly yours,

Patrick H. Cantilo

October 5, 2017 - Model 520 comments of Patrick Cantilo - page 3
Mr. James Kennedy, Chair  
Receivership Model Law (E) Working Group  
C/O Jane Koenigsman  
Sr. Manager I - Life/Health Financial Analysis  
National Association of Insurance Commissioners  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106-2197  

RE: MODEL 520 COMMENTS

Dear Mr. Kennedy:

During a call on December 6, 2016, and by email dated December 15, 2016, the working group requested:

“comments on issues and implications of long-term care insurance (LTCI) insolvencies on receivership practices and processes, the guaranty fund system, the applicability of provisions within Life and Health Insurance Guaranty Association Model Act (#520) (the “Model Act”) on long-term care insurance, and any other receivership laws/regulations. Also please comment on any recommendations for solutions to the issues and implications identified. The information gathered from this request is intended to assist the Working Group in identifying issues for discussion and consideration as it prepares to address the following 2017 charges:

Evaluate and consider the changing market place of long-term care products and the potential guaranty fund impact.

Evaluate the need for amendments to Model 520, Life and Health Insurance Guaranty Association Model Act, to address issues arising in connection with the insolvency of long-term care insurers.

I offer the following comments addressing the second of these charges. The views I express are strictly my own and not offered on behalf of any client or organization. They are informed generally by my experience with troubled insurers and insurance regulation during the last four
decades and specifically by my work with troubled long term care insurers during the last five years. In summary my comments are:

1. The assessments for LTCI failures should be allocated among all life and health insurer members of the guaranty associations, not just or principally health insurers.
2. Section 3.B.(2)(c) of the Model Act (the “Moody’s Rollback” provision) should be clarified to exclude health insurance and LTCI benefits.
3. Consideration should be given to clarifying that the premiums that belong to the guaranty association under Section 8.D. are those portions of the total premiums for relevant policies that correspond to the portions of the policies for which coverage is provided under Section 3.B.

**DISCUSSION**

In more detail, my recommendation and the rationale for each position follows. I strive here to keep the discussion brief but will be please to expand on any of these points if requested.

**Assessments**

Section 9 of the Model Act authorizes each guaranty association to assess member insurers for amounts needed to discharge statutory obligations with respect to specific failed insurers (“Class B Assessments”) and such assessments are typically allocated by “accounts and subaccounts” corresponding to lines of insurance business. Long-term care insurance is classified as health insurance in most states though traditional health insurers sell very little or none of this product. Instead, LTCI mostly has been sold by life insurers engaged in many lines of business or by “monoline insurers” who marketed almost exclusively LTCI products. While it is impossible to design an assessment mechanism that will be viewed as perfectly fair by all assessed insurers, the disparity between the group of companies engaged in the sale of LTCI products and the group of companies likely to be assessed for the failure of such insurers is striking. In the case of the Penn Treaty companies, for example more than 75% of the aggregate assessment is likely to be borne by health insurers though they did not sell the product. On the other hand, many life insurers never sold LTCI and fewer still do so presently. Because there are so few viable monoline LTCI insurers in the market, creating a stand-alone LTCI subaccount would be impractical. It simply would not have a remotely adequate assessment base. Instead, I propose that the assessment burden be spread over the broader industry. To accomplish this, I propose that the following subsection be added as Section 9.C.(4) of the Model Act:

> For purposes of this Section long term care insurance shall be deemed to be both life and health insurance and the subaccount for life insurance described in Section 6.A.(1) shall be aggregated with the account for health insurance described in Section 6.A.(2) for purposes of determining each member insurer’s share of a Class B assessment necessary to discharge the association’s responsibilities with respect to long term care insurance issued by the impaired or insolvent insurer.

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1Unless specified otherwise, all statutory references are to the Model Act.
There clearly can be many other ways of reallocating part of the LTCI burden away from health insurers to other sectors of the industry. I offer this approach as one that could be relatively easily implemented.

**Moody’s Rollback**

Largely because of the Penn Treaty insolvency and the desire of certain health insurers to mitigate their resulting assessment liability, there has been much debate about the applicability of Section 3.B.(2)(c) (the Moody’s rollback provision) to the inflation benefits provided by many long term care insurance policies. I will not describe this debate in any detail here as that discussion alone could consume volumes. Suffice it to note that in my view when the Moody’s rollback provision was adopted it was for the purpose of mitigating guaranty association liability for certain investment contracts in the belief that investment expectations were not deserving of the same “safety net” protection as consumer insurance products. No one believed at the time that these provisions would or should serve to reduce benefits under long-term care or other health insurance products. Suggestions to the contrary would simply be disingenuous. Many technical arguments can be offered pro and con applicability of the Moody’s rollback provision to long term-care insurance, such as whether the inflation protection features at issue are truly “based on a rate of interest.” I leave that debate to others or for another day. Suffice it to note that in my view the overriding public policy is and should be not to reduce safety net protection for long-term care insureds on this basis. To avoid that result I propose that Section 3.B.(2)(c) be amended as follows:

A portion of a policy or contract other than one for long term care or other health insurance to the extent that the rate of interest ...

**Premium Allocation**

In the context of long-term care insurance failures, a potentially material issue exists with respect to the allocation of the future premium to be paid by policyholders under the insurer’s continuing policies after the guaranty associations are triggered. Specifically, should such continuing premium be (1) paid in its entirety to the guaranty associations, or (2) allocated between the guaranty associations (as to the covered portion of the contracts) and the liquidator (as to the uncovered portions)?

There is not much precedent for this issue because historically the life and health contracts for which life and health guaranty associations became responsible were fully assumed by the guaranty associations or other insurers and/or did not provide for continuing premiums. LTCI failures differ in that a material portion of a policyholder’s contractual benefits may exceed guaranty association limits and will therefore not be covered. At the same time, the underlying contracts require the payment of premiums unabated through termination of the contract or until waived due to onset of a claim. Under these circumstances the fairness and propriety of the guaranty associations collecting all the premium but continuing only part of the coverage is a legitimate issue. Especially to the extent that the liquidator will make efforts to provide some replacement coverage for the portions of the underlying LTCI policies not covered by guaranty associations, it is not only fair but important that the portion of the premium corresponding to the uncovered contractual coverage be left with the liquidator for that purpose.
In truth, the Model Act and similar statutes may already address this sufficiently in the definition of premiums:

"Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 3B except that assessable premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to one individual, one participant and one contract owner. "Premiums" shall not include:

(1) Premiums in excess of $5,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, or

(2) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

Model Act, Section 5.Q. Emphasis added. However, to avoid ambiguity and continuing debate, it may be appropriate to amend Section 8.D of the Model Act as follows:

Premiums due or received for coverage after entry of an order of liquidation of an insolvent insurer for the portions of policies or contracts for which coverage is provided under Section 3B shall belong to and be payable at the direction of the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premium collected by the Association. The Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

The assets of failed LTC insurers are allocated between the guaranty associations and the liquidator in proportion to coverage without controversy. Similar allocations are followed in other types of insolvencies in which material portions of the contractual benefits owed to policyholders are “uncovered” by the guaranty associations. See for example workers’ compensation insolvencies. It is hard to conceive of a principled argument against similar allocations of future premiums.

I would be happy to answer any questions about these matters. Thank you for your courtesy in considering my comments.

Very truly yours,

Patrick H. Cantilo

January 26, 2017 - Model 520 comments of Patrick Cantilo - page 4
September 11, 2017

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

RE: Kaiser Permanente preliminary comments to Receivership Model Law Working Group drafting committee

Dear Chairman Kennedy and Members of the Working Group:

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

1. Lack of a record for the drafting group  
KP participates regularly in numerous committees, task forces and working groups at the NAIC, mostly within the structure of the B Committee. All of the groups we can recall keep minutes of their proceedings, including, for example, the current drafting group at the Model #22 Working Group. For other parts of this process, this working group has kept minutes.

We were surprised by the announcement this would not occur for the proceedings of the drafting group. The NAIC policy to keep records of such meetings helps to provide interpretative assistance to any regulators, legislators or interested parties who have questions about what was discussed, what was omitted from discussion and in general provide a framework for understanding how model language was developed.

The decision not to keep records was not discussed, to our knowledge, and we believe such a decision is consequential and worth considering publicly and on the record.

2. Issues in Section 6; Subaccounts within the health account; dual commissioners; pre-funding  
KP recommends that, like the Life Insurance account, the Health Insurance account be divided into subaccounts that address the significant differences between health insurers and HMOs. The subaccount structure protects different kinds of companies from subsidizing one another, and we believe that structure is equally important for the Health account. We have provided language to accomplish that in the attached language.

We have also provided brief comments on two other issues we view as potentially significant, the situation where two different commissioners regulate life insurers and HMOs, and the proper
Kaiser Permanente Responses
NAIC Receivership Model Law Working Group

terminology to use when referring explicitly in a model act like this to the new proposals that an
individual state is making. It is our understanding that the proposal from Colorado to pre-fund
the health account is far from the norm, and would be a significant departure from the current
model. While the working group may choose to adopt that in the model act, references such as
“the Colorado proposal” will have no referent in current law. This problem is exacerbated if the
working group does not keep records of the proceedings of this drafting group. We propose a
full and open discussion of pre-funding guaranty associations, and adequate documentation in
the records of this group to assure that the subject of the discussion can be reviewed if
necessary.

We appreciate the opportunity to provide these initial comments, and will provide additional
comments as the discussion moves forward. 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
September 21, 2017

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

RE: Kaiser Permanente comments to Receivership Model Law Working Group drafting committee

Dear Chairman Kennedy and Members of the Working Group:

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

1. Drafting Note on Tax-Exempt and Non-Profit Health Insurers and HMOs
   The drafting group asked for comments on a drafting note to address the unique situation of tax-exempt and not-for-profit health insurers and HMOs. This is a business form that has no true equivalent in the life insurance side of the guaranty associations, and the proposed inclusion of HMOs into the model act makes the issue more prominent.

   Tax exemptions and non-profit status arise out of the charitable missions of hospitals in the early part of the 20th century. HMOs like KP and others which integrate hospitals fully into their systems have incorporated that social mission while developing systems of health care that are adapted to the modern practice of medicine.

   Some language in the current proposal acknowledges that these differences can result in inequities and unfairness, such as when non-profits do not pay state premium taxes. We believe that this principle should be fully articulated in a drafting note to make sure states are aware of possible repercussions of tax exemptions or non-profit status that could disadvantage those business forms, given the laws in a particular state. Because state laws differ considerably, we believe a drafting note is the most appropriate approach. The drafting note we propose could be placed after Definition (J) of “health benefit plan.”

DRAFTING NOTE: States where tax-exempt and/or non-profit HMOs or health insurers operate should consider whether it is appropriate to exclude them from state Guaranty Associations for policy reasons. If they are included in the Guaranty Associations, states should review the laws applicable to those companies to assure that they do not have an effect that would disadvantage them with respect to health insurers or life insurers -- for example when a premium tax offset
available to for-profit insurers would not be available to non-profits. It is the intent of the NAIC that the changes made to this model do not apply to any member insurer or type of member insurer inequitably.

We appreciate the opportunity to provide these comments, and will provide additional comments as the discussion moves forward. 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
October 5, 2017

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

RE: Kaiser Permanente comments to Receivership Model Law Working Group drafting committee

Dear Chairman Kennedy and Members of the Working Group:

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

1. **Assessments must be equitable**

   The proposed language to split assessments 50/50 is based on a private agreement between the life insurance industry -- through its trade organization, ACLI -- and several health insurers who also have HMOs. It is not based on any market data for long-term care policies, but is explicitly based on a forced outcome that ignores state markets in general, and long-term care markets in particular. KP is in strong opposition to this proposal.

   We must emphasize that this was not an agreement between two industries. Such an agreement would have been negotiated and approved by ACLI and AHIP, with each trade industry representing the opinions of its full membership, acting as the organizational representative of all members. As we have noted, very large health insurers that also have HMOs in their corporate structure represent their own unique business and policy interests, and could not be proper representatives of HMOs that have any other structure, status or mission.

   But even if the proposal had been the result of well-understood industry practices, it must be rejected because it is fundamentally inequitable. It candidly states that it is intended to divide the life and health assessments equally, but as several members of this drafting group have noted in the past, long-term care policies are not sold equally between the life and health insurance sides. CIGNA states in its letter of February 7 that major medical health insurers wrote
only about 3% of long-term care policies while shouldering the burden of 75% of the assessments. That is a telling discrepancy.

In fact, according to NOHLGA’s figures for 2014, the 25 largest life insurers wrote 71% of long-term care policies, and health insurers wrote about 21%, with about 6% written by “other” lines. To take a market that is split in anything like those proportions and force allocation of the assessments 50/50 is the definition of inequity.

These figures will and should be different in different states, and the model should reflect that and allow states to determine the proper division of long-term care policies in their own markets across those two accounts. The proposed language here simply ignores both the market data on long-term care and the principle of equity.

We believe that the methodology already established in the model should be used to determine the premium volume for the long-term care business written by members of each of the two major accounts: calculate the proportion of premiums received on long-term care business in each state over the three most recent calendar years, and allocate to each account its own proportion of that total. (Model #520, section 9 (C)(2) (now numbered as (3)). At the very least, the methodology the board determines to use in its discretion must be fair and reasonable.

This could be accomplished with an amended version of Patrick Cantilo’s proposal. His language correctly acknowledges that long-term care insurance has some characteristics of both life and health insurance. However, its aggregation of the life and health accounts implies that life and health assessments for long-term care should simply be in proportion to the wider markets for life insurance and health insurance. This is also apparently the point of the spreadsheet distributed by the working group this afternoon – to focus the discussion on the relative share of the overall life and health insurance markets, rather than on the relevant question for this group: the share of long-term care insurance sold by each of those markets.

We would propose the following addition to the language:

For purposes of this Section long term care insurance shall be deemed to be both life and health insurance. **For purposes of determining each member insurer’s share of a Class B assessment for the failure of a long-term care insurer, the assessment shall be in proportion to the premiums written on business in this State by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became insolvent—and the subaccount for life insurance described in Section 6.A.(1) shall be aggregated with the account for health insurance described in Section 6.A.(2) for purposes of determining each member insurer’s share of a Class B assessment necessary to discharge the association’s responsibilities with respect to long term care insurance issued by the impaired or insolvent insurer. Class B assessments for long-term care insurance shall be divided equitably between the two accounts.**
2. Separate sub-accounts should be available in the Health Account for Health Insurers and HMOs, subject to a determination by the commissioner that each subaccount would have adequate capacity for its market.

As KP stated verbally on the drafting group call of September 22 regarding section 6 of the model, we strongly urge the creation of two sub-accounts within the Health Account, as the model does for the Life Insurance and Annuity Account.

The primary concern expressed in the drafting group was that there might be cases where one side of the health care market would not be adequate to support subaccounts. This is a reasonable concern, but clearly is not the case in all states. If the commissioner determines that creation of two subaccounts in the health account would lead to inadequate capacity in either subaccount, a drafting note can specify that there may be a single health account, subject to periodic market review.

In states where there is a reasonably robust market for both HMOs and health insurance companies, this language reinforces the general rule that participation in the guaranty association is for the purpose of providing a secure environment for other participants in that same market segment.

Long-term care is a unique exception to the general rule, and should not become the reason to create a broader change where the NAIC requires different lines of insurance to subsidize one another.

PROPOSED LANGUAGE IN SECTION 6, DESCRIBING THE ACCOUNTS AND SUB-ACCOUNTS:

(1) The life insurance and annuity account which includes the following subaccounts:
   (a) Life insurance account;
   (b) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and
   (c) Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(2) The health insurance account which includes the following subaccounts:
   (a) Health insurance account;
   (b) HMO account.

DRAFTING NOTE: In states where the commissioner determines that there is an inadequate market to support two subaccounts in the health insurance account, the commissioner may combine those subaccounts in order to assure adequate capacity to address an insolvency in either the health insurance or HMO line of business. The determination of an inadequate market should be reviewed periodically for market changes that would support separate subaccounts.
We appreciate the opportunity to provide these comments, and will provide additional comments as the discussion moves forward. 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
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Section 6. Creation of the Association

NAIC Model 520 with draft Colorado proposed amendments

Section 6. Creation of the Association

A. There is created a nonprofit legal entity to be known as the [State] Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or write health maintenance organization business in this State. The Association shall perform its functions under the plan of operation established and approved under Section 10 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the Association shall maintain two (2) accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(a) Life insurance account;

(b) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(c) Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(2) The health insurance account, which includes the following subaccounts:

(a) The health insurance account;

(b) The health maintenance organization account.

B. The Association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

Drafting Note: Please see appendix (xx) for amendments to Section 6 to implement the Colorado pre-funding approach for a health benefit account.

Comment [DFL1]: How to address the situation where two different commissioners in a state have authority over members?

Comment [DFL2]: For purposes of the model act, should this be addressed in some other way? Since there is nothing in current Colorado law that this would refer to for future reference, this could create confusion or misunderstanding.
October 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: Kaiser Permanente comments to Receivership Model Law Working Group drafting committee: Proposed drafting note for section 6 on HMO subaccount and amendments to ACLI/Arbor Strategies group of health insurer-HMOs draft language on 50/50 split

Dear Chairman Kennedy and Members of the Working Group:

Kaiser Permanente (KP) appreciates the opportunity to provide comments to the Life and Health Insurance Guaranty Association Model Act (#520) pursuant to requests at the in-person Chicago meeting. Proposed drafts of KP’s drafting note for Section 6 on the HMO subaccount and proposed amendments to draft language provided by the ACLI/Arbor Strategies group of health insurer-HMOs were exchanged, without substantial agreement. In each proposal, KP urges flexibility for state regulators to make state-specific determinations based on state markets and conditions. We believe this is consistent with long-standing NAIC policy in virtually all other areas, and is particularly important in the disjointed market for long-term care insurance.

1. **Assessments must be equitable**

KP continues to urge that commissioners retain their authority, and not impose an artificial, result-specific allocation preferred by the life insurance industry and several health insurance-HMO company structures.

This proposal does not foreclose the result the life insurers and their health insurance-HMO supporters desire. It gives each commissioner the authority to determine, in any particular state, what methodology and factors will lead to an equitable division between the very different life and health insurance components of the long-term care market. If a commissioner determines that conditions in that state or that market would make a 50/50 split equitable, the commissioner can determine a methodology and factors, such as those proposed to this group, that will reach that result. A commissioner who makes a different determination about the equitability of assessing
health insurers a far greater share of the long-term care market than they have ever written or would wish to write may approve a methodology and factors to achieve a different result.

We include as an attachment the last draft we received of the full proposed language from the ACLI/Health insurance-HMO group, with our edits. It is possible they have made subsequent changes that they will submit to the drafting group, but the relevant provision we believe works best to retain state regulatory authority is in subsection (b) of this draft:

(b) The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan of Operation and approved by the Commissioner. The methodology shall ensure that 50% of the assessments are allocated equitably between accident and health member insurers in the health account, and 50% is allocated to life and annuity member insurers in the life and annuity account, based on factors that the Commissioner approves.

2. Separate sub-accounts should be available in the Health Account for Health Insurers and HMOs, subject to a determination by the commissioner that each subaccount would have adequate capacity for its market.

KP has consistently urged the creation of two sub-accounts within the Health Account, as the model does for the Life Insurance and Annuity Account. Our proposal would apply only in states where the Commissioner determines that there is adequate capacity in that state’s HMO market to support separate accounts. This will not be appropriate in all states, but in those states where there is a mature and robust HMO market, it will prevent yet another mandated subsidy of one industry’s failures by another industry. The ACLI/Health insurer-HMO group responded that they do not believe Commissioners should have authority to make such a determination.

KP proposes the following drafting note to follow the provision in Section 6 for establishment of the Health Account:

DRAFTING NOTE: In some states, the commissioner may determine that there is an adequate market to support a subaccount in the health account for HMOs. This would follow the structure for the life insurance and annuity account: a single health account, with one subaccount for health insurers and one for HMOs. The determination of an adequate market would require evaluation of the ability of the HMO industry in that state to provide appropriate capacity for the separate subaccount.

3. Conclusion
We are happy to see that the life insurance industry is finally developing products and strategies that can help to solve the problem that has developed over so many years. Whether it is hybrid products attached to life insurance policies, or better management of market fundamentals, these improvements, along with increased regulatory oversight, seem designed to correct the long-term care market for the future. We are hopeful the difficulties of this market segment will be resolved.
We appreciate the opportunity to provide these comments, and will provide additional comments as the discussion moves forward. 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
Section 9. Assessments

A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at [insert amount] percent per annum on and after the due date.

B. There shall be two (2) classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.

C. (1) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments.

(2) (a) The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts, and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(b) The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan of Operation and approved by the Commissioner. The methodology shall ensure that 50% of the assessments are allocated equitably between accident and health member insurers in the health account, and 50% is allocated to life and annuity member insurers in the life and annuity account, based on factors that the Commissioner approves.

Drafting Note: The purpose of Subsection C is to allocate the responsibility for an insolvency of a long-term care member insurer fairly evenly between member insurers in the health account, industry, and member insurers in the life and annuity account, industries. As it is likely that life and annuity member insurers will be subject to assessments from the health account, and health and HMO member insurers will be subject to assessment from the life account, the Commissioner should take care to address this, as well as other factors relevant to the unique long-term care market. The formula below should be utilized by guaranty associations to ensure that member insurers in the health industry pay 50% of the assessment and member insurers in the life and annuity industries pay 50% of the assessment.

In determining the share that shall be allocated pursuant to paragraph (3)(b) of this subsection, guaranty associations should use the following formula:

\[ X = \frac{0.50 - \text{Life insurer's share of HA}}{\text{Life insurer's share of LIAA} - \text{Life insurer's share of HA}} \]
in which the “X-factor” represents the percentage of LTC assessments assigned to the life and annuity accounts, HA represents the guaranty association Health Account, and LIAA represents the guaranty association Life Insurance and Annuity Account.

(3) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

*   *   *   *   *

*   *   *   *   *
October 10, 2017

James Kennedy, Chair
Receivership Model Law (E) Working Group
C/O Jane Koenigsman
Sr. Manager I - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

RE: Model 520 Comments

Dear James:

We write in response to the October 5 letter of Patrick Cantilo, which suggests the addition of a drafting note to Section 8(D) of the Life and Health Insurance Guaranty Association Model Act (#520) (the “Model Act”) concerning an allocation of premium between the guaranty associations and the liquidator. We maintain that a drafting note as suggested by Mr. Cantilo is not appropriate.\(^1\) It purports to identify an ambiguity in the Model Act and, rather than correcting this supposed ambiguity, provides an alternative provision that would mark a drastic change from decades of insolvency practice. It suggests an insolvency system that is unworkable and very different from the system that the Model Act envisions now.

Collection of premium and furnishing of coverage by liquidation estates is unworkable.

Under the current system, when a life or health insurance company enters liquidation, guaranty associations continue coverage and the liquidator promptly winds up the affairs of the company, adjudicates proofs of claim and distributes the assets. Guaranty associations are equipped to collect premium and provide statutorily mandated coverage. Liquidation estates are not. Having a liquidation estate collect ongoing premium carries with it the obligation to provide ongoing coverage. This would require the estate to stay open for many years, and in the case of long term care insurance, decades. It would entail collecting premium, investing it, adjusting policy claims, administering coverage and the like – in short, setting up a new insurance company or something equivalent. Liquidators are not equipped to do this. Their job is to displace the management and wind up the affairs of the company, not continue its operation into the long term future. It is the guaranty

\(^1\) We represent a group of major medical insurers in the Penn Treaty liquidation where the liquidator has sometimes asserted that premiums could be allocated between the guaranty associations and the liquidation estate.
associations that are charged with the administration of claims and the furnishing of replacement coverage.

**Paying future premiums to the estate imposes additional burdens on policyholders and the estate while providing uncertain benefits to policyholders**

In almost every insolvency, premiums are not adequate to support the business. In a case like Penn Treaty, the premiums are so inadequate that rate increases are needed just so coverage at the guaranty association limits is priced properly on a going forward basis. Allocating a portion of the premium to over the limit claims on some undefined basis exacerbates this problem for everyone. In the first instance, it means that the actuarially justified rate increase to be sought by guaranty associations will have to be greater, thereby requiring policyholders to pay more overall. They would pay an actuarially justified rate to the guaranty association for its coverage plus an amount to the estate for an unknown - and unknowable - amount of coverage in excess of guaranty association limits.

The benefits received by the policyholder from the premium being paid to the estate for over the limit coverage are speculative at best. It would be impossible to know at any given time which policyholders will have claims in excess of policy limits or how much those claims will be. As such, it would be impossible for any policyholder to know what benefit he or she might receive as a result of continued payments of premium to the liquidation estate.

If states decided to leave guaranty associations with inadequate premiums based on an allocation to the estate for over the limit claims, and thereby force the associations to levy larger and larger assessments on its members, the associations would suffer greater losses, and those losses would be passed on to taxpayers through premium offsets in most states, and remain with member companies in others. In a case such as Penn Treaty, where the losses to the system will be in the billions, passing further losses to the taxpayers and the industry to provide a highly uncertain benefit to only a small subset of policyholders is dubious public policy.

Moreover, Mr. Cantilo deals only in passing with the significant practical issues that would be involved in an allocation of premium between covered and uncovered claims. He suggests that in the case of long term care insurance, it could be done simply by measuring gross premium reserves. But this overlooks the proposition that the guaranty associations are entitled to be paid an adequate premium for their ongoing coverage. No public policy has been identified that would support depriving guaranty associations of adequate premium for future coverage.

**The Model Act does not contemplate premium allocation**

Mr. Cantilo suggests that there is debate as to whether the Model Act provides an allocation of premium to claims in excess of guaranty association limits. To our knowledge, this has never been done in a case, and for good reason – no statute supports it.

Under the Model Act and the state laws based on it, the guaranty associations have the right to receive all premiums with respect to these policies. Section 8D of the Model Act states:
Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

The following definitions from Section 5 apply:

“Contractual obligation” means an obligation under a policy or contract or certificate under a group policy or contract or portion thereof for which coverage is provided under section 3.

“Covered policy” means a policy or contract or portion of a policy or contract for which coverage is provided under Section 3.

“Premiums” means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. “Premiums” does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 3B except that assessable premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to one individual, one participant and one contract owner. “Premiums” shall not include:

1. Premiums in excess of $5,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, or
2. With respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

Reading these sections together, the guaranty associations are entitled to receive “premium” if the policies are “covered policies.”

Mr. Cantilo has sometimes suggested in the Penn Treaty case that the liquidator is entitled to a portion of premium based on an incorrect interpretation of the definition of “premium.” The definition of premium carves out the portion of premium for which coverage is not provided under Section 3B. Section 3B(1) enumerates the types of policy covered but states “except as limited by this Act.” This could be interpreted to incorporate into the limitations the particular coverage limits included in Section 3C. However, the definition of “premium” eliminates this possible interpretation by specifically providing that “assessable premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to one individual, one participant and one contract owner.” This provision makes it clear that if a policy is covered, the
association gets *all* of the premium even if the policy has limits that exceed the guaranty association limits applicable to individual coverage.²

**The proposed drafting note is not appropriate**

No other drafting note in the Model Act does what the proposed drafting note does. It starts by positing that there are differing interpretations of a provision in the Model Act. But rather than suggesting that the Model Act be clarified, it leaves the ambiguity in place and proposes alternative language that could be adopted to make a change to the Model Act. The proper course of action here would be to eliminate any ambiguity in the statutory language. Although we do not think the Model Act is unclear, the elimination of the word “assessable” from the definition of “premium” would close the door on this.

The change proposed by Mr. Cantilo would be a fundamental change in the law, and would entail a significant public policy debate to discuss the issues previewed above. This debate is not specifically within the Working Group’s current charge, and is not an issue that must be resolved in order to carry out the overarching goal of stabilizing the state-based guaranty fund system. Engaging in this debate now doubtless would engender substantial delay, and will likely prevent the Working Group from reaching its goal.

**Very truly yours,**

[Signature]

Harold S. Horwich

² The use of the words “assessable premium” in the definition of “premium” is somewhat puzzling because it is not used elsewhere in the coverage and benefits sections. Assessable premium is a concept that is used in connection with assessments to the member insurers of the guaranty associations to fund the cost of benefits. It seems most likely that “assessable” in this context just means payable under the policy. This definition has nothing to do with assessments against guaranty association members because the definition of premium is tied to the insolvent company’s policies, not the policies of assessed member insurers. The term “assessable” should probably be eliminated from the Model Act to avoid any future controversy.
Re: Model 520 Comments

Dear James:

We appreciate the opportunity to submit comments regarding potential revisions to the Life and Health Insurance Guaranty Association Model Act (#520) (the “Model Act”) with respect to Section 3B(2)(c) of the Model Act (the “Moody’s Adjustment”).

The Receivership Model Law Working Group (the “Working Group”) has posed two threshold questions in connection with the Moody’s Adjustment: (1) should the Moody’s Adjustment provisions expressly exclude or include long term care insurance, in particular the benefit increase riders that annually raise benefit levels based on a stated rate of interest, and (2) if the Moody’s Adjustment, as currently drafted, should not apply to long term care insurance, should the Model Act incorporate some type of coverage limitation to benefit increase riders on long term care insurance policies?

Although there are differing views regarding the application of the Moody’s Adjustment to long term care benefit increase riders, the purpose of the Moody’s Adjustment is clear: limit the guaranty associations’ long term exposure to provisions in the policies that are materially out of line with market interest rates at the time of the liquidation. The provision recognizes that the protection provided by the guaranty associations must strike a balance between covering the policy as it was issued and prevailing market conditions at the time the guaranty association is triggered.

The rationale of the Moody’s Adjustment provision applies equally to long term care benefit increase riders. These riders, particularly on older blocks of long term care policies, are typically the most underpriced feature of the policy, and often materially contribute to the failure of the company. Moreover, the stated benefit increase rate (almost always 5% annually) has vastly outpaced the actual rate of increase in the cost of care.
If the Moody's Adjustment does not provide an acceptable means by which to address this issue, we encourage the Working Group to consider a provision that does. While we do not have a draft proposal today, we are working on developing one and hope to have it for consideration soon.

Very truly yours,

[Signature]

Harold S. Horwich
October 22, 2017

James Kennedy, Chair
Receivership Model Law (E) Working Group
C/O Jane Koenigsman
Sr. Manager I - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

RE: Model 520 Comments

Dear James:

We appreciate the opportunity to submit comments regarding potential revisions to the Life and Health Insurance Guaranty Association Model Act (#520) (the “Model Act”) with respect to Section 3B(2)(c) of the Model Act (the “Moody’s Adjustment”). The drafting group has decided to recommend a change to the Model Act that would eliminate long term care and other health policies from the Moody’s Adjustment. We submit that the rationale which supports the application of the Moody’s Adjustment to annuities and life insurance policies supports the application of at least some adjustment to the accrual rate of benefit increase riders to long term care and other health insurance policies.

As was noted by at least one regulator in the course of proceedings on an earlier version of the Model Act, “the model act is based on the principle that guaranty association protection is a limited resource and that some coverage exclusions are necessary and appropriate.” 1996 Proc. 4th Qrtr p. 956. The Moody’s Adjustment is an exclusion that limits the guaranty associations’ long term exposure to provisions in the policies that are materially out of line with market interest rates at the time of the liquidation. The provision recognizes that the protection provided by the guaranty associations must strike a balance between covering the policy as it was issued and prevailing market conditions that affect the associations, member companies, their policyholders and taxpayers at the time the guaranty association is triggered. The Moody’s Adjustment imposes a rate of interest on annuities and life insurance products that reflects market rates.

The rationale of the Moody’s Adjustment provision applies equally to long term care benefit increase riders. Long term care insurance is typically part of a policyholder’s retirement planning, much like an annuity or a life insurance product with an investment feature. The benefit increase riders, particularly on older blocks of long term care policies, were typically set at five percent and were frequently the most underpriced feature of the policy (often materially contributing to the failure of the company).
We understand that the drafting group has proposed to eliminate the application of the Moody’s Adjustment to long term care insurance and other health insurance policies because of a potentially harsh result for policyholders. However, based on the policies that underlie the existence of the Moody’s Adjustment, some level of adjustment should exist.

By this letter, we wish to propose the following as a provision that would be added to Section 3(B)(2) of the Model Act.

A portion of a long term care, long term disability or other health insurance policy or contract to the extent that benefits increase or accrue on and after the date on which the member insurer becomes an impaired or insolvent insurer under this Act, at a rate or other factor that exceeds the Core - Consumer Price Index averaged over the preceding three calendar years.

This provision recognizes that the protection provided by the guaranty associations must strike a balance between covering the policy as it was issued and prevailing market conditions at the time the guaranty association is triggered. The proposed provision differs from the Moody’s adjustment in two important respects.

- First, unlike the Moody’s Adjustment, the proposed provision does not roll benefits back from their existing level as at the date of liquidation. This avoids what might potentially be a harsh result for a policyholder that had set expectations on a particular level of daily coverage.
- Second, the adjustment is based on the Core Consumer Price Index rather than an interest rate. This reflects that the benefit increase riders are typically sold as protection against inflation. The three-year average of the Core Consumer Price Index has not exceeded 5% since before 1990, and is currently 1.8%. Policyholders who have had 5% inflation riders have enjoyed many years of benefit increase at rates well above actual inflation prior to liquidation.

The prospective reduction of the benefit increase to a current level of inflation strikes a balance between the policyholder’s contractual expectations and the economic realities facing the guaranty associations, member companies, their policyholders and taxpayers.

Thank you for your consideration of this important addition to the Model Act.

Very truly yours,

*Hal Horwich*

Harold S. Horwich
October 10, 2017

Chairman James Kennedy
NAIC Receivership Model Law Working Group (RMLWG)

Re: Proposed Changes to Model 520, Section 8D

Dear Chairman Kennedy and RMLWG Members,

RMLWG’s current work stream has appropriately focused on several fundamental, discrete, real-world issues related to resolutions and legacy LTC policies, in an effort to achieve broader GA coverage, equitable allocations of resolution costs, and operational effectiveness. Given the tight time frame within which RMLWG is operating, finding solutions even to the fundamental questions before the Group is a daunting task, and RMLWG has wisely avoided being distracted by non-core issues.

The recent suggestion to change long-standing provisions of Section 8D is precisely the sort of non-core issue that we believe ought not to be pursued as part of RMLWG’s pending project. We say that, in part, because this is an issue as to which examples of real-world problems supposedly addressed by the proposed change are exceedingly rare. We further believe that the proposed change is not supported by theory, facts, or public policy. Finally, arriving at a “solution” that would be clear, fair, and easy to implement by receivers and GAs would be very difficult.

For all those reasons, we suggest that this issue be deferred for RMLWG’s next-round review of the L&H GA Model, and not pursued as part of the current effort. The difficult questions now expressly before RMLWG will be even harder to resolve if we divert energy and attention away from the task at hand, particularly for an academic question that will bring only significant controversy to the project.

In the hopes that they may help focus any discussion of the topic, should it be discussed in the next-round review of this Model Act, we note for the record our more detailed preliminary comments, set forth below.

“Issue” Background

1. For practical purposes, any issue over allocating policy premium arises (and will arise) in very few insolvency cases. Annuity and life contracts typically are transferred to assuming carriers. Furthermore, and especially since adoption of the ACA, both traditional individual and group health insurance have been cancelled shortly after liquidation and replaced in the
marketplace. The context in which the proposed change might apply is largely limited to LTC contracts.

2. Notwithstanding some erroneous comments recently repeated, in reality only a relatively small number of claims for LTC (and other health policies) are projected ever to exceed GA limits.

3. No one knows at the time of liquidation which small percentage of an issuer’s policies then in force eventually will have claims exceeding GA limits. We do know that a substantial majority of policies will never produce claims exceeding GA limits.

4. Once claims go over the applicable GA limit, a GA stops collecting premium.

5. The premium related to the over-limit claims (assuming it could be calculated) would be a relatively small portion of the overall premium.

Discussion

1. Policies and premiums do not naturally or logically have “within limits” and “over limits” components. There is no practical or rational way to divide premium between covered and uncovered portions of policies. If such an attempt were made, it would have to account for the fundamental actuarial fact that, on a per-dollar-of-protection basis, coverage likely to be claimed at the “working level” (in this case, within GA benefit levels) is – and should be – more expensive than coverage that is unlikely to be claimed at a higher, “excess” level.

2. Premium on policies in the insolvency setting (in particular for legacy LTC contracts) in virtually all cases will be inadequate. In the Penn Treaty liquidation, for example, the full policy premiums are significantly inadequate to support even benefit levels at GA limits. As a consequence, almost all affected GAs are seeking actuarially justified rate increases (which many regulators have already approved). Diverting premium from GAs would mean that GAs would need to seek proportionately higher premium rate increases from Commissioners in order to bring covered LTC premiums in line with premiums being paid outside liquidation. In turn, that would mean that many policyholders – the very people sought to be benefited by the proposed change to Section 8D – would pay even more in premiums.

3. It is not clear what benefit Policyholders would obtain from paying premiums to the liquidator for the uncovered portion of a policy. They certainly would not benefit from paying the liquidator additional premiums at one hundred cents on the dollar for protection on uncovered policy claims that, by definition, would receive only some cents on the dollar.
Conclusions

The proposed change to Section 8D involves concerns that are more theoretical than real. The change does not relate to (and appears to conflict with) the principal objectives of RMLWG’s current project. Given the complicated and controversial nature of this peripheral issue, RMLWG should not take the risk of diverting the Group from success in its fundamental objectives. The proposal should be deferred for consideration during a future RMLWG review of the L&H Model Act. In the event that the issue is later revisited, we may then have further comments.

We would be happy to respond to any questions from the Chairman, members of RMLWG, or other interested parties.

Yours very truly,

Peter G. Gallanis
President
NOLHGA
States may consider establishing a pre-funding arrangement for both insurance companies and health maintenance organizations that write health benefit plans to meet their guaranty association assessment obligations. To pre-fund, member insurers writing health benefit plans would collect a set amount per member or per certificate per month and remit that amount directly to the state guaranty association. The pre-funded amounts would be utilized by the member insurers to satisfy class B assessment obligations for future insolvencies. When the fund reaches a statutory cap, the pre-funding would stop. In the event of a depletion of the fund below the statutory cap, the pre-funding assessment would be reinstated.

By establishing a pre-funding arrangement, it allows for the use of interest and investment income to lessen the impact of insolvencies on state taxpayers. Pre-funding also spreads the assessment obligations amongst policyholders on a pre-funded basis and does not require the member health insurers or HMOs to look to the state taxpayers for recoupment. In addition, member insurers in the health industry that do not pay income or premium taxes would be offered a recoupment methodology that is the same as other member insurers in their markets. States interested in establishing a pre-funding arrangement should take the steps necessary to protect policyholders who rely on a stable safety net from potential legislative diversion of these funds and insulate the pre-funding moneys collected for future health benefit plan insolvencies.
These comments are submitted in response to the request for comment on the October 10 Drafting Group call. I've developed some suggested definition language to consider that would clarify the status of HMOs and HMO coverage under the revised Model Act by defining the umbrella term “insurance policies” – for the limited purpose of this Act – to include HMO contracts and annuity contracts, notwithstanding language that might appear elsewhere in the state’s Insurance Code deeming one or both of these types of coverage to be something other than an “insurance policy” for other purposes. I’ve included two options to consider for Paragraph 3(B)(1), one that closely tracks the current Model, another that seems simpler and accomplishes the same purpose. If this is adopted, there would be conforming revisions made in various other places in the Model. This eliminates the inconsistent usage of the term “health benefit plan” in the current draft to serve two different and contradictory purposes, reserving that term (consistent with what seems to be the consensus expressed on the calls) for the modern equivalent of “major medical coverage” (the $500,000 basket), regardless of whether it is written by an HMO or by a traditional insurer.

This project involved revisions to Paragraph 3(A)(1), and in the process, that addresses, at least provisionally, one of the issues raised on the call – clarifying that payments made directly to providers under managed care contracts should be treated as the equivalent of claims. As a general rule, this seems to be the correct result, and I would expect it to be consistent with how most guaranty funds have treated provider payments under (fully-insured) managed care networks administered by traditional insurers (often under alphabet soup rubrics such as PPO/PPA/EPO/ACO). Although some exceptions to this general rule might be appropriate, they should be limited in scope, and many of them might really be matters of coordinating with actions taken in the receivership process (such as treating claims as preferences or subordinated equity-like claims).

As for the Moody’s Question, if it applies at all to benefits that were sold for a separate premium and were always intended to provide protection against inflation that outpaces investment returns, the proper analogy wouldn’t be a benefit acceleration rate that exceeds a reasonable market return. Perhaps it might be a benefit acceleration sold for a premium whose pricing assumptions depend on investments that exceed a reasonable market return. I don’t know enough to know whether this is unique to LTC or might also be implicated by other square pegs in round holes.

Finally, I’ve also included for consideration an attempt to redraft the statutory language that codifies the 50–50 allocation between market sectors (which still seems to me as good an attempt at a consensus allocation as we can reasonably hope for), and explain the reasoning in plain language as possible. The “Appendix 2” could be reworked as statutory language for states that really need to hardwire the allocation formula into statute, but I think it almost speaks for itself as to why the statute should codify the desired end result and the details left to the Guaranty Association Plan of Operation.

Thanks for considering these thoughts
-- Bob Wake, Maine Bureau of Insurance
Section 2. Purpose

A. The purpose of this Act is to protect, subject to certain limitations, the persons specified in Section 3A against failure in the performance of contractual obligations, under life insurance policies, and health insurance policies, health benefit plans, maintenance organization contracts and annuity contracts specified in Section 3B, because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

Section 3. Coverage and Limitations

A. This Act shall provide coverage for the policies and contracts specified in Subsection B:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, includes, but is not limited to, persons or entities that provide healthcare services to members or enrollees under the HMO's contracts, of the persons covered under Paragraph (2), including health care providers rendering services to covered enrollees under a health insurance policy or certificate;

B. (1) [option 1] This Act shall provide coverage to the persons specified in Subsection A for policies or contracts of direct, non-group life insurance, annuities, health insurance, health benefit plans, or annuity policies or contracts, maintenance organization coverage and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

B. (1) [option 2 – my preference] This Act shall provide coverage to the persons specified in Subsection A for insurance policies, as defined in Section 5C(3)(M), issued by member insurers and providing life, health or annuity coverage or direct, non-group life insurance, health insurance, health benefit plans, or annuity policies or contracts, coverage and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit

Comment [JMK1]: Based on 9/25/17 working draft of MO520
Comment [RAW2]: I would keep this language here even if we define all these to be "policies," because this explanation should be clear, simple, nontechnical, which includes not depending on specially-defined terms.
Comment [JMK3]: 9/20/17, moved from drafting note to 3.A (1).
Comment [RAW4]: I have a definition of "enrollee" in my back pocket if we decide we really need one, but it’s a well-understood term and we don’t get into defining similar terms that get used in the Model.
Comment [RAW5]: Add a cross-reference to the definition of "insurance policy" if we feel the need to make crystal clear that this includes HMO providers, but the point of defining "policy" is that we shouldn’t need to do this. (The scope of this clause certainly should not be limited to HMO providers – we’ve been doing this since forever for PPO providers and for other providers with assignments of benefits.)

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administration contracts, unallocated annuity contracts and funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

[In the Alternate Version of Section 3 in the Appendix, change the first sentence in the same manner as the preferred option, and regardless of which option is preferred, keep existing language of second sentence: “Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.”]

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[Section 5]

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Comment [JMK6]: 9/22/17. FLAG – should this be simplified to “member” instead of “member insurer”

Comment [RAW7]: Will we need to keep this variant, or can it go away when we make the conforming amendments? I didn’t look through the 100+ times the word “owner” appears to see if it’s ever important?
**Section 9. Assessments**

There shall be two (2) classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.

C. (1) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments.

(2) The amount of a Class B assessment shall be allocated for assessment purposes among the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances, provided that any portion of an assessment that is attributable to long-term care insurance written by the impaired or insolvent insurer shall be allocated between the accounts according to a methodology set forth in the plan of operation and approved by the commissioner, designed to ensure that the long-term care assessment is allocated equally between health insurers and life insurers before the application of any abatements under Subsection D or aggregate limits under Subsection B.

Drafting Note: A formula for allocating long-term care assessments in accordance with Paragraph (2) is set forth in Appendix 2, with an explanation of how it was derived.

(23) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State for those calendar years by each assessed member insurer on policies or contracts covered by each account, for the three (3) most recent calendar years for which information is available preceding the year in which the impaired or insolvent insurer became impaired, bears to premiums received on business in this State for those calendar years by all assessed member insurers.

(24) The amount of class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated 50% to the health account with the remaining 50% allocated to the life insurance and annuity account. The percentage of long-term care insurance premium allocated to the life insurance and annuity account shall not be considered health premium for the purpose of calculating class B assessments for the health account, but rather considered as life premiums or term care insurance premium allocated to the life insurance and annuity account.
annuity premiums, respectively, for the purpose of calculating class B assessments for the life and annuity account.

Drafting Note: The purpose of Section (C)(3) is to allocate the responsibility for an insolvency of a long-term care member insurer evenly between member insurers in the health industry and member insurers in the life and annuity industries. As life and annuity insurers will likely be subject to assessments from the health account, the formula found in Appendix II should be utilized by States to ensure that member insurers in the health industry pay 50% of the assessment and member insurers in the life and annuity industries pay 50% of the assessment.

(4) For purposes of this Section long term care insurance shall be deemed to be both life and health insurance and the subaccount for life insurance described in Section 6.A.(1) shall be aggregated with the account for health insurance described in Section 6.A.(2) for purposes of determining each member insurer’s share of a Class B assessment necessary to discharge the Association’s responsibilities with respect to long term care insurance issued by the impaired or insolvent insurer.

(2454) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

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

The purpose of this formula is to allocate the assessment so that half of the assessment is borne by insurers and insurance groups that are predominantly in the business of life insurance and annuities, and the other half is borne by insurers (including HMOs) and insurance groups that are predominantly in the business of health coverage.

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 Account. The reason the assessment is not divided 50–50 between the accounts is that both types of insurers are subject to assessment for both accounts, but not in equal accounts. To be precise, if the life account’s share of the assessment is set to be x%, then the health account’s share will be (100-x)%, and the life insurers’ share of the assessment must be:

10/3 – FLAG for further discussion on next call

Comment [JMK16]: Suggested text from Patrick Cantilo.
x%*(life insurer share of life account) + (100-x)%*(life insurer share of health account)

Therefore, once we know the relative proportions in which each type of insurer contributes to each account, we can solve for the value of x that makes the share 50%. We could, of course, do the same calculation from the health side, and it would produce the same allocation between the life and health accounts, because for each account, the two sectors' shares must add up to 100%. (However, the breakdown of the life account between industry sectors is independent of the breakdown of the health account, and the breakdown of each account will be different for each insolvency year, so this formula must be recalculated each time a long-term care assessment is levied.)

**Generalized formula for life insurers’ share of LTC assessments**

\[
\text{Life insurer share} = (\text{Life insurer share of HA} \times \text{Health Account GA assessments for LTC}) + (\text{life insurer share of LIAA} \times \text{Life & Annuity Account GA assessments for LTC})
\]

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

\[
\text{Life insurer share} = (\text{Life insurer share of HA} \times (1 - X\text{-factor})) + (\text{life insurer share of LIAA} \times X\text{-factor});
\]

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

\[
.50 = \text{Life insurer share of HA} - \text{Life insurer share of HA} \times (X\text{-factor}) + \text{life insurer share of LIAA} \times (X\text{-factor})
\]

\[
.50 - \text{Life insurer share of HA} = (\text{life insurer share of LIAA} - \text{Life insurer share of HA}) \times (X\text{-factor})
\]

**Therefore:**

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

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

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The Formula

At the Chicago meeting, someone suggested that it might be useful to have the actual formula, not just the explanation of how it was derived, so here it is. (Paul Graham told me he also did the math, and amazingly, we got the same result.)

Life Account Share of Assessment =

\[(50\% - \text{Life Carrier (LC) share of Health Account}) / (\text{LC share of Life Account} – \text{LC share of Health Account})\]

If we had gone through the same process from the Health Carrier (HC) perspective rather than from the LC perspective, the result would look like this:

Health Account Share of Assessment =

\[(50\% - \text{HC share of Life Account}) / (\text{HC share of Health Account} – \text{HC share of Life Account})\]

Some notes:

- This is the result of walking through Appendix 2 and then solving for “x.”
- This formula works because we expect that each industry’s share of its own account will be greater than 50%, which makes both numerators positive. This means that 50% must be greater than each industry’s share of the other account, which makes both denominators positive.
- Although the denominators have different inputs, they’re actually the same. The reason is that within each account, the two industry shares add up to 100%. This is probably easier to visualize from an example than from slogging through the algebra. For example: suppose the LC share of the Life Account is 94%, and the HC share of the Health Account is 78%. In that case, the HC share of the Life Account must be 6%, and the LC share of the Health Account must be 22%. The denominator could be described either as “94% - 22%” or as “78% - 6%,” but either way, it’s 72%.
- And that explains why the math works out. At the top of the page, starting from first principles, we independently developed separate formulas for the LC and HC shares of the assessment. If we did it correctly, they had better add up to 100%. And we just saw in the previous bullet that the Health Account share of the LTC assessment could also have been phrased as:

\[(50\% - \text{HC share of Life Account}) / (\text{LC share of Life Account} – \text{LC share of Health Account})\]

So if we add it to the Life Account share, we get, as expected:

\[((50\% - \text{HC share of L.A.}) + (50\% - \text{LC share of H.A.})) / (\text{LC share of L.A.} – \text{LC share of H.A.})\]  
\[= (100\% - (\text{HC share of L.A. + LC share of H.A.})) / (\text{LC share of L.A.} – \text{LC share of H.A.})\]  
\[= (100\% - ((100\% - \text{LC share of L.A.}) + \text{LC share of H.A.})) / (\text{LC share of L.A.} – \text{LC share of H.A.})\]  
\[= (\text{LC share of L.A.} – \text{LC share of H.A.}) / (\text{LC share of L.A.} – \text{LC share of H.A.}) = 100\%\]
Finally, it might also aid in understanding the formula to see how it works in the limiting cases. If each account were entirely self-contained, with no “crossover” assessments at all, then each industry’s share would simply be \((50\% - 0) / (100\% - 0) = 50\%\). In other words, a 50–50 split between the accounts is the same as the desired 50–50 split between the industry sectors.

And if the Health Account had such a large crossover assessment that it was split equally between the two industries, the obvious way to get the desired 50–50 split in the LTC assessment is to assess only the Health Account. And that’s exactly what the formula does, since the numerator of the Life Carrier formula goes to zero and the numerator of the Health Carrier formula becomes equal to the denominator. (If both accounts were split equally, then any allocation between the two accounts would work, but both allocation formulas would produce the meaningless result 0/0.)

As noted earlier, this formula anticipates that crossover assessments will be less than 50%. If one of the two accounts were “upside down,” with a crossover assessment of more than 50%, one of the formulas would be negative and the other would be greater than 100%, meaning that the only way to reach an equal allocation would be to charge one account more than 100% and credit the other. On the other hand, if both accounts were upside down, the numerators and the denominators would all be negative, so both fractions would once again be positive numbers between zero and 100% – that would essentially be equivalent to switching the names of the two accounts to reflect who was really paying.
Drafting Note: States that do not have health maintenance organizations (HMOs) defined in their applicable insurance laws and those states that license Health Care Service Corporations or similar organizations that undertake to provide basic health care services may want to include a definition that “Health maintenance organization” means a person, including a Health Care Service Corporations or similar organization, that undertakes to provide basic health care services to their members on a prepaid basis.

K. “Impaired insurer” means a member insurer which, after the effective date of this Act, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

L. “Insolvent insurer” means a member insurer which after the effective date of this Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

M. “Member insurer” means an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this State any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

The following is from Model 430 (http://www.naic.org/store/free/MDL-430.pdf.)

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.

W. “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.