



AGENDA
Health Insurance and Managed Care (B) Committee
Conference Call
November 9, 2009
1:00 p.m. – 2:00 p.m. EST (12 noon – 1:00 p.m. CST)

Sandy Praeger, Chair	Kansas
Joel Ario, Vice Chair	Pennsylvania
Marcy Morrison	Colorado
Kevin McCarty	Florida
Michael T. McRaith	Illinois
Carol Cutter	Indiana
Ralph S. Tyler III	Maryland
Monica J. Lindeen	Montana
Morris J. Chavez	New Mexico
Kim Holland	Oklahoma
Kent Michie	Utah
Paulette Thabault	Vermont
Jane L. Cline	West Virginia

1. Roll Call
2. Consider Adoption of Long-Term Care Insurance Model Regulation Appendix E Revisions – *Mary Beth Senkewicz (FL)/Randy Moses (SD)*
3. Consider Adoption of Regulatory Framework Task Force Report from Oct. 13, 2009 Conference Call – *Commissioner Scott J. Kipper (NV)*
4. Any Other Matters
5. Adjournment

To submit comments, please contact Jane Sung at (202) 471-3979 or jsung@naic.org.

LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 15. Reporting Requirements

- A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
- B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)
- C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.
- D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)
- E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)
- F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

~~Drafting Note: The definition of claim denied used in this reporting form is for HIPAA reporting purposes only, and is not intended to be applied to any other regulatory issues, such as market conduct examinations.~~

- G. For purposes of this section:
 - (1) "Policy" means only long-term care insurance;
 - (2) Subject to Paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
 - (3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
 - (4) "Report" means on a statewide basis.
- H. Reports required under this section shall be filed with the commissioner.

Long-Term Care Insurance Model Act

APPENDIX E

**Claims Denial Reporting Form
Long-Term Care Insurance**

For the State of _____
For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____

Company NAIC Number: _____
Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

Per Claimant – counts each individual who makes one or a series of claim requests.

Per Transaction – counts each claim payment request.

“Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	<u>State Data</u>	<u>Nationwide Data¹</u>
<u>Total Number of Inforce Policies [Certificates] as of December 31st</u>		

Claims & Denial Data

		<u>State Data</u>	<u>Nationwide Data¹</u>
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	<ul style="list-style-type: none"> Long-Term Care Services Not Covered under the Policy² 		

9	<ul style="list-style-type: none"> • Provider/Facility Not Qualified under the Policy³ 		
10	<ul style="list-style-type: none"> • Benefit Eligibility Criteria Not Met⁴ 		
11	<ul style="list-style-type: none"> • Other 		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

PROJECT HISTORY
APPENDIX E CLAIM DENIALS REVISIONS TO THE
LONG-TERM CARE INSURANCE MODEL REGULATION

1. Description of the Project, Issues Addressed, etc.

Revisions relating to Appendix E (Claims Denial Reporting Form) of the Long-Term Care Insurance Model Regulation (#641).

2. Name of Group Responsible for Drafting the Model and States Participating

The Appendix E Subgroup of the Senior Issues (B) Task Force drafted the revisions. The participating states were: South Dakota, Florida, Wisconsin, Arkansas, Nebraska, Nevada, Texas, and Pennsylvania. South Dakota was the Chair.

3. Project Authorized by What Charge and Date First Given to the Group

The Health Insurance and Managed Care (B) Committee has the following ongoing charges, which are delegated to the Senior Issues Task Force.

Develop appropriate regulatory standards and revisions to the NAIC models, consumer guides and training material, as necessary, on long term care insurance. Work with federal agencies as appropriate. Report annually (Delegated to Senior Issues Task Force);

Continue to study and evaluate evolving long-term care insurance product design, rating, suitability and other related factors, and review the existing Long-Term Care Model Act and Regulation to determine their flexibility to remain compatible with the evolving delivery of long-term care services and remain compatible with the evolving long-term care insurance marketplace. Report quarterly (Delegated to Senior Issues Task Force);

The Senior Issues Task Force authorized the formation of a Subgroup to work on revising the model regulation to address Appendix E in the Summer of 2009.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model revisions were drafted by a Subgroup of the Senior Issues Task Force chaired by South Dakota. The following interested parties, organizations, and consumer representatives were on the email list: Amanda Matthiesen (America's Health Insurance Plans), Miriam Krol (American Council of Life Insurers), Genworth Life Insurance, Prudential Life Insurance, Melissa Lawler (American Academy of Actuaries), PriceWaterhouseCoopers, Congressional Research Service, MetLife, Aegon USA, Unum Provident, Bonita Kallestad (Western Minnesota Legal Services), Barbara Cude (University of Georgia), Birny Birnbaum (Center for Economic Justice), and John Hancock Life Insurance Company.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Senior Issues (B) Task Force appointed a Subgroup at the 2009 Summer National Meeting, to be chaired by South Dakota. The Subgroup held an open conference call on August 6, 2009. Notice for

this conference call was emailed to Subgroup regulators and interested parties and posted on the NAIC website.

Prior to the August 6 conference call, Subgroup members and interested parties received and reviewed the current version of Appendix E. Industry representatives proposed draft revisions to Appendix E, which were also distributed to Subgroup members and interested parties. The Subgroup reviewed the industry's proposed revisions on the conference call, and also made additional revisions to Appendix E and to Section 15 of the model regulation. After the conference call, a final draft of the agreed-upon revisions was distributed to Subgroup members and interested parties. The Senior Issues (B) Task Force adopted the revisions at the 2009 Fall National Meeting and they were exposed for a 30 day public comment period prior to consideration by the Health Insurance and Managed Care Committee.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

This project was in response to the discovery made during compilation of the 2008 LTC Data Call Analysis and Report, which was adopted by the Health Insurance and Managed Care Committee and the Market Regulation and Consumer Affairs (D) Committee, that companies were using different methodologies to report claim denial data on Appendix E, and therefore the usefulness of this reporting was limited. The Task Force agreed that *Appendix E* should be revised and created the Subgroup. Regulators, industry and consumer groups were in agreement regarding the need to make revisions to Appendix E.

There are two distinct methods of counting and reporting claim denials that are being used by companies – per claimant and per transaction. Neither method is predominantly used, as industry reported that roughly half the companies count and report by claimant and roughly half count and report by transaction. Therefore, industry suggested that the form be amended so that companies would indicate the manner of reporting. Some states were interested in requiring that companies be required to change their methodology so that all companies were using a uniform method. However, industry stated that this would be cost-prohibitive. The Subgroup agreed to make changes to Appendix E to include the manner of reporting.

Regulators also discussed the overall goal of improving tools for state regulators and others to assess the long-term care insurance marketplace. As such, the Subgroup decided to adopt additional revisions to Appendix E that would add a query regarding in-force policies by state and nationwide. This information is intended to assist in helping regulators better put the rest of the Appendix E data in context.

Additionally, the Subgroup noted that the current drafting note following Section 15F stated that the definition of claim denied in Appendix E was limited to HIPAA reporting purposes only. In accordance with the goal of making Appendix E more broadly useful to state regulators and others in assessing the marketplace, the Subgroup decided to delete this drafting note.

7. Any Other Important Information (e.g., amending an accreditation standard).



Date: October 8, 2009

Memo To: Jane Sung, NAIC Staff to Senior Issues Task Force

Subject: 9/22/09 Draft – Adopted by Senior Issues (B) Task Force and exposed for comment on 9/22/09 (NAIC LTCI Model Regulation, Section 15 draft reporting requirements)

Comments of California Health Advocates:

We are pleased to see the NAIC actively pursuing information about denied claims for long-term care, and appreciate the opportunity to comment on the draft reporting requirements.

This reporting requirement in Section 15 G of the Model Regulation only applies to a policy for long-term care insurance benefits, and not to riders or contracts that include long-term care benefits such as annuity contracts and riders to other insurance products such as life insurance. While these products may be a small part of the overall market for long-term care insurance, they are a significant and growing source of long term care coverage. We think it is a mistake to exclude these products. The definition of a policy at G (1) should include riders and contracts that include benefits for long-term care services. We are also concerned that certificates may not be covered by this definition, since a policy would be the master group policy and not the certificates attached to such a policy. We see that the word certificate has been included in the box for inforce business on Appendix E, but the word policy is used alone in other places on the reporting form and in the definitions in G of the Regulation.

We suggest broadening the definition to include policy, certificate, rider, and contract.

Data cells 8, 9, 10, and 11 on Appendix E appear to be sub-categories of cell 7 rather than separately numbered data cells. Some of the examples shown in the footnotes could arguably result in a paid claim by an insured providing more information. In other cases we believe these data cells should be more specific. We suggest rewording as follows:

(#8) 7. a. Benefits requested for services not covered by the policy, certificate, rider or contract

(#9) 7 b. Provider or facility does not meet policy, certificate, rider, or contract definitions

(#10) 7 c. Benefit eligibility triggers were not met

We suggest deleting footnote #4.

Thanks for the opportunity to comment.

Bonnie Burns

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VIA EMAIL

October 23, 2009

Jane Sung
Senior Health Policy Analyst and Council
National Association of Insurance Commissioners

Re: September 22, 2009 Draft Revisions to Long Term Care Model Regulation Number 641

Dear Jane,

Thank you for the opportunity to comment on the proposed revisions to the Long Term Care Model Regulation.

Ohio has reviewed these proposed changes which the Senior Issues Task Force voted to adopt and expose for public comment on September 22, 2009, including:

- 1) Addition of in-force data by state and nationwide in the Appendix E reporting form;
- 2) Allowing carriers to report by claimant or by transaction in the Appendix E reporting form;
- 3) Clarification that a denial does not include a request for payment in excess of the contractual limits in the Appendix E reporting form; and
- 4) Deletion of a drafting note in the rule text, Section 15, which states the definition of claims denied used in the reporting form is for HIPAA reporting purposes only, not market conduct examinations or other regulatory issues,

Ohio has no objection to these revisions.

Best regards,

Mary Jo Hudson
Director

Drafted: 10/22/09

Regulatory Framework (B) Task Force
Conference Call
October 13, 2009

The Regulatory Framework (B) Task Force met via conference call Oct. 13, 2009. The following Task Force members participated: Scott J. Kipper, Chair (NV); Steve Poizner represented by Bruce Hinze (CA); Kevin McCarty represented by Eric Lingswiler (FL); Michael McRaith represented by Bill McAndrew (IL); Carol Cutter represented by Anita Strauss (IN); Mila Kofman represented by Bob Wake and Norm Stevens (ME); John Huff represented by Angela Nelson (MO); Monica Lindeen (MT); Ann Frohman represented by John Rink (NE); Mary Jo Hudson represented by Anne Jewel (OH); Teresa Miller (OR); Joel Ario represented by Shelley Bain (PA); Merle D. Scheiber represented by Melissa Klemann (SD); Leslie Newman represented by Shawn Hawk (TN); Alfred W. Gross represented by Ann Colley (VA); Paulette Thabault represented by Sean Londergan (VT); Sean Dilweg represented by Fred Nepple (WI); and Jane L. Cline (WV). Also participating were: Peg Brown (CO); and Linda Sheppard (KS).

1. Adoption of Task Force 2010 Charges

Jolie Matthews (NAIC) reviewed the Task Force's proposed 2010 charges. She noted that the changes from the Committee's 2009 adopted charges were technical. Commissioner Kipper asked whether potential federal health care reform legislation would impact the Task Force's activities in 2010. Ms. Matthews said there was a distinct possibility that such legislation would have such an impact. She said the Task Force's proposed 2010 charges were broad enough to include any work that the Task Force may have to do in relation to such legislation. Mr. Lingswiler motioned, and Mr. Nepple seconded, to adopt the 2010 charges (Attachment One-A). The motion passed unanimously. Florida, Nevada and Pennsylvania agreed to sponsor the 2010 charges.

2. CMS/DOL Discussion of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Other Issues

Jim Mayhew (Centers for Medicare and Medicaid Services—CMS) updated the Task Force on the status of CMS' review of state alternative mechanisms for compliance with HIPAA's market reform requirements. CMS is sending letters only to those states that have made significant changes to their alternative mechanisms since the last review. Commissioner Kipper asked if CMS would be willing to share the results of its review. Mr. Mayhew said CMS would share those results. He noted that one common issue has arisen in CMS' reviews. States have neglected to indicate that coverage under the federal State Children's Health Insurance Program (SCHIP) is creditable coverage. He said that after CMS raises this issue with a state, the state readily agrees and corrects the problem. Mr. Rink said CMS had raised this issue with his state. He said Nebraska's law includes a reference to a public health plan insurance option as being creditable coverage, which, in his opinion, would include SCHIP. He said this reference has been in the Nebraska law for a number of years and asked why CMS was now raising this issue. Mr. Mayhew said that CMS would consider SCHIP to fall within the meaning of a public health plan insurance option. CMS raised the issue because it wanted to make sure Nebraska was recognizing SCHIP as a public health plan insurance option.

Ms. Matthews updated the Task Force on the NAIC/CMS survey on state implementation of the Genetic Nondiscrimination Act of 2008 (GINA) and the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA). GINA prohibits the denial, conditioning or discrimination in the pricing of a group or individual health plan on the basis of genetic information. GINA also limits the ability of group health plans and group and individual health plan issuers to request or require genetic testing, and prohibits the collection of genetic information for underwriting or other purposes prior to enrollment. MHPAEA requires group health plans for business with 50 or more employees to provide care for mental health and substance abuse disorders that is on par with other covered medical conditions. MHPAEA does not apply to the individual or small group markets. Ms. Matthews said the survey was distributed to NAIC members on July 23, with a deadline of Sept. 4 to submit the requested information. To date, she has received 39 responses. Ms. Matthews said that for the GINA survey questions, some states referred to their state implementation activities taken for Medicare supplemental plans instead of for group health plans. She said she planned to follow-up with these states. Mr. Mayhew encouraged those states that have not yet responded to the survey to do so. He said CMS plans to use the survey results to ascertain state implementation of these federal laws.

Ms. Matthews noted that the federal agencies charged with implementing GINA issued a notice of rulemaking on Oct. 1 and published interim final regulations in the *Federal Register* on Oct. 7. The regulations are effective Dec. 7 and have a Jan. 5, 2010 comment deadline. Mr. Mayhew said the regulations for MHPAEA have been delayed. MHPAEA required the

regulations to be issued by Oct. 3. He anticipates the regulations being issued by January 2010.

3. Update on Revisions to NAIC Models Related to GINA and SCHIP

Ms. Matthews said drafts of NAIC models revised for consistency with GINA and the special enrollment provisions under the SCHIP Reauthorization bill were distributed for comment on June 5 (See Attachments Two, Three and Four of the Regulatory Framework Task Force minutes, 2nd Quarter 2009 *Proceedings*). Comments were requested on these drafts by July 17. She said no comments were received. Rather than moving forward, Ms. Matthews suggested that the Task Force hold these drafts in anticipation of additional revisions that may be necessary in light of the recently issued GINA regulations and the enactment of federal health care reform legislation. She said some of the provisions in the federal health care reform legislation currently being considered would require the NAIC to revise these models or scrap them altogether. After discussion, the Task Force agreed to this suggestion.

4. Discussion of Comments Received on External Review Model Notices

Ms. Matthews said the recently adopted Uniform Health Carrier External Review Model Act (#76) contemplates the Task Force developing and adopting a number of model notices, including a model notice related to the right to request external review and a model notice for requesting an external review. She said following the Summer National Meeting she distributed revised drafts of these model notices for comment. The revisions reflected the discussion at that meeting. She said the only comments received were from America's Health Insurance Plans (AHIP) (Attachment One-B).

Ms. Matthews said that in reviewing AHIP's comments, she would suggest that the Task Force accept the comment that corrects a drafting error in the draft model Health Carrier External Review Annual Report Form. As currently drafted, it contains the word "annual" two times in the title. AHIP suggests deleting one of those references. Ms. Matthews explained the remaining AHIP comments. With respect to AHIP's comment to consolidate the bullets under reasons for denial in the draft Model Notice of Appeal Rights, Jeff Garbardi (AHIP) said this revision would streamline the process. Ms. Matthews said AHIP suggests revising the draft Model External Review Request Form to include two additional reasons for a denial of a requested or recommended health care service or treatment. These two additional reasons would be because: 1) the health care service or treatment is not covered by the health benefit plan; and 2) the individual receiving the service is not covered by the health benefit plan. Ms. Matthews said Section 8 – Standard External Review in the Uniform Health Carrier External Review Model Act (#76) requires the health carrier to consider these reasons for the denial when making an initial determination on whether the external request is eligible for full external review. Mr. Garbardi said including these two additional reasons would expedite the process.

Ms. Matthews said AHIP suggests revising the physician certification related to experimental/investigational denials in the draft Model External Review Request Form to require the physician to detail what studies he or she relied upon to support the recommended or requested health care service or treatment. Mr. Garbardi said requiring this information would save time. Mr. Mayhew noted that including such information would not be appropriate in all cases. Ms. Matthews said AHIP suggests revising the draft Model Independent Review Organization External Review Annual Report Form to identify the state insurance commissioner to whom the report is to be sent. She noted that the draft reporting form already includes references to the state insurance department to which the form should be submitted. As such, including AHIP's suggested revision could be duplicative. Ms. Matthews said that, in addition to its previous comment concerning the word "annual," AHIP also suggests revising the draft model Health Carrier External Review Annual Report Form to require health carriers to provide information on the number of external review requests upheld and overturned. Mr. Garbardi said requiring this information to be included would help to ensure that consistent data is being collected by independent review organizations and health carriers. Ms. Matthews said Section 15 – External Review Reporting Requirements in the Uniform Health Carrier External Review Model Act (#76) allows the commissioner to request any other information the commissioner considers necessary. Mr. Garbardi said specifically including the requirement to report this information in the form itself would ensure uniformity.

Mr. Rink motioned, and Ms. Nelson seconded, to accept AHIP's suggested revision for removing the first "annual" in the draft model Health Carrier External Review Annual Report Form. The motioned passed unanimously. Mr. Rink motioned, and Mr. Hinze seconded, to adopt the model notices as revised (Attachment One-C). The motioned passed unanimously. Commissioner Kipper said the draft model notices and forms will be considered for adoption by the Health Insurance and Managed Care (B) Committee at the Winter National Meeting.

5. Update on Individual Health Insurance Policy Rescission Survey

Jennifer Cook (NAIC) said that at the Task Force's meeting at the Summer National Meeting, the individual health insurance policy rescission survey questions were finalized. Immediately following the Summer National Meeting, NAIC staff for the Market Regulation and Consumer Affairs (D) Committee identified 52 companies in the individual market that made up the top 80% of covered lives and 75% of premium volume in the marketplace that should receive the data call, which was to be based on the survey questions. Ms. Cook said the 52 companies identified involved 25 states. On Aug. 28, an organizing conference call was held with these 25 states. During the call, it was agreed that the states would send out the data call to their domiciliary companies during the first week of September giving companies 30 days from the date of their letter to submit the requested data. After a state receives the data, then the state would forward that data to the NAIC. Ms. Cook said the NAIC has received data from several companies and requests for extensions of time from others. She said it is anticipated that a preliminary report regarding the survey will be presented at the Task Force's meeting at the Winter National Meeting. David Korsh (BlueCross and BlueShield Association—BCBSA) asked whether interested parties could obtain a list of the companies involved in the data call. Ms. Cook said she believed that information was confidential, but she would ask NAIC staff handling the data call to confirm her understanding. Mr. McAndrew asked about the status of the confidentiality agreement he had requested for Illinois. Ms. Cook explained that some states have concluded that they do not need a specific confidentiality agreement with the NAIC for this data call. Others, however, such as Illinois, have decided that such an agreement is necessary. She said that she would contact Randy Helder (NAIC) to determine the status of Illinois' confidentiality agreement and follow-up with Mr. McAndrew.

6. ERISA Subgroup Report

Mr. Nepple reported that the ERISA Subgroup met in regulator-to-regulator session to discuss ongoing federal and state investigations into unauthorized MEWAs in accordance with the NAIC Policy Statement on open meetings. Mr. Wake motioned, and Mr. Lingswiler seconded, to receive the ERISA Subgroup report. The motion passed unanimously. Having no further business, the Regulatory Framework (B) Task Force adjourned.

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