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Medicare: Policy, Advocacy and Education

Insurance Products and Paying for Long-Term Care:

A Guide for Policymakers and Regulators

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Executive Summary

As the American population ages, financing long-term care has emerged as one of the most consequential and least understood challenges in consumer financial protection. The insurance products available today to help pay for long-term care — life insurance and annuities with long-term care riders and benefits, and the hybrid products that combine them — are among the most complex financial instruments sold to the general public. Yet they are frequently purchased by consumers with limited financial literacy, under pressure from commission-driven sales agents, and with little regulatory guidance tailored to this specific intersection of insurance and long-term care.

This brief provides an overview of the principal insurance products used to finance long-term care, identifies key consumer risks in each product category, and highlights the regulatory and policy considerations that warrant attention. It is intended to support the work of policymakers, insurance regulators, and consumer protection agencies in evaluating whether existing frameworks adequately protect consumers in this market.

Background and Market Context

Traditional stand-alone long-term care insurance was widely sold throughout the 1990s and into the 2000s. These policies were specifically designed to pay for care delivered in the home, adult day care, assisted living facilities, and nursing home and memory care settings.

Eligibility was triggered when a policyholder could no longer perform two or more activities of daily living — such as bathing, dressing, eating, and mobility — or required supervision due to cognitive impairment. Benefits were typically paid on a daily or monthly basis, up to a defined maximum amount, for a specified number of years.

Around 2010, most major insurers began exiting the traditional long-term care market. The industry had seriously underestimated the utilization of the benefits these policies were designed to cover. Policyholders lived longer than expected, utilized benefits at higher rates than projected, and the sustained low-interest-rate environment eroded the investment returns that carriers had counted on to fund future claims. In addition to fewer carriers willing to write traditional policies there was a wave of substantial premium increases that continues today on first generation policies sold between 1980 and the first decade of the 21st Century. Due to more realistic pricing, recent traditional LTC policies will experience premium increases in the future but more due to inflation protection than actuarial underpricing.

But many of the affected policyholders are now elderly and on fixed incomes, with no meaningful ability to maintain the coverage they struggle to afford. A small number of carriers have remained in the market or re-entered it with more realistically priced products with much higher premiums. But the population of legacy policyholders carrying older policies remains financially vulnerable.

Premium increase notices sent to these policyholders are not simple communications. They typically present a menu of options that allow the policyholder to reduce the size of the premium increase by giving up benefits — eliminating or scaling back inflation protection, reducing the daily benefit amount, shortening the benefit period, or extending the waiting period before benefits begin. These are often presented as choices, but in effect they are a forced renegotiation of a contract the policyholder entered into in good faith, often decades earlier, or an induced lapse. The tradeoffs are emotionally painful and financially complex. For younger policyholders surrendering inflation protection to avoid a near-term premium increase, for example, can significantly reduce the real value of the benefit in old age — precisely when that benefit is most likely to be needed. Regulators should ask whether the disclosures accompanying these notices are adequate to support genuinely informed decisions, ensuring meaningful benefits remain in old age.

Claims disputes often stem from differing expectations about contract language describing eligibility requirements, or definitions of when and where care can be provided. Policyholders and their families struggle with the paperwork required to justify and document the conditions that will satisfy those contractual terms and result in the payment of benefits. For someone who is already impaired — or for a family member managing their care — this is a daunting process. Delays, requests for additional documentation, and disputes over eligibility determinations are common, and the burden falls most heavily on those least equipped to handle them. Market conduct

examinations of claims handling practices are warranted — particularly among carriers that have exited the market but retain large blocks of legacy business.

In response to provider contraction of traditional policies, insurers have introduced combination or "hybrid" products — life insurance and annuities that include long-term care benefits — which now dominate the market. These products are marketed to consumers as offering a two-for-one value: a death benefit (life insurance) or account value (annuities) if long-term care is never needed, and a source of funds if it is. That framing is understandable, but it can obscure the complexity and risks to which consumers are vulnerable.

Because Medicare and most private health insurance plans do not cover long-term care, the burden of financing this care falls on individuals and families. Policymakers have a direct interest in ensuring that the products available to meet this need are well regulated, transparently marketed, and genuinely suited to consumers' long-term financial security.

Life Insurance Products With Long-Term Care Benefits

Life insurance provides a death benefit to survivors upon the policyholder's death. The two traditional forms are term life, which provides coverage for a fixed period, and whole life, which provides lifetime coverage and builds cash value over time. Newer universal life products offer greater flexibility in premiums payments and benefits, but that flexibility introduces a level of uncertainty not present in traditional whole life policies.

Many modern life insurance products include an option — either built into the policy or added as a separate rider — to "accelerate" the death benefit and use it to pay for long-term care expenses. These products are marketed as allowing consumers to receive value from the policy whether or not they need long-term care. From a regulatory standpoint, this framing requires scrutiny.

Consumer Risk Factors

The structure of accelerated death benefits as a method of compensation for long-term care expenses means that funds used for long-term care reduce — or eliminate — the death benefit available to survivors. It's important to note that consumers may not fully appreciate this tradeoff at the time of purchase. In addition, life products that provide long-term care benefits are relatively new and it is not yet known if there will be future rate increases.

There can be other risks associated with certain types of life insurance products. Internal policy costs, including the cost of insurance mortality charges and administrative fees, can reduce the account value and the ultimate benefit available, especially in variable and indexed universal products. Universal life products are sensitive to interest rate fluctuations and investment

performance. Unlike traditional whole life policies, the long-term value of these products is not fully guaranteed, and policies can lapse or lose value under adverse conditions. Consumers who purchase these products expecting a reliable source of long-term care funding may be surprised to find that the available benefit may be adversely affected.

Policy Concern:

Universal Life (UL) products have fewer guarantees in exchange for premium payment flexibility, resulting in consumer confusion, especially when the premium paid is less than necessary to ensure lifetime coverage. The calculations, benefit illustrations, and interest projection in policy documents require a level of financial literacy that most consumers lack. Commission structures incentivize sales agents to recommend more complex — and more expensive — products. Regulatory oversight of sales practices and disclosure requirements in this segment deserves renewed attention.

Key Questions Policymakers Should Ask

1. Are disclosure requirements adequate to ensure consumers understand that the death benefit and long-term care benefit draw from the same pool of funds?
2. Are sales illustrations and recommended premium levels sufficient to maintain coverage over the insured's lifetime?
3. Do commission structures create incentives to sell more complex products than consumers need?
4. What consumer protections exist when the underlying life insurance policy lapses due to inadequate life insurance policy premium that in turn may rely on overly optimistic long-term performance expectations?
5. What consumer protection exists when a rider to a underlying life insurance policy lapses?
6. Should suitability requirements for annuities (NAIC Model #275) be extended to consumers purchasing life insurance sold with long-term benefits?

Annuity Products With Long-Term Care Benefits

An income annuity is a contract in which a consumer pays a premium —typically a lump sum — in exchange for a stream of income payments beginning either immediately or at a specified future date. Most annuities, however, are sold as tax-deferred accumulation vehicles, particularly for retirement planning. Some include provisions that allow benefits to be used for long-term care expenses.

Some annuity products include investment components and are registered under federal securities law, adding regulatory complexity. The benefit structure, interest crediting method, and

payment terms are defined at the time of purchase, and the conditions under which long-term care benefits can be accessed vary considerably across annuity and life insurance products.

Consumer Risk Factors

The value of newer annuity products are tied to market performance —including Variable Annuities — (directly invested in sub-accounts) and Indexed Annuities (referencing market indices but not invested in the market) —and can gain or lose value over time.

Surrender charges, which penalize early withdrawal, can be substantial and may extend for 7 to 10 years or longer, limiting a consumer's ability to access funds in an emergency. Interest rates credited to annuity accounts can change, and the floor on those rates may be lower than consumers expect.

Annuities designed to include long-term care benefits represent a relatively new product category, and the conditions for accessing those benefits can be restrictive and difficult to understand.

As with life insurance products, the complexity of these products creates significant potential for consumer confusion and potentially unsuitable sales.

Policy Concern:

> *Annuities with long-term care features are particularly concerning when sold to older consumers on fixed incomes who may not fully understand surrender charges, interest rate risk, or the conditions under which long-term care benefits can be triggered. Regulators should evaluate whether existing suitability standards are being consistently applied in this market segment.*

Key Questions Policymakers Should Ask

1. Are surrender charge periods and conditions adequately disclosed at the point of sale?
2. What standards govern the sale of annuities with long-term care features to older consumers on fixed incomes?
3. Can the interest rate credited to the annuity decline to a level that erodes the value of the long-term care benefit over time? And if so, how is that disclosed to consumers?
4. Are the conditions for triggering long-term care benefits subject to wide variation across products?
5. What recourse do consumers have if the annuity's value declines and the long-term care benefit becomes insufficient?

Riders and Add-On Benefits

A rider is a separate contractual endorsement added to a life insurance or annuity policy. Riders can add new benefits, modify existing ones, or extend coverage in specific circumstances. In the

context of long-term care financing, riders represent an important and growing product category — and one that warrants specific regulatory attention.

Types of Riders

Accelerated Death Benefit Riders: These riders allow a policyholder to access the death benefit of a life insurance policy while still alive to pay long-term care expenses. They are the most common mechanism for incorporating long-term care benefits into a life insurance policy.

Long-Term Care Riders: These riders provide long-term care benefits under structures similar to a stand-alone long-term care policy, either separate from the base policy or after the base policy's accelerated benefit has been exhausted.

Critical Illness Riders: These riders use eligibility criteria that may resemble long-term care triggers but are structured differently. Under federal law, critical illness riders can't be marketed as long-term care insurance, yet they clearly resemble those products. Consumers and regulators should be alert to marketing practices and product structures that obscure this distinction.

Replacement or Extension of Benefit Riders: These riders are designed to replace or extend benefits used under the base policy or a separate rider.

Inflation Protection Riders: These riders are designed to increase the underlying benefit over time helping to preserve its real value. The method of calculation and the duration and limits of that increase are critical terms that require close scrutiny.

Return of Premium Riders: These riders promise to return all or part of the premium paid if the insured never uses the policy's benefits. The conditions governing this return — including time requirements and definitions of "use" — require careful review.

Regulatory Considerations

Riders are frequently sold as relatively simple enhancements to an underlying policy, but they carry their own premium obligations, benefit triggers, and guarantee structures. A rider's premium may not be guaranteed and may increase independently of the underlying policy's premium. A rider may lapse separately if the premium is not paid.

The distinction between long-term care riders and critical illness riders is a particular area of concern. Aggressive marketing of critical illness riders as equivalent to long-term care coverage is a consumer protection issue that requires regulatory enforcement attention.

Policy Concern:

The interaction between riders and their underlying policies is highly complex and frequently misunderstood by consumers. Disclosure requirements specific to riders — separate from general policy disclosure — may be warranted. Regulators should also examine whether sales

agents are adequately trained and supervised to accurately explain these riders and their connection to an underlying life or annuity product.

Key Questions Policymakers Should Ask

1. Are rider premiums subject to the same rate requirements and protections as the premiums for underlying policy?
2. Is the distinction between long-term care riders and critical illness riders adequately communicated to consumers at the point of sale?
3. What are the consequences if a rider lapses independently of the underlying policy, and are those consequences clearly disclosed?
4. Are there consequences if an underlying policy lapses independently of the rider, and are those consequences clearly disclosed?
5. Are there standards when multiple riders –critical illness, inflation protection, extension of benefits — are all attached to an underlying life or annuity product?
6. Do the conditions for activating rider benefits meet certain standards, or do they vary in ways that create confusion or enable claims disputes?
7. Are existing regulatory frameworks designed for standalone long-term care, life insurance and annuity products adequate to address the complexity of layered rider-plus-policy structures?

Conclusion and Policy Recommendations

The market for insurance products that promise to pay for long-term care has shifted substantially over the past decade. The stand-alone long-term care insurance market has contracted, and combination products — life insurance and annuities with long-term care features — have filled some of the gap. These products are, in many cases, more complex than the stand-alone policies they have replaced, and the regulatory frameworks governing them were not designed with long-term care financing in mind.

Consumers purchase these products often make commitments that will last the rest of their lives, under conditions that may not be fully understood at the point of sale. The stakes — both financial and personal — are high. The following policy directions warrant consideration:

- Strengthen and standardize disclosure requirements for all products marketed to pay for long-term care expenses, including life insurance and annuity products with riders.
- Explore whether existing suitability requirements are being consistently applied in the sale of complex combination products to older consumers.

- Clarify the regulatory distinction between long-term care riders and critical illness riders, and address marketing practices that obscure this distinction.
- Examine how premiums and internal costs used in these products can affect the amount of benefits available at the time of claim and consider whether some form of rate regulation should be developed.
- Consider whether enhanced training and oversight of sales agents is warranted given the complexity of these products and the vulnerability of the consumer population most likely to purchase them.
- Encourage consumers to seek information from the state's SHIP, and to seek help from their own trusted financial advisor, or an independent financial advisor before committing to any insurance product for long-term care financing purposes.

Planning for long-term care is a significant and unavoidable challenge for an aging population. The products available to meet that challenge deserve regulatory frameworks equal to their complexity and to the stakes involved for consumers. This brief is intended as a starting point for that conversation.

About the Author

Bonnie Burns has advocated for the interests of older Americans in Medicare and the insurance they purchase for their health and long-term care needs for more than 40 years. She has served as a consumer representative at the National Association of Insurance Commissioners (NAIC) since the program's inception in 1992. She has testified before Congressional Committee hearings and in the California State Legislature on the need to improve state and federal standards for long-term care insurance. She has also served as a technical expert and trainer for California Health Advocates, which has provided training, materials, and expert assistance to California's Medicare counseling program HICAP (Health Insurance Counseling and Advocacy Program) staff and volunteers for many decades.

Issue

Over the past decades, there have been significant innovations in cancer care that have resulted in substantially improved cancer survival rates. For all cancers combined, the 5-year relative survival rate rose from 49 percent in the mid-1970s to a milestone 70 percent among people diagnosed from 2015 to 2021.[1] Increased survival rates are due in part to the advancement of cancer treatments, which have become more specialized over the years. Advancements in precision medicine have transformed cancer treatment by enabling care teams to use a patient's genomic profile and characteristics to guide treatment decisions, reducing cancer mortality rates and improving quality of life.[2]

Biomarker testing is a cornerstone of precision medicine.* Biomarkers are molecules in the body that can indicate disease presence or severity, including subtypes of cancer.[3] This testing allows doctors to precisely target a patient's specific cancer; as a result, some patients may not have to undergo more generalized treatments like chemotherapy and radiation that may not work as well for them or may be unnecessary.[4] Unfortunately, not all communities are benefiting equally from advancements in biomarker testing and precision medicine. Although these tests show great promise, significant barriers to access – such as cost and lack of insurance coverage – remain.[5] To help address these concerns and inequitable access, some states have enacted laws to expand coverage of biomarker testing.[+] While state biomarker coverage laws are part of the solution and have the potential to improve uptake, they are only one tool for expanding access to biomarker testing and additional actions are needed to reduce barriers.

The Impact on Cancer Patients

For cancer patients, it is crucial to receive the right treatment at the right time. Biomarker testing helps physicians tailor their care plan and can provide access to life-saving treatments. In a 2023 survey of cancer patients and survivors, over three-quarters (77%) of those who have had biomarker testing agree that it gave their providers valuable information that improved their ability to treat the patient's cancer.[6] A uterine cancer survivor from North Carolina shared that after being told she had 6 months to a year to live, biomarker testing connected her to an immunotherapy trial that ultimately saved her life.

Some cancer treatments can also significantly impact patients' quality of life in the short-term – including side effects like severe fatigue, infection, nausea, lack of concentration, depression – and in the long-term – like heart or nerve damage or fertility problems.[7] Biomarker testing can reduce risk of exposure to these adverse side effects from unnecessary treatment.[8] In a survey of cancer patients, half of respondents reported they were able to avoid unnecessary treatments or procedures because they had biomarker testing.[6]

To ensure that patients have access to these cutting-edge tests when supported by medical and scientific evidence, it is crucial that health plans provide adequate coverage. Without access to biomarker testing, enrollees might have to choose between forgoing potentially game-changing testing and paying a large bill. After Marilyn from North Carolina was diagnosed with Stage 4 breast

* While biomarker testing is a critical component of cancer care, it is also used to guide treatment decisions in a growing range of other conditions and diseases including autoimmune diseases such as rheumatoid arthritis, rare diseases, mental health conditions, preeclampsia, Alzheimer's disease, and other neurological conditions.
+ This paper focuses on state biomarker legislation; federal legislation and requirements are outside its scope.

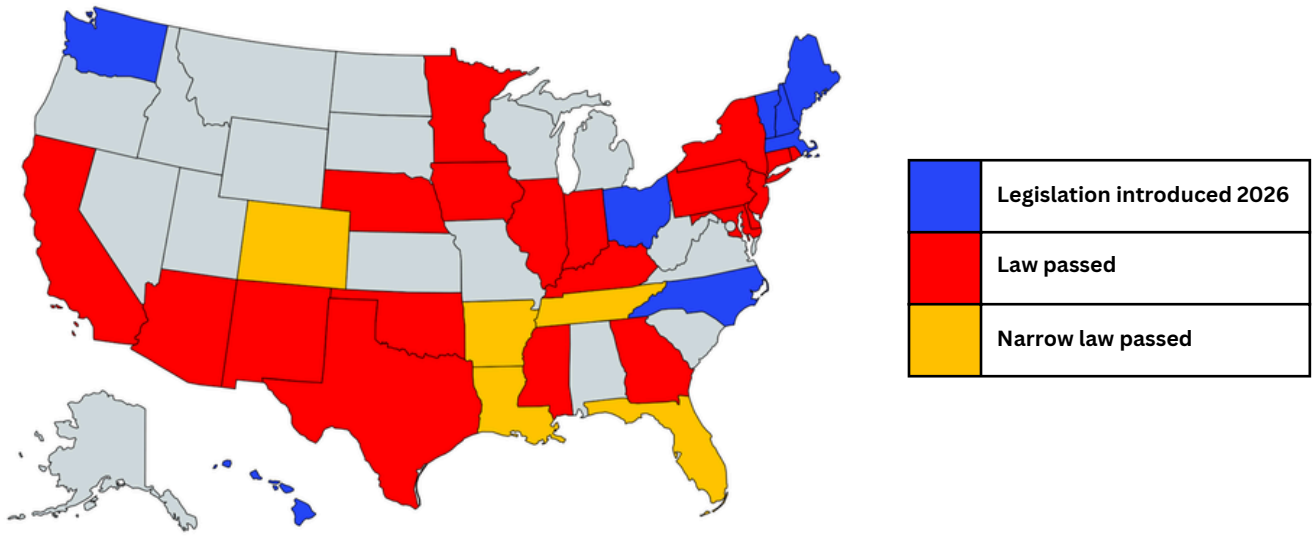
cancer, she received biomarker testing to determine exactly what type of breast cancer she had and identify alternative targeted treatment options. As a former senior level health insurance executive, she was shocked to receive an $8,000 bill for the testing that she assumed would be covered. While Marilyn faced significant out-of-pocket costs for testing in a state that has not passed a biomarker coverage law, she noted "[her] biomarker testing has opened up treatments that can keep [her] alive for years to come."[9]

"My biomarker testing has opened up treatments that can keep me alive for years to come. How could they deny me that?" - Marilyn, breast cancer patient from North Carolina

Key Issues in Covering Biomarker Testing

As biomarker testing has become an increasingly important tool for guiding treatment decisions, some states have enacted legislation to expand insurance coverage for these tests. As of July 2026, 25 ǂ states have passed laws requiring some level of biomarker testing coverage.[10] However, these vary in scope and coverage criteria. For example, some laws, such as in Arkansas[11] and Louisiana,[12] require coverage only in private plans, while Florida's[13] law applies only to Medicaid and state employee health plans. Patients in the remaining states or excluded plans may have no or limited coverage, depending on their plan, resulting in uneven access across the country and a fragmented insurance coverage landscape.

Legislation to Expand Access to Biomarker Testing



Note: This chart was updated 7/23/2026
Legislation enacted: AZ, AR*, CA, CO*, CT, DE (awaiting signature), FL**, GA, IL, IN, IA, KY, LA*, MD, MN, MS, NE^, NJ, NM, NY, OK, PA, RI, TN**, TX'
Legislation introduced in 2026: DE, HI, MA, ME, NH, NC, OH, VT, WA
* Private plans only **Public plans only ^Nebraska law applies to a limited list of diseases and conditions

Even in states that have enacted biomarker testing coverage laws, implementation and enforcement challenges can limit their impact. Provider knowledge of biomarker testing and awareness of coverage requirements play a significant role in whether patients receive testing. As such, many patients may not know these tests are available or relevant to their care.[14] In addition, the documentation and

ǂ This number includes Delaware which has a biomarker coverage bill awaiting the governor's signature.

administrative requirements from insurers can be lengthy, which physicians often cite as a challenge to timely testing.[14] A lack of transparency in coverage decisions and onerous utilization management techniques, such as prior authorization, can further restrict access.

Despite these challenges, states that have enacted biomarker testing coverage laws have generally experienced more favorable testing trends than the national average.[14] For example, biomarker testing rates among Medicaid patients with non-small cell lung cancer (NSCLC) fell by 4.8 percent nationally from 2021 to 2024.[14] In contrast, during the same period, rates declined less sharply in Arizona (-4.0%) and increased in California (+1.5%) and Illinois (+9.1%), all of which have enacted biomarker coverage laws.[14]

Several states have adopted additional policies and strategies to encourage biomarker testing uptake. For example, in May 2026, the Illinois legislature passed Senate Bill 3509 to strengthen the state's existing biomarker law by updating key definitions, ensuring coverage for evidence-based testing options, and increasing transparency in insurer coverage decisions and utilization management practices to promote more equitable access.[15] California[16] and Texas[17] have also sought to reduce administrative barriers within their Medicaid programs by establishing processes to request coverage for additional biomarker tests. In addition, insurance commissioners in states such as Arizona,[18] Georgia,[19] Illinois,[20] Kentucky,[21] Louisiana,[22] and Oklahoma[23] have issued insurance guidance bullets to clarify coverage requirements and promote more consistent implementation. These efforts highlight the significant potential of biomarker coverage laws, while also demonstrating that complementary policies and administrative/regulatory actions post enactment may be necessary to ensure broad and equitable access to biomarker testing.[§]

State Action to Improve Biomarker Testing Implementation

States	Strategy	Actions
Illinois[15]	Make access more equitable	Updated key definitions in biomarker laws related to coverage and insurer transparency.
Indiana[24]	Identify required procedure codes	Issued a guidance bulletin outlining procedure codes that meet the criteria for coverage.
California and Texas[16, 17]	Reduce administrative barriers	Established processes to request coverage for additional biomarker tests within Medicaid.
Arizona[20]	Highlight instances of non-compliance	Issued a guidance bulletin providing examples of denied coverage for biomarker testing and clarifying requirements.
Georgia[19]	Identify required coverage categories	Issued a guidance bulletin including a non-exhaustive list of tests and categories that meet the coverage threshold.
Kentucky[21]	Support enforcement of coverage requirements	Issued a guidance bulletin clarifying and reinforcing biomarker coverage law requirements, including that insurers do not have discretion to require additional or different coverage criteria, such as prior authorization requirements.
Louisiana and Oklahoma[22, 23]	Clarify coverage criteria	Issued guidance bulletins clarifying the interpretation of the law and defining the coverage threshold.

[§] In the Notice of Benefit and Payment Parameters (NBPP) for plan year (PY) 2027 Final Rule, CMS finalized a policy requiring states to defray the cost of state-mandated benefits in certain situations. As states assess the implications of this policy for existing biomarker testing coverage requirements, ACS CAN urges policymakers to recognize the importance of maintaining access to biomarker testing for patients for whom it may benefit.

Policy Recommendations

Advancements in biomarker testing have transformed cancer treatment, improving survival and quality of life by connecting patients with the therapies most likely to benefit them. Coverage of this testing is an essential step towards patients accessing precision treatments. ACS CAN supports policies to expand insurance coverage of comprehensive biomarker testing. ACS CAN recommends that:

- In states without biomarker coverage laws, state policymakers enact comprehensive legislation** that would require Medicaid and state-regulated private plans to cover evidence-based biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, with coverage requirements that keep pace with scientific advancements.
- In states with biomarker coverage laws, state regulators work with interested stakeholders (providers, insurers, and patient groups) to ensure ongoing compliance with the legislation and to eliminate any barriers to coverage.
- States work with provider organizations to develop and disseminate provider education tools to support awareness of biomarker coverage requirements and facilitate ordering and appeals.
- Insurance commissioners in states with existing biomarker laws issue bulletins and issue ongoing guidance to promote uniformity in the application of required biomarker test coverage, facilitate necessary oversight, and conduct outreach to plans to ensure ongoing compliance.
- State insurance commissioners and Medicaid directors monitor implementation and investigate appeals of denied claims as well as lab and provider complaints.

** See Mississippi's law for an example of comprehensive legislation: https://billstatus.ls.state.ms.us/documents/2026/pdf/HB/0500-0599/HB0565SG.pdf

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State-mandated benefits and ACA defrayal obligations

Héctor Hernández-Delgado and Wayne Turner

States have historically addressed gaps in health care coverage by requiring insurers to cover specific benefits. However, under the Affordable Care Act (ACA), states must defray the cost of newly enacted state benefit mandates that apply to Qualified Health Plans (QHPs), the subsidized health coverage sold through the ACA's Marketplaces. State mandated benefits established since December 31, 2011, are considered in addition to the ACA's ten essential health benefits (EHB) and may be subject to defrayal.

Although defrayal requirements have been in effect for well-over a decade, states continue to seek greater clarity from the Centers for Medicare & Medicaid Services (CMS) regarding what constitutes a new benefit mandate and when defrayal might be triggered. Recent CMS changes to defrayal regulations have only added to the confusion.[1]

This brief describes the regulatory framework governing the ACA's defrayal requirements, identifies key issues for state policymakers and advocates, and recommends ways to protect access to needed health care benefits and services that meet the needs of state residents.

1. The ACA, defrayal, and essential health benefits (EHB)

The ACA has made comprehensive health care coverage more affordable to millions. The ACA's Marketplaces allow individuals and families to purchase QHPs that meet federal standards for coverage and value. Low- and middle-income people may qualify for premium tax credits (PTCs) to lower monthly premiums, and cost sharing reductions (CSRs) to lower out-of-pocket costs. At the same time, the QHPs sold on the ACA Marketplaces must provide a

[1] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Final Rule*, 91 Fed. Reg. 29526 – 29877, 29864 (May 20, 2026), https://www.govinfo.gov/content/pkg/FR-2026-05-20/pdf/2026-10050.pdf (hereinafter "NBPP/2027 Final Rule").

comprehensive set of services in at least ten essential health benefit (EHB) categories.[2] Insurers may not impose annual or lifetime limits on services considered EHB, which are also subject to cost sharing caps.[3]

States may require QHPs to offer benefits in addition to EHB.[4] However, these additional required benefits may be subject to defrayal.[5] Specifically, the ACA states "A State shall make payments – (I) to an individual enrolled in a QHP offered in such State; or (II) on behalf of an individual described in subclause (I) directly to the QHP in which such individual is enrolled; to defray the cost of any additional benefits…"[6] Moreover, benefits provided by QHPs in addition to EHB, as well as additional benefits required by a state, must not be taken into account when determining PTCs or CSRs.[7]

CMS first established regulations implementing the ACA's defrayal requirement in 2013.[8] CMS has made several changes to defrayal rules, most significantly in the 2027 Notice of Benefit and Payment Parameters Final Rule (discussed in Section 3 below). However, the basic defrayal framework has remained largely consistent.

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[2] 42 U.S.C. § 300gg-6(a); 42 U.S.C. § 18022(a)(2). The ten EHB categories are: (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; and (10) Pediatric services, including oral and vision care. In addition to QHPs, EHB coverage standards also apply to non-grandfathered individual and small group plans.
[3] 42 U.S.C §§ 300gg-6(b); *id*. § 18022(c). Note, EHB cost sharing protections apply to large employer plans not subject to EHB coverage standards.
[4] 42 U.S.C. § 18031(d)(3)(A); 45 C.F.R. § 155.170(a)(1).
[5] 42 U.S.C. § 18031(d)(3)(B); 45 C.F.R. § 155.170(a)(2).
[6] 42 U.S.C. § 18031(d)(3)(B)(ii).
[7] 26 U.S.C. § 36B(b)(3)(D); 42 U.S.C § 18071(c)(4). The premium that QHP issuers report as attributable to EHB is commonly referred to as the ''EHB percent of premium." Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans Final Rule*, 85 Fed. Reg. 29164 - 29261, 29219 (May 14, 2020, https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf (hereinafter NBPP/2021).
[8] Dept. of Health & Human Srvs., *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule*, 78 Fed. Reg. 12834 – 12872 (Feb. 25, 2013), https://www.govinfo.gov/content/pkg/FR-2013-02-25/pdf/2013-04084.pdf (hereinafter "EHB Standards Final Rule")(*codified at* 45 C.F.R. § 155.170).

a. Defrayal required for newly enacted state-mandated benefits

Benefits required by state action after December 31, 2011, are considered in addition to EHB and may be subject to defrayal.[9] States must calculate the cost of additional required benefits according to accepted actuarial principles and methodologies, conducted by a member of the American Academy of Actuaries.[10] The calculation of the additional benefits' costs must be done prospectively, to "allow for the offset of an enrollee's share of premium and for purposes of calculating the premium tax credit and reduced cost sharing."[11] Federal regulations are silent as to whether defrayal payments may be made concurrently with premiums (*e.g.*, monthly), or retrospectively, based on actual claims data. States may opt to pay plan enrollees directly or the QHP issuer.[12] Finally, states, not CMS, are responsible for determining which state-required benefits are in addition to EHB and subject to defrayal.[13]

b. Certain benefit changes are not subject to defrayal

States may make certain benefit changes that are not subject to defrayal. For example, CMS regulations specify that benefits required for the purposes of compliance with federal requirements are considered EHB and not subject to defrayal.[14] These may include requirements to cover preventive services; requirements to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); and the removal of discriminatory age limits from existing benefits.[15]

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[9] 45 C.F.R. § 155.170(a)(1).
[10] 45 C.F.R. § 155.170(c)(2).
[11] EHB Standards Final Rule, 78 Fed. Reg 12838.
[12] 42 U.S.C. § 18031(d)(3)(B)(ii); 45 C.F.R. § 155.170(b).
[13] 45 C.F.R. § 155.170(a)(4). In 2020, HHS instituted an annual reporting requirement for state-mandated benefits requiring defrayal. NBPP/2021, 85 Fed Reg. 29164, 29261 (May 14, 2020), (added subsection (f) to § 156.111), https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf. CMS removed annual reporting in 2022, Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2023 Final Rule*, 87 Fed. Reg. 27208 , 27390 (May 6, 2022), https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf.
[14] 45 C.F.R. § 155.170(a)(1).
[15] NBPP/2021, 85 Fed Reg 29218. Note that QHPs and other plans offered by issuers receiving federal financial assistance are subject to the ACA's nondiscrimination protections under Section 1557 (42 U.S.C. § 18116; 45 C.F.R. § 92.207 (prohibiting "marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, disability, or any combination thereof, in health insurance coverage or other health-related coverage")). EHB prescription drugs and other benefits must also comply with EHB

Changes to cost-sharing or benefit delivery do not trigger defrayal. CMS defines "state-required benefits'' to include the care, treatment and services that an issuer must provide to its enrollees.[16] Other state requirements addressing benefit delivery method, including "state rules related to provider types, cost-sharing, or reimbursement methods would not fall under [CMS's] interpretation of state-required benefits" subject to defrayal.[17] For example, more that two dozen states have capped co-pays for insulin in state regulated plans, including QHPs.[18] These state requirements do not trigger defrayal.

c. Prescription drugs covered beyond benchmark minimums are considered EHB

Federal rules set minimum EHB coverage standards for prescription drugs. QHPs and other EHB plans must cover - one drug per US Pharmacopeia class and category, or the same number of drugs in each class and category as the state's EHB benchmark plan, whichever is

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nondiscrimination requirements (42 U.S.C. § 18022(b); 45 C.F.R. § 156.125 ("a non-discriminatory benefit design that provides EHB is one that is clinically-based")). *See also* Center for Consumer Information and Insurance Oversight (CCIIO), CMS, *2027 Final Letter to Issuers in the Federally-facilitated Exchanges* (May 2026), https://www.cms.gov/files/document/2027-final-letter-issuers.pdf (incorporating *2017 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 29, 2016) at 45, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2017-letter-to-issuers-2-29-16.pdf ("if an issuer does not cover a single-tablet drug regimen or extended-release product that is customarily prescribed for HIV patients and is just as effective as a multi-tablet regimen, absent an appropriate reason for the exclusion (such as a substantial difference in the cost of the two regimens), such a plan design might effectively discriminate against, or discourage enrollment by, such HIV patients would benefit from such innovative therapeutic options. As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost formulary tiers, that plan design might effectively discriminate against, or discourage enrollment by, individuals who have those conditions"); Dept. of Health & Human Srvs., Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg.10,822, 10,823 (Feb. 2027), https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

[16] EHB Standards Final Rule, 78 Fed Reg 12838. See also NBPP/2027, 91 Fed. Reg. 29587

[17] Dept. of Health & Human Srvs., *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70647 (Nov. 26, 2012), https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

[18] Rebecca Smith, et al., *Impact of state and federal insulin out-of-pocket cost caps on the type 1 diabetes population*, Milliman White Paper (Feb. 2026), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/3-16-26_Milliman_Breakthrough-T1D_Insulin-OOP-Cost-Paper.pdf.

greater.[19] CMS clarified that drugs covered in excess of the regulatory minimum are considered EHB, subject to ACA cost sharing and other protections.[20] These drugs would also not be subject to defrayal, unless states require coverage since December 31, 2011.[21]

d. What is a state action?

One area of significant confusion is what constitutes a state action for the purposes of defrayal. While CMS has provided some clarification in guidance and discussion in rulemaking, questions remain. For example, CMS clarified that state action can include legislation, regulations, guidance, or other actions.[22] CMS has further stated that "a law requiring coverage of a benefit passed by a state after December 31, 2011, is still a state-required benefit requiring defrayal even if the text of the law says otherwise."[23]

States have relied on assurances from CMS that benefits which have been added or improved through the EHB benchmarking process would not trigger defrayal. In a 2018 guidance, CMS expressly provided that benefits included in a new EHB benchmark plan would not be treated as state mandates and therefore would not be subject to defrayal under 45 C.F.R. § 155.170

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[19] 45 C.F.R § 156.122(a). In 2018, then CMS Administrator Seema Verma recommended imposing mandatory, nationwide caps on EHB prescription drug coverage. *See* Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Services, Memorandum to Sec, Azar, Dept. of Health and Human Servs., *Re: Key 2020 Payment Notice Issues, Policy #4 – Establishing a National Drug Count for the Essential Health Benefits Prescription Drug Benefit,* 14-18 (Aug. 29, 2018) (on file with NHeLP). Administrator Verma acknowledged that such cuts would result in significant harm to consumers where "[i]nsufficient coverage could cause conditions to worsen, which could cause public health problems (e.g., preventable spread of contagious diseases) and greater costs to the health care system." *Id*. at 16. Verma conceded that the proposal would make it harder for consumers to access the prescription drugs they need and would lead to adverse selection by insurers. *Id.* 16-18. Secretary Azar did not advance Verma's proposal.

[20] 45 C.F.R § 156.122(f).

[21] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program Final Rule,* , 89 Fed. Reg. 26218, 26410 (Apr. 15, 2024), https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf (hereinafter NBPP/2025).

[22] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2017 Final Rule*, 81 Fed. Reg. 12242 (Mar. 8, 2016), https://www.govinfo.gov/content/pkg/FR-2016-03-08/pdf/2016-04439.pdf.

[23] NBPP/2021, 85 Fed. Reg. 29219.

unless they were mandated after December 31, 2011 "through legislative or regulatory action separate from an EHB-benchmark plan selection process."[24]

However, CMS declined to codify this clarifying language in its most recent revision to regulations implementing defrayal (discussed further in Section 3 below).

e. CMS enforcement authority

Under federal rules, states have authority to determine what benefits, if any, are state-mandated benefits subject to ACA defrayal obligations.[25] However, CMS has previously noted that some states may not be complying with defrayal obligations.[26]

According to CMS:

> [I]f the Secretary determines that a state or Exchange has engaged in serious misconduct with respect to compliance with requirements under Title I of the PPACA, which includes the requirement that states defray the cost state benefit requirements in addition to EHB, HHS is authorized to rescind up to 1 percent of payments otherwise due to a state per year until corrective actions are taken by the state that are determined to be adequate by the Secretary.[27]

In response to the 2024 Government Accountability Office (GAO) review of CMS oversight of defrayal obligations, "HHS concluded that [it] would take a more targeted approach where HHS provides written guidance on how to assess State-required benefits paired with continued individualized technical assistance and outreach to States."[28]

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[24] Ctrs. for Medicare & Medicaid Servs, *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (Oct. 23, 2018), https://www.cms.gov/cciio/resources/fact-sheets-andfaqs/downloads/faq-defrayal-state-benefits.pdf (hereinafter "CMS FAQ").
[25] 45 C.F.R. § 155.170(a)(4).
[26] *See, e.g.*, NBPP/2021, 85 Fed Reg 29219 ("Due to state noncompliance with defrayal of state required benefits, issuers may be covering benefits as EHB that were required by state action after December 31, 2011, that actually require defrayal under federal requirements, but for which the state is not actively defraying costs.").
[27] NBPP/2021 85 Fed Reg 29223 (citing to 42 U.S.C. § 18033(a)(4)).
[28] GAO, *Health Insurance Marketplaces: CMS Has Limited Assurance That Premium Tax Credits Exclude Certain State Benefit Costs* (Dec. 4, 2024) at 12, https://www.gao.gov/products/gao-25-107220 (hereinafter "GAO Defrayal Report").

In the most recent rulemaking, CMS stated it is "continuing to evaluate our oversight of defrayal requirements."[29]

2. State operationalization of defrayal

CMS does not publish a list of states with defrayal obligations.[30] In its 2024 review, the GAO identified a handful of states, including Maine, Massachusetts, Minnesota, Montana, Utah, and Virginia with state-mandated benefits subject to defrayal.[31] For example, Minnesota defrays the cost of certain pediatric neuropsychiatric disorders.[32] Virginia requires coverage of pediatric hearing aids of up to $1,500 per hearing aid, per ear, every 24 months.[33] However, few states provide detail on how they implement defrayal.[34]

a. Utah's implementation of defrayal

Utah provides detailed information on its defrayal processes, established through the state rulemaking process. Utah has been defraying the cost of ABA therapy provided to children diagnosed with Autism Spectrum Disorder (ASD) since 2020. In March 2019, Utah passed S.B. 95, which expanded the coverage for the treatment of autism spectrum disorder that was provided in a 2014 bill.[35] The 2019 bill removed the age requirements and 600-hour service cap from Utah's mandated coverage for treatment of autism spectrum disorder and eliminated a provision that previously allowed the Insurance Commissioner to waive the additional

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[29] NBPP/2027 Final Rule, 91 Fed. Reg 29587.
[30] CMS acknowledged the "State Required Benefits" list appearing on its website with state EHB benchmark selections is not actively updated and reflects reports from 2015. NBPP/2021, 85 Fed. Reg. 29220.
[31] GAO Report at 5, note 28 *supra*. *See also* Maine Bureau of Insurance, *A Report to the Committee on Health Coverage, Insurance, and Financial Services 131st Maine Legislature Concerning LD 1539: An Act To Provide Access to Fertility Care* (Jan. 2023), https://legislature.maine.gov/doc/9670.
[32] MINN. LAWS 62A.3097 (2025). *See also* Ashley Setala, Health Policy Director, Minnesota Commerce Depart., Health Benefit Mandates, slide 20 (Feb. 26, 2025) (estimating $139,323 in defrayal costs since 2020), https://assets.senate.mn/committees/2025-2026/3118_Committee_on_Commerce_and_Consumer_Protection/2.27%20Commerce%20Benefit%20Mandate%20Presentation.pdf.
[33] VA CODE ANN. § 38.2-3418.21 (2026).
[34] See, *e.g.*,California Health Benefits Review Program, *Essential Health Benefits: Exceeding EHBs and the Defrayal Requirement*, at 3 (2023) (noting that information about defrayal and cost in Massachusetts is not publicly available), https://www.chbrp.org/sites/default/files/2023-08/EHB_Defrayal_FINAL.pdf.
[35] *See* S.B. 95, 63rd Leg., Gen. Sess. (Utah 2019).

coverage requirement for certain health benefit plans.[36] This bill applied only to those health benefit plans offered in the individual market or large group market that were entered into or renewed on or after January 1, 2020.[37]

A fiscal note filed with S.B. 95 projected that the bill could cost the state approximately $1.7 million annually.[38] The Utah Insurance Department estimated in 2019 the defrayal obligation could cost approximately from $1.8 to $2 million between 2020 and 2022.[39]

After S.B. 95 became law in May 2019, the Utah Insurance Department requested an opinion from the Utah Attorney General to determine if the ABA therapy coverage included in the bill was a State-Required Benefit that triggered the ACA defrayal requirement.[40] The opinion confirmed that the coverage did constitute a state-required benefit triggering ACA defrayal.[41]

In response, the Utah Office of Administrative Rules published a Notice of Proposed Rule on November 1, 2019, which created a defrayal process for Utah State-Required Benefits, particularly targeting the ABA therapy benefit.[42] The proposed rules took effect January 1, 2020.[43]

The Utah State-Required Benefits defrayal system relies on carriers identifying and reporting those claims that will be subject to defrayal, such that the Insurance Commissioner can accurately project defrayal costs.[44] The Utah Health Information Network (UHIN) Standards Committee published an updated ABA therapy billing standard for carriers to uniformly identify those claims subject to defrayal.[45] The Utah Insurance Department developed a standardized

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[36] *Id*.
[37] *Id.*
[38] *See* S.B. 95, 63rd Leg., Gen. Sess. (Utah 2019) (referencing attached Fiscal Note).
[39] Utah Insurance Department, Rule R590-283 Defrayal of State-Required Benefits, *Notice of Proposed Rule, Rule Analysis, Rule R590-283* (Nov. 1, 2019), https://rules.utah.gov/publicat/bulletin/2019/20191115/44181.htm.
[40] *See Utah 2020 Rates Individual and Small Group*, UTAH STATE LEG. (2019), slide 35, https://le.utah.gov/interim/2019/pdf/00004798.pdf (estimating annual defrayal cost of $1 to $2 million). Note the GAO reported that Utah's defrayal payments totaled $4.6 million annually in 2021 and 2022. See GAO Report at 11, note 28 *supra*.
[41] *See* Rule Analysis, note 39 *supra*.
[42] *See* 22 Utah Bull. DAR File No. 44181 (Nov. 15, 2019), UTAH ADMIN. CODE r. 590-283 *et seq.*
[43] UTAH ADMIN. CODE r. 590-283-9.
[44] *See id* at r. 590-283-6.
[45] *See* Utah Health Information Network Standards Committee, *Adaptive Behavior Services/Applied Behavior Analysis (ABA) Billing Standard V.3.1*, UTAH INSURANCE DEPT., https://insurance.utah.gov/wp-content/uploads/R590-283UHIN-ABABillingStandard-v3.1.pdf.

template for insurers to facilitate the reporting of state-required benefit claims subject to defrayal.[46]

Utah's regulatory framework allows for the Insurance Commissioner to audit both carrier's claims that are subject to defrayal and carrier's processes for determining which claims are subject to defrayal.[47] Those found to be in violation of the regulatory requirements laid out in U.A.C. R590-283 *et seq*. will be subject to penalties.[48]

b. Updating EHB benchmark plans and defrayal

To our knowledge, at least three states submitted EHB benchmark proposals by the May 7, 2025, submission deadline for changes to take effect by January 2027:

- Utah – behavioral health treatment for autism spectrum disorder;[49]
- California – fertility services, improved coverage of hearing aids and durable medical equipment including hearing aids;[50]
- Nevada – expanded coverage of HIV and hepatitis C treatments, as well as drugs approved for the treatment of, and withdrawal from, opioid use disorder.[51]

However, HHS confirmed that it is pausing review of states' applications to update their EHB benchmark plans.[52] State insurance regulators from California, Utah, and Nevada with pending

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[46] Defrayal of State Mandated Benefits Data Reporting Template, https://insurance.utah.gov/wp-content/uploads/283MandateDefrayalDataTemplate.xlsx (last visited Aug. 2, 2026).
[47] Utah Admin. Code. at r. 590-283-7, note 42 *supra*.
[48] *Id.* at r. 590-283-8.
[49] Utah Insurance Department, Proposed 2027 Utah Essential Health Benefit Plan (May 5, 2025), https://insurance.utah.gov/proposed-2027-utah-ehb-plan/
[50] California Dept. of Managed Health Care, *DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx.
[51] Nevada Div. of Insurance, *Plan Year 2027 Benchmark Plan Change Actuarial Report* (Feb. 11, 2025), https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare_Reform/Individuals_and_Families/Essential_Health_Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report(1).pdf
[52] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Proposed Rule*, 91 Fed. Reg. 6292, 6302 (Feb. 11, 2026), https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf: NBPP/2027 Final Rule, 91 Fed Reg 29584.

applications, as well as consumer advocacy organizations, harshly criticized HHS for its lack of action.[53] Each of these states invested considerable time and resources developing their EHB benchmark proposals. They solicited public input, conducted hearings, commissioned actuarial analyses, engaged in deliberative processes, and in some cases enacted enabling legislation, all while relying on the EHB benchmarking framework proposed by HHS nearly 15 years ago.[54]

More states were pursuing EHB benchmark updates, but HHS quashed those efforts by rescinding, without explanation, the EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, and the Expanding Access to Women's Health Grant last year.[55]

Utah and other states simply followed defrayal regulations and CMS' assurances that "starting in PY 2025, a State that is defraying the costs of a benefit required by a mandate that is in addition to EHB under § 155.170 will be permitted to cease defraying the costs of that benefit if the benefit is included in its EHB-benchmark plan or upon updating its EHB-benchmark plan in the future to include such benefit coverage."[56]

3. Changes to defrayal under the NBPP for 2027

The 2027/NBPP Final Rule included changes to federal regulations governing defrayal for state required benefits. However, the regulatory changes will likely prove burdensome and fail to clarify state defrayal obligations.

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[53] *See* Amy Lovten, *Stakeholders Push Admin to Restart Review of EHB Benchmark Plans*, Inside Health Policy (Apr. 22, 2026); Letter from NAIC Consumer Representatives to NAIC President Scott A. White, et al., *Re: Protecting state flexibility in Essential Health Benefits* (Apr. 2, 2026), https://docs.google.com/document/d/1LblVVLDMhDPut90af1XH5WJgbNr2aaJoQEY0mdLFeWM/edit?tab=t.0.

[54] Dept. of Health and Human Srvs., Ctr. for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (Dec. 16, 2011), https://www.cms.gov/cciio/resources/files/downloads/essential_health_benefits_bulletin.pdf.

[55] U.S. Dept. of Health and Human Srvs., Ctr for Medicare & Medicaid Srvs., *EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange*, CMS-2U2-25-001 (Feb. 14, 2025), https://www.grants.gov/search-results-detail/356740; U.S. Dept. of Health and Human Srvs., Ctr for Medicare & Medicaid Srvs., *Expanding Access to Women's Health Grant*, CMS-2R2-24-001 (Sep. 6, 2024), https://www.grants.gov/search-results-detail/354660.

[56] See NBPP/2025, 89 Fed Reg 26269 (codified at 45 C.F.R. § 155.170(a)(1)).

The NBPP/2027 Final Rule amends 45 C.F.R. § 155.170(a) to provide that any state-required benefit will be considered "in addition to EHB" and subject to defrayal if, beginning in Plan Year 2028, the benefit is:

1) required by state action taking place after December 31, 2011,
2) applicable to small group and/or individual markets,
3) specific to required care, treatment, or services, and
4) not required by state action to comply with federal requirements.[57]

Some of the benefits in a state's EHB benchmark plan, including benefits that have been added or improved via the EHB benchmarking process, could be subject to defrayal in 2028 if CMS later identifies the benefit is as a state-mandate.

In the preamble to the NBPP/2027 Final Rule, CMS suggests that states may repeal required benefits to avoid defrayal obligations: "if a State repeals the underlying State action that requires a benefit, that benefit would no longer be considered a State-required benefit for purposes of § 155.170, and the State would not be required to defray its cost even if that benefit remains in the State's EHB benchmark plan."[58] Conceivably, a benefit could still be covered through the state's EHB benchmark plan even if a state repealed the benefit mandate. However, this assurance does little to help Utah and other states with pending EHB benchmark updates.

However, the NBPP/2027 Final Rule is less clear regarding what exactly constitutes a state mandate subject to defrayal. According to CMS, "[a]s finalized, any State required benefit that fulfills the four conjunctive elements at § 155.170(a)(2)(i) through (iv) would require defrayal, regardless of whether the benefit is included in the State's EHB-benchmark plan."[59]

CMS has previously said that state actions could include legislation, regulations, or some other sort of action.[60] Some states have issued bulletins or promulgated regulations requiring coverage of certain benefits pursuant to the state's EHB benchmark plan.[61] State regulations and other administrative actions implementing EHB, including legislation requiring updates to benchmark plans, could conceivably fall within CMS' definition of a state required mandate under revised § 155.170(a)(2)(i) through (iv), potentially subjecting the state to defrayal under the plain meaning of the regulatory text. Some states have enacted legislation requiring

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[57] NBPP/2027 Final Rule, 91 Fed. Reg. 29864 (codified at 45 C.F.R. § 155.170(a)(2).
[58] NBPP/2027 Final Rule, 91 Fed. Reg. 29586 ("States with benefit mandates that duplicate benefits included in the State's EHB-benchmark plan and that seek to avoid a defrayal obligation may repeal the applicable State requirement.").
[59] NBPP/2027 Final Rule, 91 Fed. Reg. 29583.
[60] NBPP/2017, 81 Fed. Reg. 12242.
[61] *See, e.g.*, 3 CCR 702-4-2-42-5.

agencies to add certain benefits through benchmarking. It is unclear if those states would need to repeal such statutes to avoid defrayal.

In its 2018 FAQ on defrayal, CMS made clear that benefits provided as part of the EHB benchmarking process would not be treated as state mandates and therefore would not be subject to defrayal, unless they were mandated after December 31, 2011 "*through legislative or regulatory action separate from an EHB-benchmark plan selection process*."[62] Commenters urged CMS to include such language in the NBPP/2027 Final Rule, including the National Association of Insurance Commissioners, which stated that "HHS should explicitly clarify that state selection of an EHB benchmark plan does not constitute 'state action' to mandate benefits."[63] However, CMS declined to include such language in the regulatory text.[64]

CMS suggests that states need not repeal a state mandate *in toto*, but could repeal a mandate as it applies to QHPs: "States with benefit mandates that duplicate benefits included in the State's EHB-benchmark plan and that seek to avoid a defrayal obligation may repeal the applicable State requirement, such that the benefit continues to be covered as EHB under the EHB benchmark plan or otherwise limit the applicability of the requirement for QHPs."[65]

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[62] CMS FAQ, at 1 (emphasis added), note 24 *supra*.
[63] National Association of Insurance Commissioners, Comments on Notice of Benefit and Payment Parameters for 2027 Proposed Rule, at 3 (March 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0812. *See also* Attorneys General from California, et al., Comments on Proposed Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, at 18 (March 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0797; Nat'l. Health Law Prog., Comments, Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Proposed Rule Proposed Rule, at 5 *March 12, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0615.
[64] CMS noted concerns raised by commenters, stating "a State's selection or update of an EHB benchmark plan under § 156.111 does not constitute a ''State action'' for purposes of defrayal and, by itself, cannot trigger a defrayal obligation. Instead, for purposes of § 155.170, ''State action'' refers to a State statute, regulation, guidance, or other requirement, separate from the State's selection or update of its EHB benchmark plan, that requires QHPs to cover a benefit that is in addition to EHB." NBPP/2027 Final Rule, 91 Fed. Reg. 29586.
[65] NBPP/2027 Final Rule, 91 Fed. Reg. 29586-29587. In footnote 120, CMS notes that imposing benefit mandates depending on a plan's status as a QHP or whether it is sold through the Exchange may violate ACA section 1252 (42 U.S.C. § 18012). The statutory text suggests that states could not impose requirements on QHPs that do not otherwise apply in the individual (or small group) market; but could remove coverage requirements from QHPs (which are subject to defrayal) while retaining them for other plans sold in the individual and small group markets.

CMS delayed the effective date for this new defrayal rule from 2027, as proposed, to 2028. CMS acknowledged "that providing States enough time to plan for and effectuate the new defrayal requirements is necessary."[66]

CMS also said that it "intends to continue to engage with States and provide technical assistance as needed to ensure States understand when a State-benefit requirement is in addition to EHB and requires defrayal.[67]

Recommendations for states

States should work to protect access to needed health care services and refrain from prematurely repealing current laws and regulations. Instead, states may seek clarifying guidance from CMS on the meaning of "state action" that would trigger defrayal obligations. State insurance commissioners and other officials should also press CMS to move forward with pending EHB benchmark update proposals.

States may not need to repeal mandates outright. Some states are considering legislative proposals granting regulator authority to temporarily suspend, rather than repeal, laws or regulations requiring benefits. Such proposals should be narrowly tailored to benefits that could be subject to defrayal and limited in applicability to QHPs, and not the broader individual and small group market (to which defrayal requirements do not apply). States should also include checks on administrative authority to suspend legislative requirements, such as a sunset provision, or otherwise tie benefit suspension federal defrayal requirements currently in effect (*e.g.*, the federal rule's effective date, a court injunction, etc.).

State mandated benefits remain an important tool to address urgent health care needs, particularly since HHS has declined to move forward with EHB benchmark updates. State officials should work with consumer groups and members of the state's congressional delegation to ensure access to medically necessary care and preserve hard fought-for consumer protections and affordability measures.

[66] NBPP/2027 Final Rule, 91 Fed. Reg. 29583.
[67] NBPP/2027 Final Rule, 91 Fed. Reg. 29587.

Marketplace Open Enrollment Outlook

Supplemental Materials

[Potential Settlement In Data Marketing Partnership Could Leave More Consumers Exposed to Skimpy Coverage] – **Georgetown Center on Health Insurance Reforms**

[A Former TV Writer Found a Health-Care Loophole That Threatens to Blow Up Obamacare] - **Bloomberg**

CLAIRE HEYISON & LUCY CULP

Ceres' New TCFD Analysis Report

www.ceres.org/insurance

IMSA

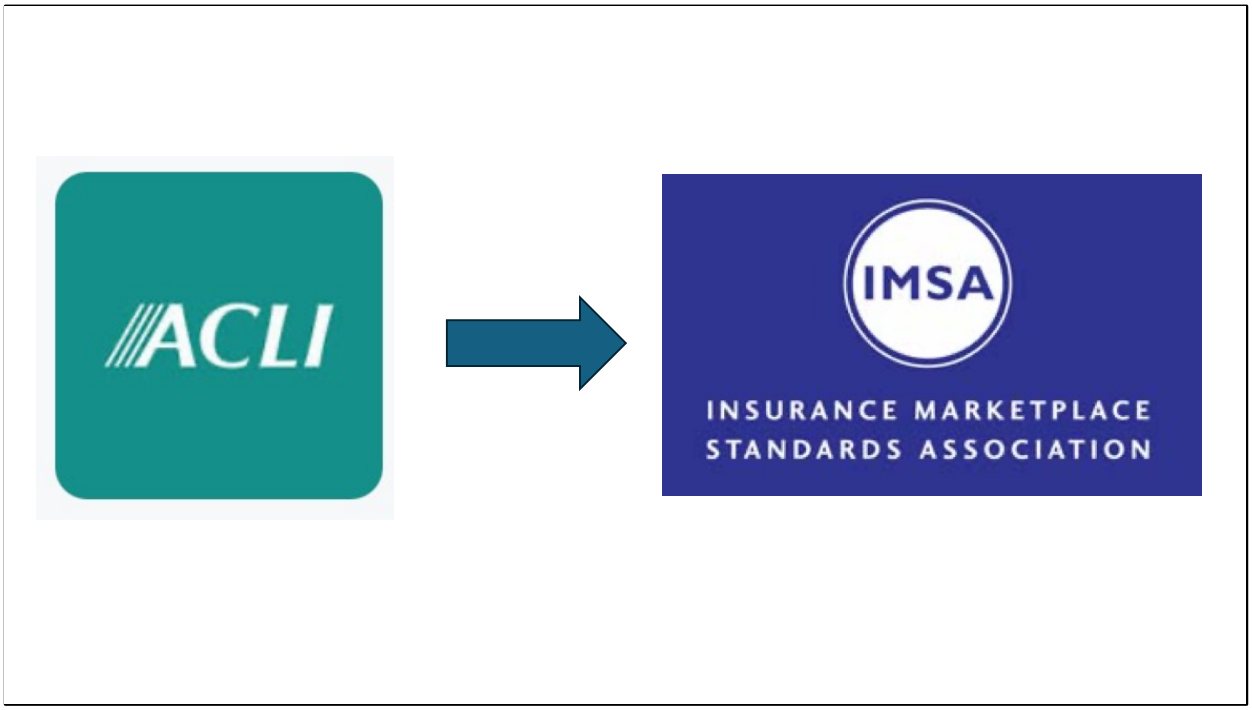
Insurance Marketplace Standards Association

Strengthening Oversight: The Critical Role of Ethical Standards in Market Conduct Examinations

Richard M. Weber, MBA, CLU, AEP
NAIC Consumer Representative
Life Insurance Consumer Advocacy Center

The Insurance Marketplace Standards Association – and the principles it promoted – can strengthen regulatory oversight. I call it "The Critical Role of Ethical Standards in Market Conduct Examinations."

Inspiring IMSA in the mid-1990s were a number of issues negatively affecting the life and annuity industry: To name just two: More than a dozen class action lawsuits against major carriers for Vanishing Premium UL policy illustrations – and the bad publicity around nurses in Florida being offered free medical exams without being told they were applying for life insurance policies.



The ACLI helped create IMSA, and it became independent in 1997.

The virtues of IMSA were proclaimed to the National Organization of Life & Health Insurance Guaranty Associations – NOLHGA – in a presentation at its 2004 National Meeting.

The IMSA Principles of Ethical Market Conduct

Each life insurance company subscribing to these Principles commits itself in all matters affecting the sale of individually sold life and annuity products …

The IMSA Principles of Ethical Market Conduct were created to influence ethical market conduct in all matters affecting the sale of individually sold life and annuity products.

The IMSA Principles of Ethical Market Conduct

1. To conduct business according to high standards of honest and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself.

The first Principle is often recognized as the Golden Rule.

The IMSA Principles of Ethical Market Conduct

2. To provide competent and customer-focused sales and service.

Customer-focused sales and service.

The IMSA Principles of Ethical Market Conduct

3. To engage in active and fair competition.

Engage in active and fair competition.

The IMSA Principles of Ethical Market Conduct

4. To provide advertising and sales materials that are clear as to purpose and honest and fair as to content.

Provide advertising and sales materials that are clear as to purpose and honest and fair as to content.

The IMSA Principles of Ethical Market Conduct

5. To provide for fair and expeditious handling of customer complaints and disputes.

Provide for fair and expeditious handling of customer complaints and disputes.

The IMSA Principles of Ethical Market Conduct

6. To maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct.

Maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct.

The MISSING IMSA Principle

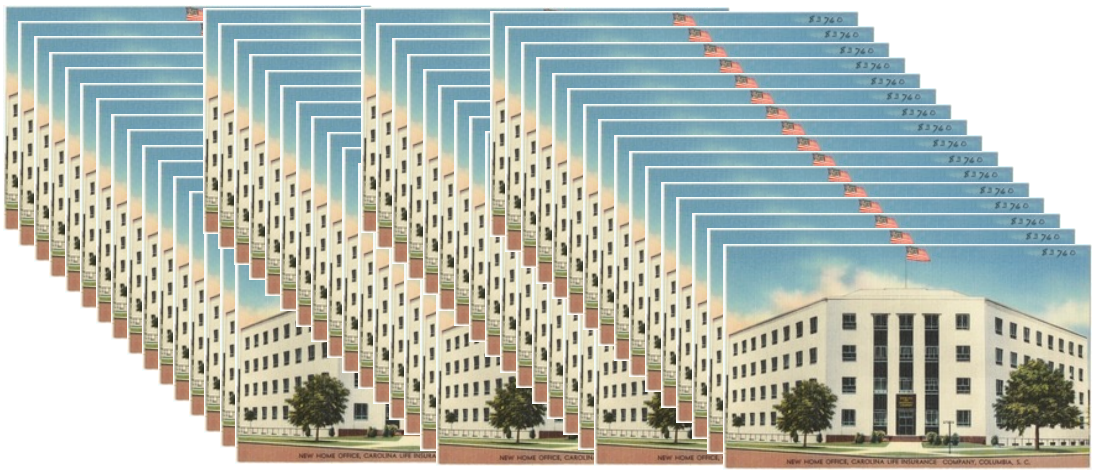
7. Marketplaces cannot be truly and fairly competitive without transparency. Consumers care about the market conduct performance of the insurers they do business with. Price is important, but not more so than trust and transparency.

TRANSPARENCY

AND the MISSING principle: The life and annuity marketplaces cannot be truly and fairly competitive without transparency. Consumers care about the market conduct performance of the insurers they do business with. Price is important, but not more so than trust and transparency.

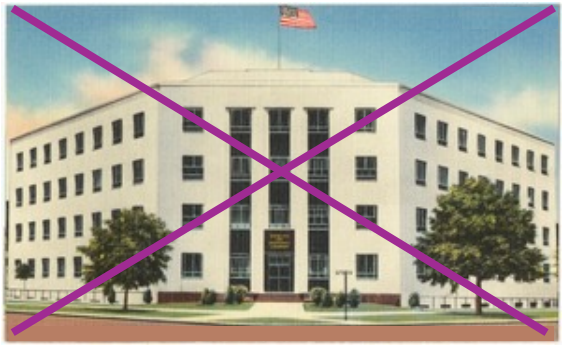
First 3-year Membership Cohort (1998-2000)

219 U.S. Carriers



219 carriers, including many of the largest, agreed to join IMSA, investing substantial dollars and personnel resources to develop the Processes and Procedures that would support the Principles.

But by 2010 …



But, despite initial carrier enthusiasm, the cost of creating those processes and procedures to support the 6 Principles eventually led to fewer and fewer membership renewals. Along with some internal issues within the IMSA organization itself, IMSA ceased to exist by 2010.

A concept whose time has come back?

My belief as a Consumer Representative is that IMSA's Principles of Ethical Market Conduct are a concept whose time has come BACK!

A concept whose time has come back?

- Consumer satisfaction is graded “C” at best (J.D. Power, 2025)

Consider: Consumer satisfaction with insurance in general only reached a “grade” of 700 out of 1000 by polled consumers – a grade of “C” - at best! (J.D. Power, 2025)

A concept whose time has come back?

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- 90% of agents fail in the first 4 years (A.M. Best)

90% of recruited life insurance agents fail in their first 4 years. (A.M. Best)

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"Most life policies fail to terminate as a death benefit" ("Lapse-Based Insurance" by Daniel Gottlieb and Kent Smetters, June 6, 2016)

From "Lapse-Based Insurance"

> "These annualized rates [of lapse] lead to substantial lapsing over the multi-year life of the policies. About $30.8 trillion of new individual life insurance coverage was issued in the United States between 1990 and 2010 (ACLI, 2015), and around $24 trillion of in-force coverage was dropped during this same period.

“… almost 25% of *permanent* insurance policyholders lapse within just three years of first purchasing the policies; within 10 years, 40% have lapsed. According to Milliam USA (2004), almost 85% of term policies fail to pay a death claim; nearly 88% of universal life policies ultimately do not terminate with a death benefit claim.”

“In fact, 74% of term policies and 76% of universal life policies sold to seniors at age 65 never pay a claim.”

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37 demutualizations (1990 to early 2000s) resulted in more shareholder than policyholder focus. From "The Feeling Was De-Mutual" in the "Retirement Income Journal," July 2026 by Kerry Pechter, the 37 carriers were:

The Demutualization Wave of the 1990s and 2000s	
Life Insurance Company (Year of Demutualization)	
Acacia Mutual (1997)	Midland Life (1994)
American Mutual (1996)	Minnesota Mutual Life (1998)
AmerUS Life (1997)	Mutual of New York (1998)
American United (2000)	Mutual Life of Canada (2000)
Ameritas (1997)	Mutual Service Life (2005)
Canada Life Assurance (1999)	National Travelers (2000)
Central Life Assurance (2000)	Nationwide Life (1997)
Equitable Life (1992)	Northwestern National (1989)
General American (2000)	Ohio National (1998)
Guarantee Mutual Life (1995)	Phoenix Home Life (2001)
Indianapolis Life (2001)	Principal Mutual (2001)
Industrial-Alliance (Canada) (1999)	Provident Mutual (2002)
John Hancock (2000)	Prudential (2001)
Lafayette Life (2000)	Security Mutual of Nebraska (1999)
Manufacturers Life (1999)	Standard Insurance (1999)
Metropolitan Life (2000)	State Mutual Life (1995)
Lafayette Life (2000)	Sun Life of Canada (2000)
Manufacturers Life (1999)	Union Mutual (UNUM) (2000)
	Western & Southern Life (2000)
Sources: Roger A. McEowen, "Tax Impact of Demutualization –The Saga Continues," Iowa State University Center for Agricultural Law and Taxation, August 11, 2008. Lal C. Chugh and Joseph W. Meador, "Demutualization in the Life Insurance Industry: A Study of Effectiveness," Financial Services Forum, College of Management, University of Massachusetts-Boston, November 2006.	

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- New and complex investments
- De-mutualization: shareholder vs policyholder focus
- 25% of consumers buy life/annuities "online" (market.us)

More consumers are buying "online" – but little service or "human" value-add. "Hybrid" shopping is becoming a big thing – researching insurance/annuity issues online, with 75% buying from an agent – but 25% buying online – and online buying is increasing. (www.market.us)

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- Decline in life insurance ownership – just 50% of U.S. households (rfi.global)

Over the last 20 years, household life insurance has declined to just 50% ownership. Combined with the move away from death benefits toward a focus on living tax benefits (even in the "middle market"), what was once a vital safety net for American families is moving in the wrong direction. Not only is this perilous for families who lose income due to disability or premature death – but it adds to the pressure on the economy's social support structure. (**RFI.global** "How shifting US household dynamics are redefining life insurance).

Specific Ask

- Establish a Working Group to reconcile the needs and concerns of the various constituents to an updated, NAIC-based IMSA – to include carriers, regulators, and CONSUMERS

My specific “ask”

Establish a Working Group to reconcile the needs and concerns of the various constituents to an updated, NAIC-based IMSA – to include carriers, regulators, and CONSUMERS (or at least Consumer Representatives to the NAIC!)

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- Establish a Working Group to reconcile the needs and concerns of the various constituents to an updated, NAIC-based IMSA – to include carriers, regulators, and CONSUMERS
- Reformat and define the SEVEN principles

Reformat and define the SEVEN principles

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- Create an IMSA-like component to the introduction of the Market Conduct Examiner's Handbook as a helpful starting point for new market conduct regulators.

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IMSA

Insurance Marketplace Standards Association

Strengthening Oversight: The Critical Role of Ethical Standards in Market Conduct Examinations

Richard M. Weber, MBA, CLU, AEP
NAIC Consumer Representative
Life Insurance Consumer Advocacy Center

Waiting for the Light to Shine

(Big River)

Richard M. Weber, MBA, CLU

NALU, CLU, MDRT, GAMA, AALU, NAIC, LOMA, LIMRA, LIFE, LUTC, IMSA. What does this list have in common? Most readers know the answer: they're all acronyms for life insurance industry organizations. The translation of this alphabet soup will be very familiar to most agents - except, perhaps, that last one. IMSA stands for the Insurance Marketplace Standards Association, and relatively speaking is the new kid on the block.

In the last 10 years or so, the image of the life insurance industry has been adversely affected by under-performing policies (relative to their sales illustrations), under-performing (and sometimes failing) carriers, and over-enthusiastic sales presentations that failed to mention that the product/service being sold was life insurance. IMSA is a direct result of ACLI (there go those initials again) efforts to help the carriers and the industry regain an image of ethical conduct on behalf of the carriers (and hopefully for the employees and agents who provide policies and services to the general public.)

Originally likened to the "Good Housekeeping Seal of Approval," broad certification of compliance with IMSA's *Life Insurance Ethical Market Conduct Program* is hoped to be the key to public and financial press acceptance, and therefore represents a new standard of performance. "How are your ratings?" and "Are you IMSA Certified?" could have equal weight in the eyes of an agent who is evaluating possible carrier engagements. It might even become such an evaluation criterion for consumers and advisers.

Certification of compliance to IMSA's *Life Insurance Ethical Market Conduct Program* is now being sought by most major insurance companies, but no company will be allowed to announce its certification before April 1, 1998 This allows companies the time to conduct the appropriate self-assessments and independent assessments while at the same time prevent trivialization of the process through a race to be "Number One." In fact, it's possible that as many as 50 - 100 life insurance companies may be able to simultaneously announce their successful attainment of certification 7 months from now.

What's it all about

In its preamble to assessment, IMSA is defined as follows:

> "The Life Insurance Ethical Market Conduct Program of the Insurance Marketplace Standards Association (IMSA) seeks to encourage and assist participating companies in designing and implementing sales and marketing procedures that benefit and protect the consumer. The assessment process is intended to encourage and assist insurers continually to review and modify their policies and procedures in order to improve their

> market conduct practices and those of the industry. By promoting collective performance improvement, the Program aims to strengthen consumer confidence in the life insurance business. The current Market Conduct Program applies to individually-sold life insurance and annuity products."

A carrier who chooses to participate in the program (this process is voluntary) must adopt the Principles and Code (see sidebar) and then proceed with a two-step assessment process. In Step #1, the company will conduct a self-assessment using an IMSA-provided questionnaire and handbook. Typically, insurer CEOs are assigning overall responsibility for IMSA certification to an officer-level employee who then assembles a cross-departmental team. Once the team is convinced that it can say "YES" to the 27 major areas of self-examined processes, Step 2 involves engaging an IMSA-trained and certified Independent Assessor, who reviews the company's self-assessment and independently confirms or denies the affirmative responses to the Principle's questions. Certification is only awarded when 100% of the responses are "YES."

With the satisfactory completion of a life insurance company's self-assessment *and* independent assessment - and the appropriate application - IMSA will confer membership for a period of 3 years. The carrier must re-assess and re-apply every 3 years after initial membership has been granted.

As you will see when we review the questions themselves, they are broadly worded process questions. It's especially important to understand that the assessment doesn't evaluate whether the processes are the *most* effective that the carrier could have created, but simply that such processes are addressed, are deployed, and are monitored.

What's it to you?

Since this "seal of approval" is a carrier process and since many major companies are going to go through *whatever it takes* to announce on April 1, 1998 that it is so certified, is there any reason for agents to understand this process?

Similar to the informal IMSA theme of "getting to yes": YES! Agents need to be aware of the process because new standards of sales practice and market conduct will likely be imposed on agents. What you do and how you do it is about to enter into a new realm of scrutiny, and it's important that agents understand what's being asked of them. It's also important to know if you'll be able to make a living -or- be able to continue doing what you do and how you've been doing it!

In the next few months, we will look at the Elements of Compliance, including a review of the 27 questions in the IMSA Questionnaire and how each question is broadened into three aspects: Approach, Deployment, and Monitoring. In total, 162 responses are the result of this process, and all responses must be YES in order to achieve certification.

The IMSA Principles of Ethical Market Conduct

Each life insurance company subscribing to these principles commits itself in all matters affecting the sale of individually-sold life and annuity products:

1. To conduct business according to high standards of honest and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself.

2. To provide competent and customer-focused sales and service.

3. To engage in active and fair competition.

4. To provide advertising and sales materials that are clear as to purpose and honest and fair as to content.

5. To provide for fair and expeditious handling of customer complaints and disputes.

6. To maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct.

Rhythm of Life

(Sweet Charity)

As discussed last month, certification of compliance to the Insurance Marketplace Standards Association's *Life Insurance Ethical Market Conduct Program* is now being sought by many major insurance companies. While no company is allowed to announce its certification before April 1, 1998, these companies are now actively completing a self-assessment to determine if it meets IMSA's requirements. Following self-assessment is an independent confirmation as a prelude to achieving certification from IMSA.

CONCEPT OF ASSESSMENT

There are 27 primary "questions" supporting the 6 Principals involved in the IMSA certification process. With respect to each of these questions, there are three "aspects" that the carrier's self-assessors and independent assessors must take into account: Approach, Deployment, and Monitoring. Each of these aspects has two additional questions to clarify a YES or NO to the primary question. (See Sidebar) All told, with the 6 additional questions associated with the aspects of the 27 primary questions, there are a total of 162 YES responses required for IMSA certification.

Further, there are specific indicators associated with each aspect of each of the 27 questions. Not all indicators apply to all situations or all carrier processes (fortunately, the assessment does not have to get to YES on all the indicators: in total, there are 373 of them!) With the exception of those indicators that explicitly address the establishment of, responsibility for, communication and monitoring of policies and procedures, no single indicator is essential. What is essential is that some appropriate indicator(s) support the three aspects of each question.

To answer "yes" to a question, an insurer must be able to provide evidence that supports each of the six components under the three aspects of the question. If any component is not adequately demonstrated, a "no" answer would result. For example, an insurer may have extensive evidence of policies and procedures in place for the approval of sales and marketing materials, such as procedures manuals and communication strategies, as well as have designated someone to be responsible for the policies and procedures. However, unless the insurer can also provide evidence that use by distributors of sales and marketing materials is routinely monitored (for example, through a periodic review process) and that it results in follow-up action, all aspects of the question will not have been addressed. The result would therefore be a "NO" answer to the question, and a failure to receive IMSA certification until the failing aspect has been re-addressed and a YES can be achieved.

ASPECTS

1. Approach

- Does the insurer have in place policies and procedures that address the objective of the question?

- Is someone (individual or team) responsible for establishing, maintaining, communicating, deploying, and monitoring these policies and procedures?

Every aspect of every question has two components to be addressed. Under Approach, the first component determines if those policies and procedures have been adopted. It's noteworthy that the independent assessor is not forming an opinion on their operating effectiveness, but merely if they've been adopted.

2. Deployment

- Are these policies and procedures communicated?

- Does the insurer consistently use these policies and procedures?

It is not sufficient to affirm that policies and procedures are used; there must be evidence of consistency (but again note: *effectiveness* is not measured). For example, to determine whether advertising approval guidelines are consistently used, the carrier's own assessment team - and the independent assessor - should look at each line of business or product line covered by the Ethical Code of IMSA.

3. Monitoring

- Does the insurer routinely monitor the operation of these policies and procedures with a view toward achieving the intended result?

- Does the insurer act upon the information received?

The assessors would verify that the insurer routinely obtains information to identify, investigate, and resolve deviations from the expected and to identify whether the deviation is anomalous or systemic. Further, the assessors would also address how the information is gathered, in order to determine whether it is likely to be reliable and complete.

The insurer must also act upon the information received. The assessors should evaluate whether the insurer does take appropriate action on information obtained from the monitoring process to correct deviations and reduce the probability of future deviations.

In order to be able to answer "yes" to the Monitoring aspect of the question, it is essential that the insurer take appropriate corrective or follow-up action when information indicates necessary improvements or potential problems in the implementation or operation of policies and procedures. There should be clear documentation of actions taken in response to information received through the monitoring of market conduct activities.

PROCESS

It's important to understand the practical realities of the IMSA process: as previously indicated, the assessment is not designed to judge the quality or effectiveness of the various processes and procedures; this is beyond the scope of what was intended for certification. On the other hand, it would be expected that insurance companies who are pursuing certification are doing so for reasons beyond the PR value of declaring their "Good Housekeeping Seal of Approval" April 1, 1998. Presumably the *spirit* of the Ethical Code is as important as the *letter* of the Code, and it is here that carriers will hopefully add quality and effectiveness studies of their own.

Also, the assessments can only provide reasonable assurance to management that its objectives will be achieved. Breakdowns in these systems can occur as a result of unintentional behavior or even individual misconduct. This could include simple error or mistake, faulty judgment, fraud or collusion. Of course, there should be additional processes in place that would catch errors and mistakes, whether those are unintentional or malicious.

PRINCIPAL #1

The first of the Principals of IMSA Ethical Market Conduct is "To conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself." In support of that objective, there are 5 questions:

> **Question 1.1** Does the company have policies and procedures that are designed to reasonably assure determination of customers' insurable needs or financial objectives in the marketing and sales of its individually-sold life and annuity products?
>
> **Question 1.2** Does the company encourage its distributors to use fact-finding tools for determining customers' insurable needs or financial objectives in the marketing and sale of individually-sold life and annuity products?
>
> **Question 1.3** Does the company have in place policies and procedures designed to reasonably assure compliance with laws and regulations applicable to the marketing and sale of individually-sold life insurance and annuity products?
>
> **Question 1.4** Does the company, in a way appropriate to its size, participate in activities that support the enhancement of life insurance industry ethical market conduct practices?

Question 1.5 Has the company adopted and distributed to employees and distributors a written statement which includes full support for the concepts in the Principles and Code?

Readers may recognize this first Principal as derived from the Golden Rule, and its variation incorporated in the American Society of CLU & ChFC's Ethical Pledge. Each of these 5 questions in support of the Principal is the minimum of what we agents would expect of ourselves, our peers, and our insurance companies. Included in these questions are "feel good" affirmations of ethical conduct and intention, as well as some specific requirements that the company has put into place procedures and processes for agents to ascertain the customer's needs. Next month, as we continue to review the 27 questions in support of the 6 Principals of Ethical Market Conduct, we'll see how the processes and procedures suggest, among other things, the need for agents to ascertain product suitability based on specific client circumstances.

Summary of IMSA Aspects

The following table summarizes the guidelines for assessing the policies and procedures bearing on the three aspects of each question:

Approach	• Relevant to question by seeking to achieve its objectives. • Sufficient time elapsed to demonstrate operation. • Responsibility assigned (for all aspects of question).
Deployment	• Communicated. • Consistently used (across distribution channels and product lines covered by Code). • Sufficient time elapsed to demonstrate consistent use. • Scope sufficient, with no major gaps or material deficiencies.
Monitoring	• Information routinely sought. • Deviations identified, analyzed, investigated. • Action taken to correct deviations and reduce probability of future ones.

I Get Carried Away

(On the Town)

As we have discussed in the last two articles on *Due Care*,, certification of compliance to the Insurance Marketplace Standards Association's *Life Insurance Ethical Market Conduct Program* is now being sought by many major insurance companies. While no company is allowed to announce its certification before April 1, 1998, these companies are actively going through a self-assessment process to determine if it meets IMSA's requirements. Following self-assessment is an independent confirmation as a prelude to achieving certification from IMSA.

The first Principal reviewed was the "Golden Rule" principal and its 5 questions in support of that Principal. Each question has 3 aspects (Approach, Deployment, and Monitoring), and each aspect has 2 clarifying question. All answers must indicate YES for certification to be granted by IMSA. In addition, each question and aspect also has its own Indicators - but not every Indicator will apply to every carrier and process, and YES is *not* required on every one of the 373 indicators covering all 27 questions underlying the 6 Principals.

Principal #2

Principal #2 requires a certified insurance company "To provide competent and customer-focused sales and service." To that end, the following 6 questions are posed:

> **Question 2.1** Does the company have, use, and monitor selection criteria which enumerate the qualifications for its distributors?
>
> **Question 2.2** Is there a process to provide reasonable assurance that distributors are licensed or meet other applicable requirements and, where required, are appointed for writing business on behalf of the company?
>
> **Question 2.3** Are there policies and procedures designed to reasonably assure that distributors and employees involved in the sales process receive training to help customers meet their insurable needs or financial objectives?
>
> **Question 2.4** Are distributors provided with descriptive materials of the insurer's product features and operations?
>
> **Question 2.5** For its employees involved in the sales process, does the company provide, and for its distributors, does it provide or encourage (through communications) participation in, periodic training on compliance with laws and regulations related to the marketing and sale of insurance products and the concepts in the Principles and Code, in a way appropriate to its distribution system?
>
> **Question 2.6** Does the company provide or encourage participation in periodic continuing education programs or communications, appropriate to its distribution system, for distributors and employees involved in the sales process?

As readers will probably have noticed in the review of the two Principals we have covered so far - and their combined 11 clarifying questions - few of us would quibble with the tone, scope, meaning, and intention! From an insurance company's standpoint, however, enormous time, resources, and not an insignificant amount of money is being applied to getting to YES for IMSA certification. In addition to the efforts being taken with this certification process by insurance companies, there are enormous implications for agents: agents will be on the downhill path of the resulting rules, processes, and procedures called for in the 27 questions.

One intriguing example of the implication for agents is the inevitable conflict to be experienced by any agent who is appointed by more than one insurance company. Indeed, the typical agent is probably appointed with a dozen or more insurers in order to have a complete and competitive inventory of policies for various client needs. If Carrier A has developed a set of rules, regulations, procedures, and processes that allow it to get to YES for IMSA certification - and Carrier B has a somewhat different set of rules and procedures - how is the agent to manage the conflict? Often we don't know "which company" or "which product" we're going to end up using in a given client situation, and as a number of questions in various Principals will suggest, there's a "Catch-22" inherently working against the agent/broker! It would be impossible to prospectively and simultaneously comply with 2 different sets of rules; how will we manage the conflict as it compounds with the addition of a *dozen* brokerage relationships?

The implication for point-of-sale brokerage does not appear to have been considered in the formulation of the IMSA certification process. As a result, several organizations including LIMRA International (through its Independent Producer Clearinghouse project), and the National Association of Independent Life Brokerage Agencies (NAILBA) are attempting to design and gain consensus amongst brokerage carriers for a "broker *up*" solution as opposed to the current "carrier *down*" approach. Much work will need to be accomplished to resolve the inherent conflicts between brokerage and "career" companies and the agents who hold appointments across a wide spectrum of those companies.

Principal #3

Principal #3 is simplicity itself: "To engage in active and fair competition." It sounds easy; who could argue with fair competition? But it may not be so easy in reality. The questions in support of this Principal are:

> **Question 3.1** Has the company established and communicated guidelines which are designed to allow its distributors and employees involved in the sales process to understand what fair competition is?
>
> **Question 3.2** Does the company have policies and procedures in place designed to provide customers with information they need in order to ascertain whether replacements of life and annuity products may or may not be appropriate?

Question 3.3 Does the company have policies and procedures for monitoring replacements which includes a system for tracking, identifying, and addressing deviations from its guidelines?

Question 3.4 Does the company have a policy that prohibits distributors and employees involved in the sales process from making disparaging remarks about competitors? ("Disparaging remarks" do not include relevant, factually accurate information.)

This Principal focuses on the point-of-sale and agent activity, especially in the area of "bashing" and replacement. Notice that the carrier's requirement is - for example - to have processes "…designed to allow its distributors … to *understand* what fair competition is." This is, of course, a good idea, but there is no enforcement requirement in order to obtain certification. It's incumbent upon the insurance company to create its own process of enforcement and penalties for violating pre-established standards. We agents would be well-served by insisting that our companies go *beyond* the certification process and create real standards by which we can all live - and expect to be enforced.

Next month we will complete our examination of the IMSA *Life Insurance Ethical Market Conduct Program* as we review Principals 4-6.

Growing Pains

(A Tree Grows In Brooklyn)

As we have discussed in the last three articles on *Due Care*, certification of compliance to the Insurance Marketplace Standards Association's *Life Insurance Ethical Market Conduct Program* is now being sought by many major insurance companies. While no company is allowed to announce its certification before April 1, 1998, these companies are actively going through a self-assessment process to determine if it meets IMSA's requirements. By this time in the process (January 1998), companies who expect to achieve and announce certification on April 1, 1998 should have completed the self-assessment phase and be well on their way to completing the independent confirmation as a prelude to achieving "on time" certification from IMSA.

The last Principal reviewed was the "Fair Competition" Principal and its 4 supporting questions. Recall that each question has 3 aspects (Approach, Deployment, and Monitoring), and each aspect has 2 clarifying question. All answers must indicate YES for certification to be granted by IMSA.

Principal #4

Principal #4 once again focuses on activities at the point of sale: "To provide advertising and sales materials that are clear as to purpose and honest and fair as to content."

> **Question 4.1** Does the company have policies and procedures in place designed to provide reasonable assurance that during the sale and solicitation of individually-sold life and annuity products customers receive information consistent with making buying decisions about what is appropriate for them?
>
> **Question 4.2** Are policies and procedures in place to reasonably assure that materials used in the sales process are clear and understandable in light of the complexity of the product and the sophistication of the buyer?
>
> **Question 4.3** Does the company have policies and procedures designed to reasonably assure compliance with laws and regulations related to advertising and sales material?
>
> **Question 4.4** Are there policies and procedures for providing reasonable assurance that sales illustrations or other representations used in the sales process of premiums, considerations, costs, values, and benefits are accurate and complete, and appropriately disclose guaranteed and non-guaranteed elements?

Key to this Principal is Question 4.1; an old issue is being given new life wherein procedures are required so that "…customers receive information consistent with making buying decisions about what is appropriate for them" Another phrase of art for this process is *determining the suitability of the customer for the product(s) being recommended and sold*.

I refer to **affirmative product suitability** as being an old issue because it's one that's been around a long time: by what objective means do we consistently recommend a given type of product for a given set of circumstances? Few agents have such objective methods, and giving at least us "old hand" agents our professional due, there was a time when our knowledge and professionalism was all that was required to make a competent and appropriate product recommendation. In 1967 - my first year as a licensed agent - I didn't face too many product selection / suitability challenges (I don't know about you, but I basically had two products to sell: term at $3.25/$1000 for a 35-Male and whole life at $18.00/$1000).

1997, on the other hand, offers many challenges not present 30 years ago: we have a feeding frenzy of litigation against agents and their companies; a financial press that appears anti-agent and anti-permanent insurance; a regulatory environment that is imposing suitability standards at this very moment; *and* the average broker has *hundreds* of individual product choices cast amongst the many carrier appointments we maintain to be "competitive."

To cast the problem at a more practical level: if we asked a group of agents - *any* group of agents - to make a product recommendation from an extensive "case study" containing the "client's" objectives and complete financial data … what percentage of the resulting recommendations would be largely similar - and dissimilar? Most home office compliance officers to whom I've posed that question turn a not-so-subtle shade of gray and change the subject. Their reaction stems from the knowledge that the failure to establish, perform, and monitor such processes are at the heart of successful claims by plaintiffs and their attorneys against the insurance agents and companies.

Principal #5

Principal #5 is focused on the customers and their ability to address perceived problems: "To provide for fair and expeditious handling of customer complaints and disputes." These questions generally speak for themselves:

> **Question 5.1** Does the company have policies and procedures for complaint handling that provide reasonable assurance of compliance with laws and regulations?
>
> **Question 5.2** Does the company provide an easily accessible way for customers to communicate complaints?
>
> **Question 5.3** Are the policies and procedures designed to reasonably assure that the complaint information gathered is being used to act upon customer complaints and to analyze and eliminate their root causes?
>
> **Question 5.4** Does the company have policies and procedures to reasonably assure that it makes good faith efforts to resolve complaints and disputes?

There's a very practical reason that the industry needs to establish customer-focused complaint resolution: the aforementioned lawsuits have become the de factor standard for dealing with

complaints. In order to avoid the high cost (and high negative publicity) of lawsuits, enhanced complaint resolution would appear to be in everyone's best interest.

Tying back to the certification process itself, complaint handling may require different treatment depending on the distribution channels supported by an individual carrier: if a company uses both direct marketing and agents in the distribution of its products, the application of the complaint handling policies and procedures should be consistent with the objectives of the question, even though the policies and procedures may vary in their execution.

Principal #6

The last Principal to review is: "To maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct." This principal seems to speak for itself; without it, there can be no assurance that all the effort that went into establish procedures will be to anyone's benefit - except for the paper manufacturers.

> **Question 6.1** Has management established and does it enforce policies and procedures designed to reasonably assure compliance with the Principles and Code?
>
> **Question 6.2** Have supervisory responsibilities been assigned, either directly or by contractual provisions with independent intermediaries, to reasonably assure that the policies and procedures for monitoring compliance with the Principles and Code and applicable laws and regulations are being met?
>
> **Question 6.3** Does the company provide compliance training sessions on the Principles and Code and applicable laws and regulations, for employees involved in the sales process, and make available to distributors instruction on such compliance requirements?
>
> **Question 6.4** Does the company have policies and procedures that require internal auditing and monitoring of information related to the sales practices of its distributors and employees involved in the sales process?

Conclusion

In the last 4 issues on *Due Care* we have been reviewing what may turn out to be the most profound change in the life insurance industry since the Armstrong Investigations were conducted almost 100 years ago. Those investigations - in response to alleged widespread financial abuses within the life insurance industry - brought about sweeping changes in policy non-forfeiture values, carrier solvency requirements, commission and expense limitations, and a host of other regulations in response to market "abuses."

With many parallels across that almost-100-year gap, the Insurance Marketplace Standards Association is attempting to resolve more recent concerns for market conduct abuses through an industry-sponsored, *voluntary,* and *self*-regulating process. Industry leaders recognize that state and federal regulators would be only too happy to create a 21st Century version of the Armstrong

Investigations to respond to alleged abuses; those same leaders - rightly I believe - know that fixing the problems ourselves is infinitely preferable to having the type of regulatory response that was imposed on the insurance industry in Great Britain. Regulations imposed there in 1995 are viewed as largely responsible for a 50% reduction in the amount of insurance sold in 1995 (compared to 1994), and a greater than 50% reduction in the number of agents in the last 5 years.

The life insurance industry in the U.S. may be in danger of experiencing similar declines to those of Great Britain *if* we're not able to deal with our own issues. And from an agent's perspective, it's rather daunting. We are now encountering

- Enormous competitive challenges within the financial services industry
- Changing demographics with "boomers" less interested in permanent life insurance (especially whole life)
- The incredible appeal of variable products - until the next big market correction
- Model Illustration Regulations (what is it about 14 page illustrations that make them more understandable?)
- Market Conduct audits
- Capital Gains tax reductions challenging the historic advantage of "tax deferred inside buildup"
- IMSA

Our challenge is nothing less than industry *implosion* or *transformation*. As insurance companies who intend to not merely survive but *thrive* into the 21st Century begin to certify their ethical conduct through IMSA - and as the public and press gain awareness and grant credibility to the process - we will all be better off for the extra effort it is requiring to focus on appropriate market conduct at all levels of insurance selling and servicing. Hopefully the agent's survival will be successfully tied to the survival and "thrival" of those companies.

PRINCIPLES OF ETHICAL MARKET CONDUCT

Each life insurance company subscribing to these principles commits itself in all matters affecting the sale of individually-sold life and annuity products:

1. **To conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself.**

2. **To provide competent and customer-focused sales and service.**

3. **To engage in active and fair competition.**

4. **To provide advertising and sales materials that are clear as to purpose and honest and fair as to content.**

5. **To provide for fair and expeditious handling of customer complaints and disputes.**

6. **To maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct.**