November 27, 2017

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

Sent via email to: Jane Koenigsman

RE: Proposed revisions to the Life and Health Insurance Guaranty Association Model Act (#520)

Dear Chairman Kennedy and Members of the Working Group:

The Alliance for Community Health Plans (ACHP) appreciates the opportunity to comment on the exposed draft revisions to the Life and Health Insurance Guaranty Association Model Act (#520).

ACHP is a national organization bringing together innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are community-based, non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for more than 19 million Americans in 27 states and the District of Columbia in the commercial market and exchanges and for Medicare, Medicaid, and federal, state, and local public employees.

ACHP recognizes NAIC’s efforts to address issues related to the financial problems facing the long-term care (LTC) insurance industry. ACHP’s members have an interest not only in the well-being of our members, but in the well-being of the larger communities in which we operate. The policy holders of LTC insurance products should be protected from carrier insolvencies and receive the benefits due to them.

From the beginning of the Working Group’s consideration of this issue, the proposed solution has reflected an agreement between the life insurance industry and several large, national, for-profit health insurers. HMOs were not included in the deliberations that led to this agreement and have not supported it. ACHP has voiced its concerns in writing and conferences calls and at the summer meeting. We remain opposed to the draft model law revisions.

The proposed 50/50 split of future assessments between life and health insurers (including HMOs) has no basis in the reality of the market, either nationally or state by state. It is a highly inequitable solution. Life insurers sell far more LTC policies than do health insurers – and HMOs sell none at all. In 2014, the 25 largest life insurers wrote about 70 percent of LTC policies and health insurers wrote about 20 percent. Moving to 50 percent is, frankly, a boon to the life insurers and a potential huge new cost to health insurers and HMOs.
Further, as opposed to some health insurers, HMOs do not sell long-term care insurance. As a matter of most states’ licensure laws, HMOs are not able to offer such products under HMO state licenses. The revision to the model act exposes HMO members to potentially higher premiums if there is an assessment, with no offsetting potential for those members to benefit.

ACHP believes that it is bad policy and precedent to change the long-standing distinction between health insurers and HMOs in this one model act. The core relationships between members covered by an HMO and policyholders of a health insurance company are significantly different. NAIC has consistently recognized this difference by developing model acts, provisions, and forms that in turn are reflected in the very different ways in which HMOs and insurers are regulated by states – in some cases by different departments.

We respectfully suggest that the NAIC has not adequately considered the consequences of the proposed revisions for many model acts and state laws and regulations. The proposed changes may necessitate revisions in other NAIC model acts that relate directly or indirectly to HMOs and the state laws and regulations based on those model acts. These include: the NAIC HMO Model Law, the Model Regulation to Implement Rules Regarding Contracts and Services of HMOs, the Risk Based Capital for HMOs Model Act, Insurance Holding Company System Regulatory Act and the Unfair Trade Practices Model Act.

We believe other solutions are available, certainly including a division of assessments that reflects the long-term care market in each state. We urge the Working Group not to approve the proposed revisions, but rather to work with all stakeholders to develop an equitable solution.

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

Sincerely,

Howard B. Shapiro, PhD
Director of Public Policy
November 21, 2017

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

Jane M. Koenigsman, FLMI  
Sr. Manager I – Life/Health Financial Analysis  
National Association of Insurance Commissioners  
1100 Walnut St., Suite 1500  
Kansas City, MO 64106

RE: Comment regarding Model 520: Life and Health Insurance Guaranty Association Act

Dear Mr. Kennedy and Ms. Koenigsman:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including nearly 90 provider-based health plans and more than 270,000 affiliated physicians, the American Hospital Association (AHA) appreciates the opportunity to share our comments regarding the National Association of Insurance Commissioners’ (NAIC) proposed revisions to Model 520, Life and Health Insurance Guaranty Association Act. The AHA appreciates NAIC’s leadership in helping states address issues regarding long-term care insurance market insolvencies, particularly in the wake of the liquidation of the insurer Penn Treaty.

The NAIC’s Receivership Model Law E Working Group was tasked with revising Model 520 to specifically address guarantee association assessments and coverage issues identified in the recent long-term care insurer insolvencies. Life, health and annuity insurers are required by state law to participate in the states’ life and health insurance guaranty associations. The guaranty associations use funds raised by assessments to continue coverage and pay claims when such an insurance company becomes insolvent. During the course of the NAIC working group’s deliberations, the AHA expressed concern over the group’s decision to broaden the scope of Model 520 to include Health Maintenance Organizations (HMOs). Our comments will focus on the following two issues:

- the inclusion of HMOs in state guarantee associations; and
- the application of the guarantee association assessment.
Inclusion of HMOs in State Guarantee Associations
The AHA appreciates the challenges many state insurance commissioners face in managing long-term care insurance insolvencies. However, we believe the NAIC working group’s recommendation to include HMOs in the model act is solely to increase the pool of funds to the guarantee association and is not based on sound policy since HMOs do not sell long-term care products and states regulate HMOs and insurers differently. For example, California has established a separate Financial Solvency Standards Board within the state’s Department of Managed Health Care to provide oversight of risk-bearing health care organizations, which is different from the licensing of other types of insurance.

The NAIC has long recognized the differences between insurance and HMOs through its separate HMO model act, as well as other guidance. NAIC’s HMO model act does not require HMOs’ participation in guarantee associations, but rather requires that HMOs protect their enrollees against insolvency structurally, such as by limiting contracts to one year and holding enrollees harmless against providers. This change in approach could increase rates for consumers as HMOs account for these new costs. The AHA recommends that NAIC amend proposed Model 520 to remove all references to HMOs from the legislative text and replace them with drafting notes, where appropriate, that direct states to determine the scope of the state guarantee associations.

Guarantee Association Assessment
In addition to expanding the guarantee associations’ pool of entities for which assessments can be levied, Model 520 prescribes an assessment formula in the event of long-term care insurer insolvency. Specifically, 50 percent of the assessment would come from life and annuity insurance companies, which write the bulk of long-term care policies, and 50 percent would come from health insurers and HMOs, despite the fact that HMOs do not write such policies. This prescriptive formula is written into the model act, which is a departure from past NAIC policies to defer such decisions to the states. The AHA recommends that this formula be struck from Section 9 (C) of Model 520 and be replaced with language that allows states to determine the proportionately of any assessment between members of the state guarantee associations.

Thank you for your consideration of our comments. We look forward to working with NAIC on efforts to address how to improve the stability of the long-term care insurance market and prevent such insolvencies from occurring. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, vice president for coverage and state issues, at mollysmith@aha.org or Molly Collins Offner, director of policy, at mcollins@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis & Development
November 27, 2017

Mr. Richard J. Badolato,
Chair, Receivership and Insolvency Task Force and
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

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 Balolato and Chairman Kennedy:

On behalf of the American Council of Life Insurers (“ACLI”)\(^1\) and Arbor Strategies, LLC (representing a coalition of national health insurers and health maintenance organizations)\(^2\) we are writing to support the adoption of the revised Life and Health Insurance Guaranty Association Model Act (#520) (“Revised Model Act”) as exposed by the Receivership Model Law Working Group (“Working Group”). We urge the Working Group and the Receivership and Insolvency Task Force (“Task Force”) to adopt the Revised Model Act

The Revised Model Act helps to ensure the continued stability of the state-based guaranty fund system and the health carriers that fund the health accounts of those systems. The Revised Model Act also accomplishes three important goals:

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

---

\(^1\) The ACLI is a Washington, D.C.-based trade association with 290 members 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](http://www.acli.com)

\(^2\) The members of this coalition, Aetna, Anthem, Cigna, HCSC and UnitedHealth, together provide health coverage to more than 227 million members worldwide and offer a wide range of health offerings including major medical coverage and HMO products.
2. It treats all participants in the comprehensive health insurance marketplace—HMOs and major medical carriers—equally; and

3. It provides stability and fairness for the guaranty funds and provides additional solvency protections for consumers of health insurance and HMO products.

The existing assessment formula for long-term care insurance insolvencies is not sustainable. The Revised Model Act correctly addresses the clear differences in treatment between the life insurance industry and the health insurance industry. The NAIC, working with the ACLI and the major players in the health insurance industry, developed much needed changes to the assessment formula that spreads the cost across the entire health and life insurance industry. The Revised Model Act appropriately broadens and re-aligns the assessment base for long-term care insurance related insolvencies among life and health carriers to reflect the evolution of the long-term care insurance market. The realignment of the assessment formula in the Revised Model Act corrects the inequities that occurred under the existing law and more accurately reflects the rapid growth of life insurance and annuity hybrid products in the long-term care insurance marketplace.

In addition, the Revised Model Act also recognizes, and makes allowances for, how health care coverage has evolved. There are new products and new competition in today’s marketplace. The existing model law favors one type of health coverage (HMOs) over other types of health insurance coverage. This creates an unjust and inequitable situation for consumers, who are denied the ability to purchase health care products in a robust and competitive market.

The Working Group correctly concluded that excluding HMOs from the guaranty fund assessment system is an outdated concept. The health market has changed dramatically over the decades since the NAIC originally excluded HMOs from the assessment base of guaranty assessment health accounts. The health insurance market and the HMO market have, to a large extent, converged and the Revised Model Act properly addresses this convergence by designing a properly functioning system to protect consumers in the event of insolvencies and to ensure the long-term stability not only of the guaranty fund system, but also of the health insurance and HMO marketplace.

Finally, the Revised Model Act recognizes the societal benefits of a functioning and fair safety net for customers of long term care insurance. We believe that the entire life, annuity, and health insurance industry, including HMOs, should participate in meeting this societal need. The revisions also recognize the importance of providing the purchasers of HMO coverage with the full and comprehensive protections that are provided under the guaranty fund system.
We urge the members of the Working Group and the members of the Task Force to adopted the Revised Model Act.

Please feel free to call either of us if you have if you have any questions regarding our comments. Thank you.

Sincerely yours,

Bruce Ferguson  
American Council of Life Insurers  
Senior Vice President, State Relations  
(202) 624-2385  
bruceferguson@acli.com

Chris Petersen  
Arbor Strategies, LLC  
Principal  
(703) 847-3610  
cpetersen@arborstrategies.com
November 27, 2017

VIA ELECTRONIC MAIL
Mr. James Kennedy
Texas Department of Insurance
Chair, Receivership Model Law (E) Working Group
c/o Jane Koenigsman
Sr. Manager, L/H Financial Analysis
National Association of Insurance Commissioners (NAIC)
jkoenigsman@naic.org

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

Dear Chairman Kennedy:

I write on behalf of the Blue Cross Blue Shield Association (BCBSA) regarding the proposed revised Life and Health Insurance Guaranty Association Model Act (#520). BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one in three Americans.

BCBSA participated in the Receivership Model Law Working Group’s Drafting Group process and we thank you for your leadership during this thoughtful, deliberative and comprehensive review of the Model Act. We believe that the Working Group’s final work product will bring fairness to the current inequitable situation health insurers face with long-term care insurer insolvencies by spreading the liabilities for those insolvencies more broadly. We hope to see the Model adopted by the NAIC with the same urgency as the Working Group acknowledged.

At this time we have one concern to bring to the Working Group’s attention. New Subsection (B) of Section 13, Credits for Assessments Paid (Tax Offsets) – OPTIONAL, was added specifically to address the ability of tax-exempt health insurers to recoup assessments they may pay after becoming a member of the Guaranty Association. Unfortunately, this provision could inadvertently create an uneven playing field for certain health insurers. The provision makes this post-assessment surcharge permissive, rather than mandatory, which means that companies may decide not to recoup their assessments and not include the surcharge on future policies. This decision would allow those companies to price their products lower than those companies adding...
the surcharge and would give them an unfair competitive advantage in the marketplace. One way to address this concern would be to add the following sentence to the Drafting Note paragraph on Page 35 of the Model, specifically addressing Subsection (B):

“If a state chooses to adopt this provision, the surcharge mechanism should be applied to all health insurers in a given market so as to avoid disparate treatment of similarly situated entities.”

This additional sentence would provide states the opportunity to more fully consider this recoupment option and avoid the creation of winners and losers in the market.

Again, thank you for your leadership in this effort. If you have any questions or need additional information, please do not hesitate to contact me at (202)626-4802, or at paul.brown@bcbsa.com.

Sincerely,

Paul S. Brown

Paul S. Brown
Managing Director - State Affairs
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:

First, congratulations on your excellent leadership in concluding a complete review and selective revisions of the Life and Health Insurance Guaranty Association Model Act (#520) (the “Model Act”) in essentially 8 weeks. Give the history of comparable NAIC undertakings, this is an unprecedented accomplishment.

Second, thank you for this opportunity to offer my comments about the product that resulted from that work. I was an active participant and nothing herein should be interpreted as suggesting that I was not given a reasonable opportunity to present my perspectives during the drafting group’s deliberations. Rather, I address here principally matters that the drafting group deliberately did not address conclusively at this stage.

As usual, 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:

Support for the Model

The Chair and this committee went to extraordinary lengths to solicit and consider the views of all the constituencies materially affected by the proposed revisions. Inevitably, not all of the comments received were accepted and incorporated in the final product. That would have been impossible given the breadth of, and frequent clash among, these comments. Nonetheless, the process that produced the final proposed revisions took all comments into account and included a number of compromises resulting from those comments. For example, the innovative approach
adopted with respect to the allocation of long-term care (LTC) assessments between the life and annuity insurers on one hand, and the health insurers and health maintenance organizations (HMOs) on the other, largely adopted a compromise reached by members of those industry segments apart from the work of this Working Group.

The Chair and the committee devoted substantial efforts to addressing the concerns of the industry and what resulted is undoubtedly a compilation of many reasonable compromises. **It is appropriate then that this Working Group and the Task Force receive assurances from representatives of the industry that they will support adoption of these proposed amendments of the Model Act without material changes.** It would be a fundamental breach of the implicit collaborative nature of this process for the industry to advocate at individual state legislatures changes to the Model Act inconsistent with those proposed by this Working Group.

**Moody’s Rollback**

I commend the drafting group for clarifying that Section 3.B.(2)(c) of the Model Act1 (the “Moody’s Rollback” provision) does not apply to health insurance and LTCI benefits. The Chair invited representatives of certain health insurers (Health Insurers) that advocated for the application of the Moody’s Rollback to “inflation riders” in the policies issued by failed LTC insurers to submit their proposed alternative proposal. Because of the need to complete the work on the Model Act on the agreed time-line, however, consideration of this alternative proposal, along with certain other issues, has been deferred. There are many reasons why application of the Rollback to LTC insurance simply does not make sense. Those can be considered later but I offer the Working Group and the Task Force an important data point.

The key reason offered in support of reducing “inflation rider benefits” in LTC policies is that they are too generous given our low interest rate environment. These riders typically increase maximum policy benefits by up to 5% annually. That premise underlying suggestions that it be subjected to rollback - that the resulting benefits are too generous - is simply incorrect. On September 26, 2017 Genworth (the nation’s largest LTC insurer) announced the results of its annual cost of care survey for services typically provided by LTC policies. It concluded generally that “the annual median cost of Long Term Care services increased an average of 4.5% from 2016 to 2017...”

Specifically:

- Home health aide services rose by 6.17% to $21.50/hour;
- Homemaker services increased by 4.75% to $21/hour;
- Adult day health care services went up by 2.94% to $70/day;
- Assisted living facilities rose by 3.36% to $123/day or $3,750/month;
- Semi-private room nursing home care went up by 4.44% to $235/day or $7,148/month; and
- Private room nursing home care increased by 5.50% to $267/day or $8,121/month.

Whatever argument may be offered in support of taking away these benefits, for which insureds pay separate premiums, the suggestion that they are a windfall is simply without foundation.

---

1Unless specified otherwise, all statutory references are to the Model Act.

November 26, 2017 - Model 520 comments of Patrick Cantilo - page 2
**Premium Allocation**

Further 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. The drafting group deferred discussion of this issue in favor of completing its work on other issues now. Should review of the Model Act resume, this issue should be given further attention.

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 have been fully assumed by the guaranty associations or other insurers and/or because the underlying policies 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 that the payment of premiums continue 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 (at least until they discontinue benefits) 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.

Arguably, the Model Act and similar statutes may already address this 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

---

November 26, 2017 - Model 520 comments of Patrick Cantilo - page 3
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 to be consistent with Section 5.Q. 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 LTC premiums.

**CONCLUSION**

None of these comments is intended as criticism of the proposed revisions of the Model Act. The proposed revisions reflect informed analysis and appropriate compromise of competing positions. They resolve important issues and should be adopted expeditiously. My comments are addressed to adoption of these proposed revisions without change and to matters that should be considered should the Model Act again be reviewed for additional potential revisions. 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

November 26, 2017 - Model 520 comments of Patrick Cantilo - page 4
November 16, 2017

VIA EMAIL

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

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

Dear Chairman Kennedy and Members of the Working Group:

On behalf of HealthPartners, we appreciate the opportunity to provide comments on proposed changes to the Life and Health Insurance Guaranty Association Model Act (#520).

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

Recognizing that the drafting process is well along, we’d like to focus on the issue of equity, which is at the core of this issue.

Although the drafting note on page 30 states that the proposed method of apportioning the burden of assessments is equitable, we strongly disagree. 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. Non-profit integrated health care organizations such as HealthPartners were neither party to this agreement nor in agreement with it.

Our mission is to improve health and well-being in partnership with our members, patients and community.
This proposed allocation is not based on 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. 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. 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. As a result, HealthPartners is in strong opposition to this proposal.

Looking at this more locally, 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.

In addition, we would like to reiterate positions that we expressed in an earlier letter. We want to be on record as being opposed to the inclusion of HMOs into this model for the following reasons:

- **Health Maintenance Organizations are structured and regulated differently, particularly solvency.** HMOs are regulated under different constructs and rules than insurance companies. For example, in Minnesota, HMOs have historically been required to be non-profit. They are regulated not by the Department of Insurance, which also oversees the state Guaranty Association, but rather by the Department of Health. They have separated and distinct solvency requirements as required under the model act as well as separate as well as unique investment rules and other financial requirements.
- **In Minnesota, HMOs are statutorily excluded from the state Guaranty Association.** Given these very different requirements, HMOs are not a good fit for including in a state Guaranty Association.
- **In addition, while any organization currently included in a state Guaranty Association is legally allowed to offer a long-term care policy if it follows appropriate regulatory requirements, HMOs are NOT allowed to offer long-term care coverage. Therefore, HMOs should not be required to cover the insolvencies of a type of coverage from which they are specifically excluded from offering.**
- **Non-profit vs. for-profit** We also suggest that any discussion of HMOs in relation to Guaranty Associations consider the challenges inherent in requiring a non-profit to bear the weight of an assessment, particular for a for-profit insolvency. In Minnesota, all HMOs are currently and historically non-profit. While our state law just recently changed to allow for-profits, there are none in the state. This creates a very important
challenge for including our HMOs in the state Guaranty Association. We have neither the access to capital nor the level of reserves to address a significant assessment.

- **Making HMOs financially responsible for the insolvency of long-term care insurers would increase premiums, with no benefit to HMO enrollees.** Assessing HMOs for long-term care (LTC) insolvencies would lead to an increase in HMO premiums, with no benefit to HMO enrollees. The guaranty associations were formed to have companies writing similar lines of business cover the losses from an insolvent carrier in that line of business. HMOs are not in the insurance business and certainly not in the LTC market. HMOs are subject to a unique set of insolvency protections which impose costs that are not applicable to health insurers. As noted above, the existing NAIC Life and Health Guaranty Association Model Act has excluded HMOs for many years; there is no evidence that this exclusion has had any negative impact on the competitiveness or growth of health insurers across the country. And there is also no evidence that this exclusion has put HMO enrollees at risk.

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

Sincerely,

Dave Dziuk  
Chief Financial Officer  
HealthPartners
November 27, 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 on proposed Model #520 revisions

Dear Chairman Kennedy and Members of the Working Group:

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

The problem with the current model is not that HMOs are excluded, it is that life insurers are included in a way that has allowed them to evade the vast majority of their responsibility. According to the NAIC’s data, life insurers have responsibility for 75% of long-term care sales, while health insurers are responsible for only 18%. The assessments for Penn Treaty made a mockery of those proportions, but the proposed solution here continues to disregard the actual figures. Rather than holding life insurers responsible for their full share of the long-term care market, the proposed 50/50 split offloads a third of their share to the health insurance market. Five health insurers have agreed to that in exchange for offloading their part of the offload to the larger HMO industry. It is clear that this agreement treats these five health insurers (with their own co-branded HMOs) far better than the current assessment structure, but the life insurance industry continues to be assessed far less than its share while health insurers continue to bear much more than their fair burden; HMOs, which have little if any interest in long-term care insurance, find themselves with what the market participants refuse to accept.

As we have from the start, KP urges the NAIC to reject the 50/50 split because of this serious public policy discord. At the very least we request a model that provides flexibility for state regulators to make state-specific determinations about how to deal with long-term care failures based on state markets and conditions.

The private agreement being offered here specifically incorporates the details of an unfair, inequitable private agreement among the life insurance trade association and those few health insurance/HMO companies that chose not to be represented by their own trade association. It is
notable that there have been no arm’s-length negotiations between comparable industry trade organizations to inform the working group’s decisions.

The primary issue here from the start has been concern about long-term care insolvency; to the extent HMO solvency has come up, it has been eclipsed by the overriding problems in long-term care. Yet the actual market share of long-term care policies has been assiduously avoided.

The participants in the private agreement had their own business interests in focusing on other ways of dividing up the known world. In contrast, we offer the NAIC’s own data to show how grossly inequitable that private agreement is. There are far more workable and equitable alternatives relying on the NAIC data showing that public policy would support a very different calculation.

Who Kaiser Permanente is, and why we are different from health insurance companies

Kaiser Permanente (KP) serves 11.8 million members in eight states and the District of Columbia, and is the largest fully integrated health plan in the nation. KP comprises three distinct entities: (1) Kaiser Foundation Health Plan, Inc., the nation’s largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; (2) the Kaiser Foundation Hospitals, which owns and operates 38 hospitals and over 670 other clinical facilities; and (3) the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan, Inc. to meet the health needs of Kaiser Permanente’s members.

Since our inception in 1945, we have been recognized as an alternative model to traditional health insurance that delivers care directly to members in ways that insurers do not. Our model fully integrates all aspects of health care into a coherent delivery system connected through a uniform electronic health record, so that the highest quality care can be provided fully across physicians, clinics, labs, hospitals and pharmacies. Our electronic health record for each member is accessible to all caregivers in order to assure that current and past medical information is promptly available and reviewable without having to query each member, for example, about which medications he or she is taking. Its relevant data also informs related administrative functions.

That care management leads to the superior quality of KP care, which is nationally recognized. The National Committee for Quality Assurance just released its 2017-18 ratings, and of the 15 plans that scored at the topmost tier (approximately 1 percent of ranked plans), six of them were KP plans – the most of any organization. In California, for the tenth consecutive year KP plans were the only ones to receive the state’s highest ranking for overall clinical quality. KP’s Medicare Advantage plans consistently rank as top performers, and in CMS’s 2017 Medicare star quality ratings, Kaiser Permanente’s Northern and Southern California, Colorado, Northwest and Mid-Atlantic States regions received 5 out of 5 stars each, the highest overall rating. According to CMS, out of the more than 1.6 million beneficiaries enrolled in all 5-star Medicare Managed Care plans nationwide, 81 percent are Kaiser Permanente Medicare members.

The dominant and indispensable characteristic of KP is the health plan’s relationship with the Permanente Medical Groups in each of our regions. As noted, PMGs are independent physician group practices that contract exclusively with Kaiser Foundation Health Plan in each of our regions to
meet the health needs of Kaiser Permanente’s members. The physicians, not the health plan, have the lead on care management, formulary development, and clinical decision making.

However, that is not the only difference that distinguishes us from health insurers, or even from some of our HMO colleagues. We directly employ the health care workers who deliver care in collaboration with our PMG physicians. In 1997, KP joined with our union represented workers, managers and physicians to create our Labor Management Partnership. This unique and successful approach reinforces the alignment of our employees, physicians and management in one single mission. Today the LMP covers 120,000 union workers, 14,000 managers and 19,000 unionized physicians. It is the largest, longest-running and most comprehensive such partnership in the United States.

Such a partnership would be inconceivable for a health insurer. Only an HMO could approach health care in a way that brings employed health care professionals, physicians and managers within its structure. We will continue to fundamentally disagree that managed care is “just the same” as health insurance.

Finally, a fundamental difference cannot be ignored: the incentives of an HMO are aligned with public policy, in a way that health insurance incentives are not. In the health care context, physicians and hospitals have long had a built-in incentive to provide more care for more reward. One of the biggest advantages of managed care is to realign incentives so that they favor better care rather than just more care. While health insurers can and do recognize this problem and have made attempts to minimize it, the incentives from the insurance model -- recognized as being contrary to the dual goals of controlling costs and providing better care -- continue to exist for health insurers.

1. The NAIC model acts have always exempted HMOs from state guaranty associations for sound policy reasons. That exemption continues to be fully justified.

The asserted reasons that HMOs should be in guaranty associations is that they are “just like” health insurers. Some proponents went so far as to claim that if HMOs were not included in guaranty associations, they would simply abandon their health insurance operations and convert them to HMOs. This may demonstrate superficiality in how some particular companies view managed care, but it lacks any real basis in the known and essential differences between health insurance and managed care.

KP was one of the pioneers in prepaid health care delivered directly, rather than following the insurance model of indemnity for claims incurred by disconnected doctors, hospitals and other providers. That alternative model to care delivery has persisted. The difference between reimbursing insurance policyholders for claims they incur, and the direct provision of medical care for a prepaid fee was fundamentally different from insurance in 1945, and remains fundamentally different now.

The NAIC has long recognized the differences between HMOs and health insurance. In fact, HMOs are not defined as a form of insurance at all. While they provide health care to members, the core
relationship between persons covered under an HMO and policyholders of a health insurance company is significantly different.

*Claims vs. encounters*

Nothing demonstrates the discontinuity of treating an HMO like an insurer more than the absence of the word “claim” in the NAIC HMO Model Act. HMO members do not incur claims, they have “encounters” with the health care system. While much of the current administrative regime at the federal level continues to be based on the claims model, compliance in the HMO context requires reverse-engineering from encounters to devise surrogates for claims. This is an unfortunate necessity in a regulatory bureaucracy designed around claims.

Compare that to the Health Insurance Reserves Model Act (#10), where claims and claims reserves are critical throughout. This is insurance as it has always been. Patients who have paid in advance for medical care and receive that medical care do not need to make claims upon a third party insurance company.

*Solvency is approached differently for HMOs*

As a consequence of that primary difference in the care delivery model, the HMO Model Act deals with solvency issues differently as well, beginning with explicit protections for members. Section 19 (B) specifies that

> All contracts among health maintenance organizations, risk bearing entities and participating providers shall include a hold harmless provision specifying protection for covered persons, which may not be waived. Covered persons are to be notified that “YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION.”

In any HMO insolvency under the NAIC model, unlike in an insurer solvency, members, who would not typically have reimbursable claims, are also protected from stray bills by disconnected providers. Some health insurers now provide similar protection for their policyholders; to the extent they do this, the NAIC model for insurance insolvencies should recognize that. But the mere fact that some insurers offer this protection is not an argument that HMOs which must provide that protection should be treated the same as health insurers.

Section 20 of the NAIC model for HMOs requires a special deposit for uncovered expenditures in the event of insolvency, which is separate from an additional, required deposit under Section 18. These are not reserves as that term is understood in the insurance world. The current draft revisions do not attempt to resolve provisions like this to assure that HMOs are not subject to duplicative or inequitable requirements that guaranty associations might have.

Since covered persons in an HMO will not incur any expenses (aside from their monthly payments, and any deductibles, copayments and coinsurance that they are individually responsible for under their contracts), any potential tail for incurred claims is nearly nonexistent for HMOs. In the worst-case scenario for an HMO covered person, Section 21 of the HMO Model provides that an insolvency of their HMO will lead to an open-enrollment period to purchase
other coverage. This is separate from the ACA open enrollment rule applying to both insurers and HMOs, which is a function of the ACA’s set of interrelated rules.

**Singling out HMOs**

Further demonstrating the mismatch of the change contemplated in this draft are the other entities excluded in the definitions of Model #520, section (L) (1)-(8). In the existing model, hospital or medical services organizations, fraternal benefit societies, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or “entities similar to the above” are all grouped with HMOs. This working group’s decision to single out HMOs without any discussion of the reasons others on the list will continue to be exempted suggests that the purported reason for this change -- a broader assessment base for long-term care insolvencies -- has untapped potential that is still available.

**Tax-exempt HMOs are different**

We also stress the unique role of tax-exempt HMOs, a category with no proper equivalent outside the managed care model. Private market insurance is not a good fit with the charitable beginnings of care provided directly to the indigent in the late nineteenth century and well into the twentieth.

While insurers may take advantage of charitable contributions or other efforts available to them for sound public policy reasons, the fact that they do not provide care directly continues to distinguish them. Kaiser Foundation Health Plan, Inc’s tax-exempt, not-for-profit, mission driven model requires a different structure than a for-profit insurer, as well as a deep commitment to the larger communities in which we live and operate -- known as community benefit. Our tax-exempt status requires us to abide by many strict rules requiring significant and ongoing efforts to provide care to the underserved and the obligation to further the public good. Those rules also draw lines limiting political activity, including prohibitions on political contributions. For KP, this is not just a business choice, it is central to the mission of KP. The changes proposed in this model will deeply undercut our ability to carry out that mission as successfully as we do now.

**The five co-branded health insurers with HMOs do not represent HMOs**

We do not mean to make a judgment on the health insurance model. Many consumers prefer that model. The point is that the NAIC model acts have been based on unambiguous and fundamental differences that may be blurred by some companies, but not by all, and certainly not by KP. That is why so many insurance departments supervise HMOs and health insurance companies under distinct regulatory structures.

The fact that five co-branded health Insurers with HMOs can claim their HMOs are nearly the same as their insurance operations says a great deal about their business model, but nothing at all about what an HMO can or (in our view) should do in managing health care within a coherent, prepaid delivery system. While the ACA has, at least at present, provided rules about what benefits any kind of health care companies must provide, it has done nothing to change the way those benefits are provided (and paid for), or the underlying ways that HMOs can directly manage that care if they choose to employ that model to its fullest.

2. The private agreement is not based on available and reasonable market data; NAIC data shows that the long-term care market is dominated by the life/annuity industry.
The private agreement presented to this group was not a negotiation among similarly situated trade organizations. While the parties have not fully disclosed the circumstances or considerations that went into their agreement, the following facts are known:

1. The life insurance industry was represented by its trade organization, which had the authority to speak on behalf of all its members.
2. The health insurance industry was not represented in those original meetings. The five co-branded health insurance companies with HMOs represented their own interests. No other parties are known to have been involved in the agreement.
3. In this working group’s drafting meetings, the life insurance industry was represented, as were the interests of the five co-branded health insurance companies with HMOs. KP and ACHP represented their own interests. AHIP addressed an industry-wide issue related to Medicare/Medicaid exemptions from guaranty associations, but on the primary issue of the private agreement, they said only that they desired a more equitable division of long-term care responsibility than the current model provides.
4. The 50/50 split does not coincide with any known market data for the sale of long-term care insurance policies. On the contrary, the known data shows that the life insurance industry is responsible for 75% of long-term care sales, and the health insurance industry is responsible only for 18%.

The mismatch between industry interests
The fundamental problem with the private agreement is the mismatch between the life insurance industry, speaking through its trade association, and the private business being conducted by the five health insurance companies with HMOs.

Whatever other problems such an arrangement might have, it is surely flawed because the individual business interests of the health insurance/HMO companies may not be aligned with the rest of their industry. In contrast, the life insurance industry was able to speak with an industry-wide voice. Public policy should not be – and is not designed to be – established under conditions like this. The result of these incompatible and improbably aligned interests shows why.

The 50/50 split
The apparent premise of the working group’s decision to adopt the explicit 50/50 split is based on an approximation of the life insurance and health insurance market share nationwide – something that, of course, will be different in different states.

But that is the wrong metric. The relevant metric is the share of long-term care policies sold by each side of that industry divide. This is the metric used in assessments for the other lines of business in the current model, and the proposals here directly reject that sound approach. Addressing the overriding concern of this group to address long-term care failures cannot reasonably be achieved by expressly ignoring the long-term care market.

We have used NAIC figures to determine the appropriate data. This chart shows that the 50/50 split is not just unreasonable, but far out of proportion to the long-term care market.
The first table looks at market share by legal entity. Long-term care entities write 37% of the market, life insurers 42% and health insurers 15%. The second table shows market share by the parent company. While a minute fraction of long-term care sales do not fall under an identifiable life or health parent, 75% of sales are attributable to a life/annuity parent company, and 18% to a health company parent. Property and Casualty has the same 6% market share under either scenario, and our assumption is that the P&C companies are and will continue to be assessed for their 6% market share.

Neither of these models comes even glancingly within the 50/50 market split the model proposes to incorporate. The parent-based 75/18 split is the most reasonable approach to dividing this troubled market, since it leaves the smallest unattributable long-term care percentage to be divided among the companies to be assessed. This is also consistent with the NAIC’s larger examination of the holding company structures of insurance entities.

But even the more difficult first scenario does not remotely approach the 50/50 split. Assuming that no long-term care company is equipped to be assessed for the failures of another long-term care carrier, the most reasonable and fair option would be to divide that 37% share proportionately between life and health accounts. Under that scenario, commissioners could consider including the

---

**Allocation based on predominant business type at the Legal Entity Level**

<table>
<thead>
<tr>
<th>Entity Type</th>
<th>Number of Entities</th>
<th>Life</th>
<th>Annuity</th>
<th>A&amp;H w/ LTC</th>
<th>A&amp;H w/o LTC</th>
<th>LTC</th>
<th>Total w/o LTC</th>
<th>LTC Premium Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC</td>
<td>16</td>
<td>$0.4</td>
<td>$0.1</td>
<td>$4.6</td>
<td>$0.0</td>
<td>$4.6</td>
<td>$5.1</td>
<td>37%</td>
</tr>
<tr>
<td>Life/Annuity</td>
<td>67</td>
<td>$56.1</td>
<td>$197.2</td>
<td>$24.3</td>
<td>$19.1</td>
<td>$5.1</td>
<td>$306.6</td>
<td>42%</td>
</tr>
<tr>
<td>Health</td>
<td>80</td>
<td>$8.3</td>
<td>$6.7</td>
<td>$132.5</td>
<td>$130.6</td>
<td>$1.9</td>
<td>$141.5</td>
<td>15%</td>
</tr>
<tr>
<td>P&amp;C</td>
<td>11</td>
<td>$0.7</td>
<td>$0.7</td>
<td>$0.7</td>
<td>$0.7</td>
<td></td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>174</strong></td>
<td><strong>$93.9</strong></td>
<td><strong>$198.0</strong></td>
<td><strong>$161.4</strong></td>
<td><strong>$149.7</strong></td>
<td><strong>$12.4</strong></td>
<td><strong>$458.9</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Notes:**
We identified all legal entities with LTC business among NAIC Life and Health blank filers of 2016 statutory annual reports, excluding CA DMHC filers. All of the Life/Annuity and Health premiums including LTC were considered in the allocation to predominant type of business (LTC, Life/Annuity, Health) based on the majority of Sch T premium at the legal entity level. P&C information is based on 2016 NAIC P&C blank filers LTC premium.

**Allocation based on predominant business type excluding LTC at Parent Company Level**

<table>
<thead>
<tr>
<th>Parent Company Type</th>
<th>Number of Companies</th>
<th>Life</th>
<th>Annuity</th>
<th>A&amp;H w/o LTC</th>
<th>A&amp;H w/ LTC</th>
<th>LTC</th>
<th>Total w/o LTC</th>
<th>LTC Premium Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC</td>
<td>3</td>
<td>$6.0</td>
<td>$0.0</td>
<td>$0.1</td>
<td>$0.0</td>
<td>$0.1</td>
<td>$0.1</td>
<td>1%</td>
</tr>
<tr>
<td>Life/Annuity</td>
<td>57</td>
<td>$125.6</td>
<td>$252.9</td>
<td>$37.0</td>
<td>$27.8</td>
<td>$2.3</td>
<td>$257.6</td>
<td>18%</td>
</tr>
<tr>
<td>Health</td>
<td>54</td>
<td>$14.6</td>
<td>$3.8</td>
<td>$241.2</td>
<td>$238.9</td>
<td>$2.3</td>
<td>$257.6</td>
<td>18%</td>
</tr>
<tr>
<td>P&amp;C</td>
<td>7</td>
<td>$0.7</td>
<td>$0.7</td>
<td>$0.7</td>
<td>$0.7</td>
<td></td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121</strong></td>
<td><strong>$140.2</strong></td>
<td><strong>$254.7</strong></td>
<td><strong>$278.3</strong></td>
<td><strong>$266.7</strong></td>
<td><strong>$12.4</strong></td>
<td><strong>$674.0</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Notes:**
We identified all parent companies with LTC business in at least one Life and Health subsidiary filing a 2016 statutory annual reports with the NAIC. All of the Life/Annuity and Health premium excluding LTC was considered in the allocation to predominant type (LTC, Life/Annuity, Health) based on the majority of premium at the parent level for all subsidiaries combined. P&C information is based on 2016 NAIC P&C blank filers LTC premium. Parent companies with LTC share of more than 95% of premium are allocated to company type "LTC" to avoid allocating a primarily LTC carrier to Life/Annuity or Health.

Data source is SNL.com. NAIC statutory exhibits utilized for the Premium determination:
- Life Premium: Life Blank Schedule T Part 1 Line 95 Column 2 (Life)
- Health Blank: Schedule T Part 2 Line 59 Column 1 (Life)
- Annuity Premium: Life Blank Schedule T Part 1 Line 95 Column 3 (Annuity) + Column 5 (Other Consideration)
- Health Blank Schedule T Part 2 Line 59 Column 2 (Annuity)
- A&H w/ LTC Premium: Life Blank Schedule T Part 1 Line 95 Column 4 (Acc & Health - all LOBs) - Health Blank Schedule T Part 1 Line 65 Column 2 (Acc Health) excluding Medicare, Medicaid, FEHBP business in Columns 3-5
- LTC Premium: Accident and Health Policy Experience Exhibit Part A Line 10.3 Column 1 - Individual LTC + Part B Line 12 Column 1 - Group LTC
6% P&C market in the division, since the ultimate goal is to spread the unassessable risk of long-term care sales fairly, and if life and health have to bear a proportional share, the P&C share of the market could fairly be taken into account as well.

It is not clear from this raw data whether all of the 37% of long-term care writers are, in fact, incapable of surviving a financial assessment for their own market. Under this license-specific approach, commissioners should have the authority to determine which long-term care licensees are and are not financially sound enough to be assessed. The critical determination for guaranty associations is that participants in the relevant market should be assessed for the failure of other participants. An exception can and should be made for long-term care writers that are in financial distress, but only for them.

The major point is that in none of these scenarios is the life insurance industry share of the assessments even remotely close to what their sales of long-term care products actually are. Whether it is 75/18 or 42/15 plus some fair division of the 37%, there is no way to look at the NAIC’s own long-term care market data without finding the 50/50 split completely unacceptable public policy. In the words of the “essential” intent of this model, the 50/50 split does not “. . . assess insurers in a fair and reasonable manner.”

3. **Proposed language that would truly meet the standard of being “fair and reasonable.”**

The most fair and reasonable approach is to reject entirely the 50/50 split and make assessments based on the market share of long-term care sales attributable to a parent company that is designated as life or health:

> 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 be based on the character of the parent company of each long-term care writer and shall be divided fairly among the parent companies based on their total market share of long-term care sales of 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.

Another approach would be to proportionally assess any licensed entities that write long-term care policies, based on the market share of those companies, including licensed long-term care companies, provided the commissioner determines that any assessed long-term care companies would be financially capable of being assessed. Any share of long-term care licensees that would be placed in financial jeopardy from an assessment would be divided among other participants — again proportionately to long-term care sales in the state. Assuming, in the most extreme case, that none of the currently licensed long-term care writers would be capable of being assessed without financial jeopardy, the 37% for such licensees would be divided proportionately based on the market share of life and health lines: Life’s 42%, Health’s 15%, and possibly P&C as well. As with the health insurance industry, P&C carriers have not been involved in these discussions about the 50/50 split, and their industry-wide position is a critical consideration. However, the model’s clear intention of achieving a fair and reasonable result could include sharing this burden proportionate to their 6% share.
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 assess health insurers and life insurers for their share of long-term care sales by each licensed entity that sells long-term care policies, provided that any share of sales of long-term care policies by a long-term care insurer that the Commissioner determines would be faced with financial jeopardy from an assessment shall be divided fairly between other companies based on their market share of long-term care sales of 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. [SIMILAR LANGUAGE COULD BE INSERTED IN THE PROVISION THAT GOVERNS P&C-RELATED INSOLVENCIES]

A third option would leave the specifics to each Commissioner. This option 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 publicly 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 -- or even could lawfully write under their existing license -- may approve a methodology and factors to achieve a different result. This proposal does not foreclose the result the life insurers and their health insurance-HMO supporters desire if they can demonstrate it is equitable and fair.

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 and fairly 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. [SIMILAR LANGUAGE, IF NEEDED, COULD BE INSERTED IN THE PROVISION THAT GOVERNS P&C-RELATED INSOLVENCIES]

4. If HMOs are included in long-term care assessments, 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 that if a state includes HMOs in its guaranty association, it should consider 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.

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 within the health account for HMOs. If the commissioner determines this is appropriate, the subaccount structure 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.

5. Conclusion

It is becoming more apparent that the long-term care insurance industry is finally developing products and strategies that can help to solve the problems that have developed over so many years. These are overwhelmingly coming from the life insurance industry, which is the primary participant in the long-term care market. 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.

But they should not be resolved by the adoption of this fundamentally unfair and unreasonable private agreement. KP has been diligent in attempting to provide options that are consistent with the known data on long-term care market share, and tried to accommodate the unique problems in the current long-term care marketplace in a way that corrects the existing imbalance between the life and health accounts while not disadvantaging the health insurance industry by continuing to assess it far more than its share of long-term care sales.

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