Health Insurance and Managed Care (B) Committee

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HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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The Health Insurance and Managed Care (B) Committee met in Louisville, KY, Aug. 17, 2014. The following Committee members participated: Sandy Praeger, Chair (KS); Ted Nickel, Vice Chair (WI); Germaine L. Marks (AZ); Dave Jones represented by Perry Kupferman (CA); Marguerite Salazar (CO); Mike Chaney (MS); Scott J. Kipper (NV); Benjamin M. Lawsky represented by Robert Easton (NY); Laura N. Cali (OR); Angela Nelson (MO); J.P. Wieske (WI); and Mike Kreidler (WA). Also participating were: Steve Ostlund (AL); Jack McDermott and Rich Robleto (FL); Karl Knable (IN); Therese M. Goldsmith (MD); and Tom C. Hirsig (WY).

1. Heard a Briefing from the CHIR of the Georgetown Health Policy Institute

Sally McCarty and David Cusano (Georgetown Health Policy Institute, Center on Health Insurance Reforms—CHIR) updated the Committee on the CHIR’s work related to the federal Affordable Care Act (ACA) through the State Health Reform Assistance Network, including information on a recently released issue brief titled “Specialty Tier Pharmacy Benefit Designs in Commercial Insurance Policies: Issues and Considerations” and a recently released white paper related to qualified health plan (QHP) renewals for plan year 2015 titled “Addressing the Financial Impact of Renewals: Why Many Enrollees Could Benefit from Shopping.”

Ms. McCarty said the issue brief concerning specialty tier pharmacy benefits highlighted several issues and concerns, particularly the increasing patient share of the cost of vitaIlly needed specialty tier drugs. Specifically related to the ACA, she said another significant concern is that formulary designs with four or more tiers may implicate the new nondiscrimination provisions in Section 1557 of the ACA. That section extends existing federal civil rights protections to private health insurance and prohibits individuals from being subject to discrimination, excluded from participation or denied the benefits of health programs or activities based on race, color, national origin, sex, age or disability. Ms. McCarty said the Office of Civil Rights (OCR) within the U.S. Department of Health and Human Services (HHS) has jurisdiction and enforcement authority over this provision. She said recently, the AIDS Institute and National Health Law Program recently filed a complaint with the OCR against four insurers claiming discrimination under Section 1557 of the ACA alleging that the qualified health plans (QHPs) offered by these insurers on the Florida marketplace impose overly restrictive utilization management requirements on HIV/AIDS medications and places all HIV/AIDS medications on the highest cost-sharing tier, which discourages individuals with HIV and AIDS from enrolling in these QHPs.

Mr. Cusano said the white paper concerning QHP renewals for the upcoming open enrollment period for plan year 2015 and why some consumers could benefit from shopping describes a few of the challenges that consumers may encounter due to the complicated nature of the premium subsidy calculations, which could lead to potentially large swings in consumers’ after-subsidy premiums and tax liability implications. These potentially large swings in consumers’ after-subsidy premiums could be why some consumers could benefit from shopping rather than through the use of auto-renewal remaining with the same QHP. He said that in addition to the white paper, there is a presentation on the State Health Reform Assistance Network’s website outlining how consumers could be affected by various factors as open enrollment begins in a few months. He said these impacts could occur due to: 1) a change in plan premium related to the second lowest silver plan premium; 2) a change in the second lowest silver plan identity/premium; 3) a change in an individual’s income and/or household size; or 3) updates to the federal poverty level (FPL).

Commissioner Nickel asked if the white paper or presentation touched on the potential implications of auto-renewal for some consumers. Ms. McCarty said she was concerned that if some consumers auto-renewed in their QHP, they could be surprised later by a change in cost-sharing and premium cost. She said consumers should seek a redetermination of their eligibility for advanced premium tax credits and reductions in cost-sharing before re-enrolling to avoid such surprises. To address this issue, Mr. Cusano suggested that states might want to develop their own and/or modify the renewal notices that health carriers are required to send to consumers.
Commissioner Kreidler asked if Ms. McCarty or Mr. Cusano knew of any upcoming federal rules related to ACA implementation, such as rules concerning network adequacy or essential health benefits (EHBs). Mr. Cusano said he was aware of potential rules concerning network adequacy on which the Assistant Secretary for Planning and Evaluation (ASPE) is currently conducting a study. He said such rules could be based on the Medicare Advantage plan network adequacy standards. Mr. Cusano said he was not aware of any upcoming federal rules concerning EHBs.

2. Adopted its June 10 and May 21 Minutes

Commissioner Nickel made a motion, seconded by Commissioner Kreidler, to adopt the Committee’s June 10 (Attachment One) and May 21 (Attachment Two) minutes. The motion passed unanimously.

3. Adopted its Subgroup, Working Group and Task Force Reports

a. Consumer Information (B) Subgroup

Ms. Nelson said the Consumer Information (B) Subgroup did not meet at the Summer National Meeting, but met via conference call June 17 and plans to meet only via conference call as it works to update the Frequently Asked Questions About Health Care Reform document (FAQ document). She said that during this meeting, the Subgroup discussed the responses it received from state insurance departments about: 1) how the original FAQ document worked for them; 2) what sections they thought might need improvement; and 3) what additional topics they thought needed to be added. Based on these responses, the Subgroup devised a work plan for moving forward with the updates.

Ms. Nelson said that based on the work plan, NAIC staff is working on technical updates to any outdated information in the FAQ document. She said that at the same time, the Subgroup, its advisory group and interested parties are developing and submitting potential new questions for inclusion in the FAQ document. Ms. Nelson said NAIC staff also are developing additional new questions for inclusion in the FAQ document based on the responses from the state insurance departments. She said the Subgroup intends to hold a conference call within the next few months to review and discuss the draft revisions to the FAQ document.

Ms. Nelson said that since the Subgroup’s June 17 conference call, she has been contacted by various stakeholders suggesting that the Subgroup review other NAIC publications that touch on health insurance to see if they need updating based on the ACA. Commissioner Praeger expressed support for the Subgroup conducting such a review, but she noted that the Subgroup might have to have a charge to do so. She said the Committee would consider such a charge when it begins discussion of its 2015 Proposed Charges.

Commissioner Kreidler made a motion, seconded by Commissioner Kipper, to adopt the report of the Consumer Information (B) Subgroup (Attachment Three). The motion passed unanimously.

b. Health Actuarial (B) Task Force

Mr. Ostlund said the Health Actuarial (B) Task Force met Aug. 15. During this meeting, the Task Force adopted its interim minutes and the interim minutes of its working groups and subgroups. Mr. Ostlund said the Task Force adopted reports from its working groups. He said the Task Force also heard updates and reports from the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Cancer Claim Cost Table Work Group and the Academy’s Health Practice Council.

Mr. Ostlund said the Long-Term Care Actuarial (B) Working Group met Aug. 14. He said that during this meeting, the Working Group heard a report of the Long-Term Care Pricing (B) Subgroup, which is working on revisions to the Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation (Guidance Manual) to reflect provisions in the proposed revisions to the Long-Term Care Insurance Model Regulation (#641). Mr. Ostlund said the Working Group also heard a report from the Long-Term Care Valuation (B) Subgroup, which is working to develop principle-based reserving (PBR) requirements for long-term care (LTC) insurance. He said the Task Force also discussed PBR requirements for health insurance reserves.

Mr. Kupferman made a motion, seconded by Commissioner Cali, to adopt the report of the Health Actuarial (B) Task Force. The motion passed unanimously.
c. Regulatory Framework (B) Task Force

Mr. Wieske said the Regulatory Framework (B) Task Force met Aug. 16 and adopted its July 10 minutes.

Mr. Wieske said the Task Force discussed revised drafts of the Individual Market Health Insurance Coverage Model Regulation, which is to be a companion to the Individual Market Health Insurance Coverage Model Act (#36), and the Small Group Market Health Insurance Coverage Model Regulation, which is to be a companion to the Small Group Market Health Insurance Coverage Model Act (#106). He said the Task Force exposed both drafts for a public comment period ending Sept. 16. He said the Task Force anticipates meeting via conference call soon after the comment deadline to discuss the comments and, depending on the nature of the comments, could consider adoption of the proposed model regulations.

Mr. Wieske said the Task Force also discussed the comments received on the Accident and Sickness Insurance Minimum Standards Model Act (#170). He said the Task Force plans to continue the discussion during a conference call during the next few months and could develop a plan for moving forward to begin to consider revisions to Model #170. The Task Force also discussed the provisions of the Group Health Insurance Standards Model Act (#100). Mr. Wieske said the Task Force requested NAIC staff to revise the model for consistency with the ACA for the Task Force’s discussion during a conference call within the next few months.

The Task Force adopted the report of the Network Adequacy Model Review (B) Subgroup. Mr. Wieske said the Subgroup is continuing to meet weekly to discuss specific revisions to the Managed Care Plan Network Adequacy Model Act (#74). He said the Subgroup is still on track for completing its work by the Fall National Meeting. Mr. Wieske said the Task Force also adopted the report of the ERISA (B) Working Group. He said the Working Group has exposed an initial draft of the Stop Loss Insurance, Self-Funding and the ACA white paper for a public comment period ending Sept. 16.

Commissioner Nickel made a motion, seconded by Commissioner Weyne, to adopt the report of the Regulatory Framework (B) Task Force. The motion passed unanimously.

d. Senior Issues (B) Task Force

Commissioner Kipper said the Senior Issues (B) Task Force met Aug. 16. During this meeting, the Task Force adopted its March 14 minutes. The Task Force also received a federal update, received a report from the Health Actuarial (B) Task Force and heard an update on Medicare supplement insurance (Medigap) first dollar coverage. Commissioner Kipper said the Task Force also distributed a chart tracking state insurance department approvals of Medigap new or innovative benefits.

Commissioner Kipper said the Task Force also received an update from the Long-Term Care Guidance Manual (B) Subgroup, which is a subgroup the Task Force created jointly with the Health Actuarial (B) Task Force at the Spring National Meeting to begin work on revisions to the Guidance Manual related to the proposed revisions to Model #641. The Executive (EX) Committee and Plenary would consider amendments to Model #641 to improve rate stability standards at the Summer National Meeting. He noted that some of the work was first being developed by the Health Actuarial (B) Task Force’s Long-Term Care Pricing (B) Subgroup.

Commissioner Kipper said the Task Force also discussed data reporting for Long-Term Care Partnership policies. He said that last year, HHS ceased the collection of data from carriers; as a consequence, this data is no longer available to the states. Commissioner Kipper said the Task Force will pursue the possibility of the NAIC to collect this data. Lastly, the Task Force established a new subgroup to be chaired by California to review LTC care insurance consumer disclosures.

Commissioner Kipper made a motion, seconded by Mr. Kupferman, to adopt the report of the Senior Issues (B) Task Force. The motion passed unanimously.
4. Discussed Other Matters
   
a. NAIFA Health Insurance Survey

Steve Kline (National Association of Insurance and Financial Advisors—NAIFA) shared an overview and findings of a health insurance survey NAIFA conducted of its 331 members. He said a majority of respondents (53%) reported that their health insurance business had increased since the ACA’s enactment, and almost three-quarters of respondents indicated that they had enrolled clients in health insurance coverage through a state or federal marketplace. Mr. Kline noted that 41% of the agents surveyed had reported some difficulties working with navigators, while 59% had not. He said among the most common problems reported was navigators recommending specific QHPs to clients. Another issue reported related to the number of dental plans available on the marketplaces. Mr. Kline said NAIFA recommends that the marketplaces consider including these plans as possible options for consumers whenever possible. He also recommended that state insurance regulators consider implementing broker referral programs and better publicizing those programs already established to connect consumers with licensed insurance producers who can help them enroll in health insurance coverage.

b. NAIC Consumer Representatives’ Network Adequacy Survey

Elizabeth Abbott (Health Access California) updated the Committee on the status of the NAIC consumer representatives’ survey on network adequacy sent May 29 to each of the state insurance departments. She said only a few states have yet to respond to the survey. Ms. Abbott urged those states that have not responded to do so as soon as possible because they are about to begin the analysis of the responses and develop conclusions. Commissioner Kreidler commended the work of the NAIC consumer representatives in developing the survey as the NAIC works to revise Model #74. Ms. Abbott said that after the survey analysis is complete, the NAIC consumer representatives will share those results with the NAIC.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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The Health Insurance and Managed Care (B) Committee met via conference call June 10, 2014. The following Committee members participated: Sandy Praeger, Chair (KS); Ted Nickel, Vice Chair (WI); Germaine L. Marks (AZ); Dave Jones (CA); Mike Chaney represented by Caitlin Seale (MS); Scott J. Kipper (NV); Benjamin M. Lawsky represented by John Powell (NY); Laura N. Cali (OR); Angela Wayne represented by Angela Lane (PR); Julie Mix McPeak (TN); Todd E. Kiser represented by Nancy Askerlund (UT); and Mike Kreidler represented by Molly Nollette (WA). Also participating were: Rich Robleto (FL); and John Rink (NE).

1. Adopted Rate Stability Revisions to the Long-Term Care Insurance Model Regulation (#641)

Commissioner Kipper said the Senior Issues (B) Task Force adopted the proposed revisions to the Long-Term Care Insurance Model Regulation (#641) at the Spring National Meeting. He said the proposed revisions make improvements to the rate stability standards contained in Model #641, which the NAIC adopted originally in 2000.

Commissioner Kipper reminded the Committee that the Senior Issues (B) Task Force has been focused on possible ways to address long-term care insurance rate increases for the past several years—dating back to discussions of the former Long-Term Care (EX) Task Force in 2009, and continuing with the Senior Issues (B) Task Force’s public hearing in November 2012. He said the Senior Issues (B) Task Force began these discussions in earnest during an interim meeting in June 2013 where the Task Force began work on an initial draft of revisions to Model #641. Commissioner Kipper noted that more than 45 regulators attended the meeting. He said that, during the past year, the Senior Issues (B) Task Force worked to improve the initial draft, relying heavily upon the expertise of the Health Actuarial (B) Task Force members for their review and recommendations, as well as comments on the drafts from regulators and interested parties.

Commissioner Kipper noted that, in December 2013, the NAIC adopted a model bulletin developed by the Senior Issues (B) Task Force, which is intended to address rate increases on in-force long-term care insurance policies, including older policies and closed blocks sold prior to 2000, the date of enactment of the current rate stability provisions. He said the revisions currently being considered generally would apply prospectively to new policies. Commissioner Kipper said the model bulletin, together with the proposed revisions to Model #641, make significant improvements to the current regulatory framework regarding the issue of long-term care insurance rate increases.

Commissioner Kipper described some of the major provisions in the proposed revisions, which include changes to the actuarial certification requirement from a one-time statement at the time of initial filing to a more robust annual certification. He said companies will have to make the actuarial certification, with justification, on an annual basis, not just at the time of the initial filing. This will ensure that companies stay better attuned to dynamics in pricing and help state insurance regulators to stay more aware of what is happening. Commissioner Kipper noted that this proposed new actuarial certification requirement is similar to the IIPRC’s current certification requirement for long-term care insurance products. He said the proposed revisions also make the concept of “moderately adverse conditions” more tangible by requiring that a new minimum margin be incorporated into the calculations for premium rates.

Commissioner Kipper said his expectation is that these provisions and other improvement in oversight will result in more conservative pricing and a more consistent approach in dealing with premium rate increases. He said that, currently, there is a proposed new subgroup under the Health Actuarial (B) Task Force that will be developing revisions to recommend to the Senior Issues (B) Task Force to the Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation (Guidance Manual) to reflect provisions in the proposed revisions to Model #641. Commissioner Kipper said the proposed revisions to Model #641 also include enhanced consumer disclosure requirements to help to ensure that consumers understand the likelihood of a rate increase and are aware of their options when faced with a rate increase. This includes an important new disclosure when consumers consider actions to mitigate rate increases that may impact protections provided under a Long-Term Care Partnership policy and Medicaid eligibility.
Commissioner Kipper said the proposed revisions also expand the application of Model #641’s contingent benefit-upon-lapse provision by requiring that consumers who have held the oldest policies (more than 20 years) will receive this benefit automatically. He noted that this provision also is included in the model bulletin in order to apply it to current policyholders.

Commissioner Kipper said the proposed model revisions do not change the dual-loss ratio structure established by the rate stability amendments made to Model #641 in 2000. He explained that the 2000 rate stability revisions replaced the previous 60% loss ratio requirement with a 58% loss ratio at the time of initial pricing and at the time of rate increase to 85% loss ratio if a rate increase is requested later. Commissioner Kipper said that, while the Senior Issues (B) Task Force considered a proposed revision from the Health Actuarial (B) Task Force to raise the 85% loss ratio requirement, the Senior Issues (B) Task Force determined that such a change was not feasible at this time. However, the Senior Issues (B) Task Force will consider this proposal as part of a discussion and examination of Model #641’s entire loss ratio structure in the future.

Commissioner Kipper said the Committee received two comment letters related to the proposed revisions during the comment period. He said that, based on his review of the comments, he would not recommend any additional revisions to Model #641.

Commissioner Kipper made a motion, seconded by Commissioner McPeak, to adopt the proposed revisions to Model #641 (see NAIC Proceedings – Summer 2014, Executive (EX) Committee and Plenary, Attachment Two).

Commissioner Jones said the Senior Issues (B) Task Force should have adopted the Health Actuarial (B) Task Force’s proposed amendment to raise the loss ratio requirement at the time of rate increase from 85% to 92%. He said there have been dramatic long-term care insurance rate increases since the 85% loss ratio was adopted in 2000. Because of this, it appears that the 85% loss ratio requirement is not having the intended impact of stabilizing rates. As such, the Senior Issues (B) Task Force should have adopted the 92% recommendation as part of the model revisions. Commissioner Jones said the 92% loss ratio requirement would reduce the amount of future rate increases and encourage companies to make more appropriate initial pricing decisions.

Commissioner Kipper acknowledged Commissioner Jones’ concerns. He said the Senior Issues (B) Task Force has struggled with this issue, particularly because it is hard to figure out the future for this long-tail insurance product. Commissioner Kipper said the Senior Issues (B) Task Force decided to leave the 85% loss ratio at the time of rate increase unchanged because it felt that it addressed the initial pricing issue. He said the Senior Issues (B) Task Force also believed that the 92% loss ratio requirement would have a significant adverse impact on the growth of the long-term care insurance market and a significant impact on future policyholders. Commissioner Kipper reiterated, however, that the Senior Issues (B) Task Force has agreed to discuss this issue in the future.

Mr. Robleto expressed support for Commissioner Jones’ comments. He noted that the current 85% loss ratio already takes into account any risk related to the long-tail nature of long-term care insurance products. Mr. Robleto agreed that the 85% loss ratio does impact the amount of the rate increase, but insurers can still justify large rate increases using the 85% loss ratio.

Bonnie Burns (California Health Advocates) asked if the Senior Issues (B) Task Force has a specific time frame for beginning discussions on Model #641’s entire loss ratio structure. Commissioner Kipper said the Health Actuarial (B) Task Force has already designated the Long-Term Care Actuarial Pricing (B) Subgroup to discuss and suggest revisions to the Guidance Manual to reflect the revisions to Model #641. The Health Actuarial (B) Task Force also has appointed a new subgroup to identify the minimum enclosures associated with the new annual certification requirement. Commissioner Kipper said there is no specific timeline for completion of those revisions, but he expects the subgroups to work to complete the revisions as expeditiously as appropriate.

Mr. Rink, chair of the proposed new subgroup, said he anticipates initial discussions on revisions to the Guidance Manual related to the annual certification would take place in a few weeks. Ms. Burns asked if the new consumer disclosures would be discussed as part of the proposed revisions to the Guidance Manual. Mr. Rink said discussions of the disclosures can be included as part of the subgroup’s work.
Ms. Burns asked what NAIC group would be revisiting the proposal to increase the loss ratio requirement at the time of rate increase from 85% to 92%. Commissioner Kipper said he anticipates such a discussion occurring initially at the Senior Issues (B) Task Force’s meeting at the Summer National Meeting.

Birny Birnbaum (Center for Economic Justice—CEJ) expressed concerns with the long-term care insurance market generally. He also expressed concerns with the proposed revisions to Model #641 not going far enough to stem excessive rate increases. Mr. Birnbaum also noted that the proposed revisions do not include any provisions related to requiring premium rate decreases. In addition, he expressed concern with the possible effectiveness of the new consumer disclosures if they are not crafted in a way that makes them useful to consumers. Mr. Birnbaum suggested that consumer testing should be part of the work in developing the disclosures. Commissioner Kipper acknowledged Mr. Birnbaum’s concerns. He said, however, that he believes the proposed annual certification requirement will address many of Mr. Birnbaum’s concerns and provide a great tool for state insurance regulators in monitoring the market.

Commissioner Praeger said the current proposed revisions to Model #641 are part of state insurance regulators’ continuing work to stabilize long-term care insurance rates. She said the proposed revisions will bring some additional stability and predictability to premium rate increases without damaging the current fragile long-term care insurance market.

Bill Weller (America’s Health Insurance Plans—AHIP) said the industry supports the proposed revisions to Model #641 and plans to work with the Health Actuarial (B) Task Force’s subgroups to make the necessary revisions to the Guidance Manual, including work related to the consumer disclosures. He said the industry believes the proposed revisions to Model #641 will help to keep companies in the long-term care insurance market and possibly entice additional companies to participate.

There was no further discussion, and the motion to adopt the proposed revisions to Model #641 passed, with California voting against the motion.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Health Insurance and Managed Care (B) Committee met via conference call May 21, 2014. The following Committee members participated: Sandy Praeger, Chair (KS); Ted Nickel, Vice Chair, represented by Dan Schwartz and J.P. Wieske (WI); Germaine L. Marks (AZ); Dave Jones represented by Perry Kupferman (CA); Marguerite Salazar represented by Tom Abel (CO); Mike Chaney represented by Caitlin Seale (MS); Scott J. Kipper (NV); Benjamin M. Lawsky represented by Gerasimos Stamoulis (NY); Laura N. Cali (OR); Angela Weyne (PR); Julie Mix McPeak (TN); Todd E. Kiser represented by Tanji Northrup (UT); and Mike Kreidler represented by Molly Nollette (WA). Also participating were: Molly White (MO); and Christina Goe (MT).

1. Adopted Model Law Development Requests to Revise the Health Insurance Reserves Model Regulation (#10)

Jolie Matthews (NAIC) said the Health Actuarial (B) Task Force submitted to the Committee for adoption two model law development requests to revise the Health Insurance Reserves Model Regulation (#10). She explained that one request provides that the Health Actuarial (B) Task Force would be responsible for revising Appendix A in Model #10 to reference a new table for the valuation of individual long-term disability liabilities (Attachment Two-A). The other request provides that the Long-Term Care Actuarial (B) Working Group would be responsible for revising Section 4—Contract Reserves of Model #10 and Appendix A to reference new standards for the valuation of long-care insurance liabilities (Attachment Two-B).

Director Marks made a motion, seconded by Mr. Kupferman, to adopt the model law development requests to revise Model #10. The motion passed unanimously.

2. Appointed the Model Law Review Initiative (B) Subgroup

Ms. Matthews explained that in August 2013, NAIC support staff was sent a memorandum related to the Model Law Review Initiative (Initiative). She said this Initiative requires each NAIC parent committee to review its assigned NAIC models for compliance with the NAIC’s Procedures for Model Law Development and recommend whether they be retained as a model law, amended, converted to a guideline or archived. Ms. Matthews said that to complete this task, the Initiative requires each parent committee to appoint a small group of committee members to review its assigned NAIC models according to the NAIC model law development criteria and questions found on the Model Law Review Worksheets that the NAIC Legal Division developed. She said the Committee did not have the opportunity to work on this task before the end of the year. As such, it must complete this task this year. Ms. Matthews said she anticipated this small group to meet no more than two times prior to the Summer National Meeting to complete its work.

Ms. White asked about the NAIC models the Committee must review. Ms. Matthews said the Committee has five models: the Discount Medical Plan Organization Model Act (#98), the Health Policy Rate and Form Filing Model (Act) (Regulation) (#165), the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220), the Long-Term Care Insurance Model Act (#640), and the Long-Term Care Insurance Model Regulation (#641). She noted that the disbanded Affordable Care Act Model Review (B) Working Group has already reviewed Model #165.

Commissioner Weyne made a motion, seconded by Ms. Northrup, to appoint the Model Law Review Initiative (B) Subgroup. The motion passed unanimously. Florida, Missouri, Nebraska, Nevada, Utah and Wisconsin volunteered to serve on the subgroup.
3. Heard Updates from its Subgroup, Working Group and Task Forces

   a. Consumer Information (B) Subgroup

Brian Webb (NAIC) said the Consumer Information (B) Subgroup will be meeting prior to the Summer National Meeting to consider revisions to the Frequently Asked Questions About Health Care Reform (FAQ document). He explained that the Subgroup developed the FAQ document in 2013, and the Executive (EX) Committee and Plenary adopted it Aug. 27, 2013. It was designed for use by state insurance department consumer assistance staff as they respond to questions from consumers about their health care coverage choices. Mr. Webb said that in order for the FAQ document to remain accurate and continue to be of ongoing assistance to state consumer assistance staff, the Subgroup needs to update it to add new information and remove outdated information. He noted that, in particular, the Subgroup would have to review and incorporate, as appropriate, provisions of the most recently adopted federal regulations—Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.

   b. Health Care Reform Regulatory Alternatives (B) Working Group

Mr. Schwartzer said the Health Care Reform Regulatory Alternatives (B) Working Group is looking at the options and strategies the states might pursue under the Waiver for State Innovation, as described in Section 1332 of the federal Affordable Care Act (ACA). Section 1332 of the ACA creates the waiver and authorizes the secretary of the U.S. Department of Health and Human Services (HHS) and the secretary of the U.S. Department of the Treasury to waive all or any of the following requirements falling under their respective jurisdictions for health insurance coverage within a state for plan years beginning on or after Jan. 1, 2017: 1) Part I of subtitle D of Title I of the ACA (relating to the establishment of qualified health plans (QHPs)); 2) Part II of subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through health benefit exchanges); 3) Section 1402 of the ACA (relating to reduced cost sharing for individuals enrolling in QHPs); and 4) Sections 36B (relating to refundable credits for coverage under a QHP), 4980H (relating to shared responsibility for employers regarding health coverage) and 5000A (relating to the requirement to maintain minimum essential coverage) of the Internal Revenue Code.

Mr. Schwartzer said that, at the Spring National Meeting, the Working Group discussed the degree of flexibility the states might have in designing the waiver. He said that, at the Summer National Meeting, the Working Group plans to review the waiver process in more detail to determine if additional state flexibility is needed and, if so, discuss requesting such flexibility from HHS. Mr. Wieske also noted that the Working Group requested the Legal Authority (B) Subgroup review state flexibility and other issues related to the waiver process.

Mr. Schwartzer said the Working Group continues to discuss the issues the territories have with implementing the ACA without subsidies or the individual and employer mandates. He noted that these issues were raised during the commissioners’ April 17 meeting with President Barack Obama. Mr. Schwartzer said that, as requested during that meeting, the NAIC sent a letter to President Obama detailing these issues and asking HHS to investigate what steps the federal government might take to help alleviate the problems facing the territories. Commissioner Weyne said that, most likely as a result of the meeting with the President and the NAIC letter, Puerto Rico recently received a request from HHS for more information. She said she believed the other territories also have received inquiries from HHS.

   c. Long-Term Care Actuarial (B) Working Group

Mr. Kupferman, chair of the Long-Term Care Actuarial (B) Working Group, updated the Committee on the activities of the Working Group’s subgroups. He said the Long-Term Care Pricing (B) Subgroup recently concluded its discussion of the Kansas proposal related to long-term care insurance rate increases and distributed it for comment. He said the Long-Term Care Valuation (B) Subgroup is meeting May 22 via conference call with the American Academy of Actuaries’ Long-Term Care Principle-Based Work Group to discuss how to proceed with developing a principle-based reserving methodology for long-term care insurance valuation. Mr. Kupferman said California will be presenting its findings from its review of premium deficiency worksheets from approximately 40 to 50 companies operating in California to the Long-Term Care Valuation (B) Subgroup June 6 via conference call in regulator-to-regulator session.
d. Regulatory Framework (B) Task Force

Mr. Wieske said the Regulatory Framework (B) Task Force’s Network Adequacy Model Review (B) Subgroup met May 8 via conference call to discuss a work plan for reviewing and considering revisions to the Managed Care Plan Network Adequacy Model Act (#74). During this call, the Subgroup decided that, prior to discussing specific revisions to Model #74, it would like to hear from various stakeholders regarding their specific concerns and issues with network adequacy. Mr. Wieske said the Subgroup is meeting weekly each Thursday through June 19 via conference call to hear from the different stakeholders. He said the Subgroup hopes to finish its work to revise Model #74 by the Fall National Meeting.

Mr. Wieske said the Regulatory Framework (B) Task Force received comments on the revised drafts of the Individual Market Health Insurance Coverage Model Regulation, which is to be a companion to the Individual Market Health Insurance Coverage Model Act (#36), and the Small Group Market Health Insurance Coverage Model Regulation, which is to be a companion to the Small Group Market Health Insurance Coverage Model Act (#106). He said the Task Force most likely will review new drafts incorporating the comments, as appropriate, and any revisions needed as a result of the federal regulations—Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond—during a conference call prior to the Summer National Meeting.

Timothy S. Jost (Washington and Lee University School of Law) asked when the Task Force would begin work on the three NAIC models identified—the Accident and Sickness Insurance Minimum Standards Model Act (#170), the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) and the Group Health Insurance Standards Model Act (#100)—at the Spring National Meeting as the next NAIC models to be prioritized for review and revision. Mr. Wieske said he anticipated the Task Force holding a conference call prior to the Summer National Meeting to discuss its approach for reviewing these NAIC models.

Ms. Goe said the ERISA (B) Working Group is working to complete an initial draft of a white paper examining the issues surrounding the potential impact of small employer self-insurance on the small group market. She said it is anticipated that the initial draft will be distributed for comment in early June. Ms. Goe said that at the end of the comment period, the Working Group would most likely hold one or two conference calls prior to the Summer National Meeting to discuss the comments and revise the draft.

e. Senior Issues (B) Task Force

Commissioner Kipper said the Senior Issues (B) Task Force submitted to the Committee for its consideration the proposed revisions to the rate stability standards contained in the Long-Term Care Insurance Model Regulation, which the Task Force adopted at the Spring National Meeting. He noted that the Committee is meeting June 10 via conference call to consider adoption of the proposed revisions. Commissioner Kipper said the Task Force is working with the Health Actuarial (B) Task Force to draft revisions to the Guidance Manual for Rating Aspects of the Long-term Care Insurance Model Regulation in order to implement the details of a new annual certification requirement contained in the Model #641 proposed revisions.

4. Discussed White Paper on Role of Navigators in the ACA

Ms. Matthews said that because the Committee ran out of time at the Spring National Meeting to discuss the revised draft of Part III of the white paper on the role of navigators, producers and non-navigator personnel in the ACA (Attachment Two-C), it was distributed for comment immediately following the meeting with an April 23 comment deadline. She said one comment letter was received. Mr. Webb said Part I of the white paper, which was developed by the Producer Licensing (EX) Task Force, discusses the certification and training standards for navigators, producers and non-navigator assistance personnel. He said Part II of the white paper, which was developed by the Antifraud (D) Task Force, discusses potential fraud issues related to the activities of navigators, producers and non-navigator assistance personnel. Mr. Webb said Part I and Part II—which have both been adopted—will be combined with Part III of the white paper and distributed for comment. He noted that there would be revisions to Part I of the white paper to reflect the provisions in the recently adopted federal regulations—Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond—concerning the requirements the states may impose on navigators and non-navigator assistance personnel.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
REQUEST FOR MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is:  □ New Model Law  or  ☒ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:
   Health Actuarial (B) Task Force

2. NAIC staff support contact information:
   Eric King  
eking@naic.org  
816-783-8234

3. Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.
   Health Insurance Reserves Model Regulation (#010). Appendix A needs to be revised to reference a new table for the valuation of Individual Long-Term Disability liabilities.

4. Does the model law meet the Model Law Criteria?  ☒ Yes  or  □ No  (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states?  ☒ Yes  or  □ No  (Check one)
      If yes, please explain why
      Current valuation standards are uniform and national.
   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☒ Yes  or  □ No  (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?
   ☒ 1  □ 2  □ 3  □ 4  □ 5  (Check one)
   High Likelihood  Low Likelihood

Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5  

(Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislature will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5  

(Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No
REQUEST FOR MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☐ New Model Law or ☒ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

   Long-Term Care Actuarial (B) Working Group

2. NAIC staff support contact information:

   Eric King
   eking@naic.org
   816-783-8234

3. Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   Health Insurance Reserves Model Regulation (#010). Section 4. and Appendix A need to be revised to reference new standards for the valuation of long-term care insurance liabilities.

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)

      If yes, please explain why

      Current valuation standards are uniform and national.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

      ☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

   ☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 (Check one)

   High Likelihood Low Likelihood

   Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5  (Check one)

High Likelihood                     Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislature will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5  (Check one)

High Likelihood                     Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No
Part III

Navigator, Non-Navigator Assistance Personnel and Certified Application Counselor Outreach Functions

Open enrollment through the health insurance exchanges began Oct. 1, 2013. There are a number of individuals, each with a different function, who will play a role in assisting both individual consumers and small employers and their employees to enroll through an exchange. Navigators, non-navigator assistance personnel, certified application counselors and licensed insurance producers all will provide consumer-focused assistance with completing applications for and enrollment in qualified health plans (QHPs) and insurance affordability programs. Navigators and certified application counselors will perform these functions in all exchanges—federally facilitated, partnership and state-based exchanges. Licensed insurance producers also will perform these functions in federally facilitated and partnership exchanges and state-based exchanges, subject to any participation requirements they may establish. State-based exchanges may establish. Non-certified entities, such as the U.S. Department of Health and Human Services (HHS) “Champions for Coverage” also are described, including the outreach functions they may perform and limitations on those functions.

I. Functions of Navigators

Authorized under section 1311(i) of the federal Affordable Care Act (ACA) and federal regulations, a navigator is an entity that employs individuals trained to help consumers understand the insurance policies available through an exchange and answer consumer questions about the exchange. Navigators can answer questions about insurance affordability programs, including Medicaid and CHIP (Children’s Health Insurance Program) and educate consumers about their health insurance policy options and help them apply for coverage.

Navigator functions include a number of consumer assistance activities designed to help consumers prepare electronic and paper applications to establish eligibility and enroll in health insurance coverage through the exchange. As part of this function, a navigator can help consumers to compare QHPs and answer questions about health insurance policies in general. They also can answer questions from consumers about the differences in QHPs and what that might mean for them, but a navigator cannot recommend or suggest which QHP would be best for consumers and their families. In addition, navigators must provide referrals to offices of health insurance consumer assistance or health insurance ombudsmen established under section 2793 of the Public Health Service Act (PHSA) or to any other appropriate state agency or agencies and assist consumers with grievances, complaints or questions regarding their health plan, coverage or a determination under such plan or coverage. States may require navigators to perform additional functions or impose restrictions on the functions they may perform. However, any additional functions or restrictions that a state may decide to impose may not conflict with federal requirements such that they would “prevent the application” of federal law.

Navigators must provide information in a fair, accurate and impartial manner, and may not sell, solicit, or negotiate insurance coverage in a QHP through the exchange because these activities may only be performed by a licensed insurance producer. They also may not charge consumers for assistance, or steer them to someone who charges. Navigators may not collect premium payments on behalf of a health insurer or the exchange. Navigators are compensated through grant awards from an exchange. Federally facilitated exchanges will charge participating plans a fee to cover administrative costs, including grants to navigators; state-based exchanges may charge a fee or use other sources of funds to compensate navigators.

Navigators may not be health insurers nor have a relationship with a health insurers or stop-loss insurers. Insurance producers may act as a navigator, but if they are a navigator, they cannot receive any compensation from a health insurer in the state for which they received the navigator grant award, as provided in the signed Navigator Cooperative Agreement (whether for exchange coverage or off-exchange coverage), to avoid any conflicts of interest. In addition, to meet specific standards for selection, any entity selected as a navigator may not receive any consideration directly or indirectly from any health insurer in connection with the enrollment of any qualified individuals or employees of a qualified employer in insurance coverage in a QHP.
II. Functions of Non-Navigator Assistance Personnel

Non-navigator assistance personnel (also known as in-person assistance personnel) generally will perform the same functions as navigators. Authorized under federal regulations, non-navigator assistance personnel also can help ensure that an exchange is providing outreach, education and assistance to as broad a range of consumers as possible so that all consumers can receive help when accessing health insurance coverage through an exchange. Also, like navigators, non-navigator assistance personnel must provide referrals to offices of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA or to any other appropriate state agency or agencies and assist consumers with grievances, complaints or questions regarding their health plan, coverage or a determination under such plan or coverage.

Non-navigator assistance personnel can help consumers in a fair, accurate and impartial manner to compare QHPs and answer questions about health insurance policies in general. They also can help educate consumers about health insurance policies and help them apply for coverage. Non-navigator assistance personnel can answer questions from consumers about the differences in QHPs and how those differences might affect them, such as explaining deductibles or out-of-pocket limits. As with navigators, the non-navigator assistant personnel may not recommend or suggest which QHP would be best for consumers and their families. Also, like navigators, non-navigator assistance personnel may not sell, solicit, or negotiate insurance coverage in a QHP through the exchange because these activities can only be performed by a licensed insurance producer. Non-navigator assistance personnel also may not provide insurance coverage in a QHP through the exchange because these activities may only be performed by a licensed insurance producer. Federally facilitated exchanges will not have non-navigator assistance personnel; state-based exchanges and state partnership exchanges carrying out consumer assistance functions for a federally facilitated exchange may have such personnel and can receive federal grants to fund their activities.

III. Functions of Certified Application Counselor (CAC) Organizations

Certified application counselor (CAC) organizations can perform some of the same activities as navigators and non-navigator assistance personnel, but with some key differences. These organizations, and the individuals working for or volunteering with these organizations who are certified as certified application counselors, can: 1) provide information to individuals and employees about insurance affordability programs and coverage options; 2) assist individuals and employees in applying for coverage in a QHP through the exchange and in insurance affordability programs; and 3) help facilitate enrollment in QHPs and insurance affordability programs. Unlike navigators and non-navigator assistance personnel—who have a duty to provide referrals to offices of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or to any other appropriate state agency or agencies and assist consumers with grievances, complaints, or questions regarding their health plan, coverage, or a determination under such plan or coverage—CAC organizations are not expected to have the knowledge to make these types of referrals since their role is limited to providing enrollment assistance to consumers. In addition, unlike navigator grant applicants and non-navigator assistance personnel who cannot have any conflicts of interest to be selected, CACs applicants are required only to disclose to the CAC organization and potential applicants any conflicts of interest the CAC may have with QHPs or insurance affordability programs or other potential conflicts of interest.

CAC organizations can provide application assistance to consumers in entities such as community health centers, health care providers, social service organizations and local governmental entities. They also can help consumers to compare QHPs and answer questions about health insurance policies in general. CAC organizations also can answer questions from the consumer about the differences in QHPs and what they might mean to them, such as explaining deductibles or maximum out-of-pocket limits, but the CAC organization cannot recommend or suggest which QHP would be best for consumers and their families. However, CAC organizations must act in the best interest of the applicant. CAC organizations may not sell, solicit, or negotiate insurance coverage in a QHP through the exchange because these activities may only be performed by a licensed insurance producer. They also may not charge consumers for assistance, or steer them to someone who charges. There are no federal or state grant funds for CAC organizations, although some funding through the Health Resources Services Administration (HRSA) has been made available to federally qualified health centers to provide enrollment assistance as CAC organizations.

An organization that applies for and has been designated by an exchange to perform the functions of a CAC organization must ensure that those staff members and volunteers the organization or the exchange certifies as application counselors meet...
and comply with the application counselor certification and other requirements, including completing a federal training program to be certified as an application counselor for a federally facilitated exchange or, state training to be certified as an application counselor for a state-based exchange if the state-based exchange chooses not to use the federal training program. All exchanges whether a federally facilitated, state-based or partnership exchange must include CAC organizations.

IV. Functions of “Champions for Coverage” and Other Non-Certified Entities

Champions for Coverage are organizations that request recognition by HHS as an outreach and education partner to inform consumers about exchanges. HHS has specified a number of different ways that Champions for Coverage can carry out this function, including: 1) sending the organization’s partners, members and/or customers to the official consumer assistance sources to learn about the exchange and get coverage; 2) sending an email to its network about the exchange; 3) posting the HealthCare.gov and/or CuidadoDeSalud.gov widget on its website; 4) hanging posters and/or giving out fact sheets and brochures about the exchange; 5) hosting a conference call, webinar or other educational event about the exchange; 6) including a story about the exchange in the organization’s newsletter or other organizational publication; 7) recording and sending out a public service announcement about the exchange; 8) hosting educational sessions about the exchange for its staff and/or members; 9) connecting with its partners, members and/or customers through official exchange social media channels to share their stories; and 10) hosting enrollment sessions or fairs (ideally with computers with connectivity to the exchange website so consumers can check out the exchange online).

Champions for Coverage organizations will not be directly: 1) assisting consumers in comparing QHPs; 2) answering questions from consumers about the differences in QHPs and what those differences might mean to them, such as explaining deductibles or maximum out-of-pocket limits; or 3) assisting consumers in completing applications for enrolling through an exchange. These organizations serve only as an additional resource HHS is using to reach out to consumers and inform them on the existence of the exchange.

Further, organizations recognized as “Champions for Coverage” do not enter into any legally binding contract with HHS; however, they have consented to having their organization’s name publicly listed as a “Champion for Coverage,” and have agreed to refrain from suggesting or implying that designation as a “Champion for Coverage” constitutes an endorsement of the organization, its policies, activities or products by HHS or the federal government. In addition, participating “Champions for Coverage” entities do not become agents, employees or representatives of HHS for any purpose, and undertake their efforts without any expectation of compensation from HHS or any other federal agency. There are no training requirements for Champions for Coverage.

V. Functions of Licensed Insurance Producers and Web-Brokers

To the extent permitted by state law and if all exchange requirements are met, licensed insurance producers may enroll individuals, small employers and employees in coverage through an exchange by using an insurer’s website or an exchange pathway through which the producer assists the consumer using the exchange website. Insurance producers must ensure that if they use a website, they provide consumers with the ability to view all QHPs offered through the exchange. Like navigators and non-navigator assistance personnel, insurance producers are expected to refer consumers who have been determined to be eligible for Medicaid or CHIP to the appropriate state agency for additional assistance.

Insurance producers will be compensated by the insurer or by the consumer to the extent permitted under state law. Federal and state training and certification requirements will apply to agents and brokers who enroll or assist consumers in enrolling through an exchange.

Insurance producers also may enroll consumers through exchanges via public-facing websites. Insurance producers utilizing this method of enrollment are known as “web-brokers.” If permitted by a state-based exchange, web-brokers will provide an alternate path to QHP selection options for consumers. Through these public-facing websites, web-brokers may provide consumer information for comparing and selecting QHPs from the individual exchange. However, web-brokers using these public-facing websites, at a minimum, must disclose and display all QHP information provided by the exchange or directly by QHP issuers in a way that provides standardized comparative information on each available QHP that includes premium cost-sharing information, the summary of benefits and coverage and whether the plan is bronze, silver, gold, platinum or a catastrophic plan and satisfy other requirements, including website accessibility requirements, described in the federal rules. Web-brokers also can provide an additional channel for federally facilitated exchanges to reach consumers and to help them...
enroll in QHPs. Web-brokers must comply with all applicable state law, including state law related to compensation and appointments, as a condition of enrolling individuals through the exchange.

**Distinction from Functions of Licensed Insurance Producers**

The main distinction between the functions that can be performed by licensed insurance producers and the other types of consumer assistance entities and personnel discussed above is that only licensed insurance producers may sell, solicit, or negotiate a specific QHP through the exchange. In addition, licensed insurance producers will receive compensation from the insurer or the consumer to the extent permitted under state law related to the enrollment.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call June 17, 2014. The following Subgroup members participated: Angela Nelson, Chair (MO); Mary Childers, Vice Chair (WA); Jacob Lauten (AK) Michael Klener, Pam White and Chris Struk (FL); Linda Sheppard and Cindy Hermes (KS); Mary Butler (IA); Mary Kwei and Joy Hatchette (MD); Nina Twardowski (MN); Cathy Townes and Viara Ianakieza (NM); Kevin Jeffries (OR); and Nancy Askerlund and Jaak Sundberg (UT). Also participating were: Pamela Stutch (ME); Mary Mealer (MO); Jana Jarrett (OH); and J.P. Wieske (WI).

1. Discussed Comments and Updates to the FAQ Document

The Subgroup discussed its current task to update the “Frequently Asked Questions about Health Care Reform” (FAQ document). On its last conference call, the Subgroup decided to first query state regulators about whether the FAQ document was useful to state insurance department consumer assistance staff and ask whether the document should be updated before proceeding to begin working on revisions.

Ms. Nelson reported that the Subgroup received written comments from Washington, Maine, Maryland and Virginia, which indicated that those states believe the document is useful and should be updated. In addition, she reported that Missouri’s consumer assistance staff was also queried and provided feedback that the document is useful and should be updated with new information available. Ms. Sheppard reported that Kansas is pleased that the Subgroup is interested in updating the FAQ. Ms. Stutch also commented that Maine’s staff has found the document to be helpful.

Ms. Nelson asked whether any other states had feedback and there was none. Given the positive feedback, the Subgroup agreed to proceed with updating the FAQ document.

Marty Mitchell (America’s Health Insurance Plans—AHIP) asked whether the states have utilized similar materials available from other organizations, such as Georgetown University or the Commonwealth Fund. He noted that most of this material had not yet been available when the FAQ document was first created. Ms. Childers reported that Washington had utilized several different sources to try to best interpret the regulations, as some developments were fluid, and, therefore, it was rarely possible to rely only upon one definitive source. Mr. Wieske said that Wisconsin had used a similar approach, utilizing a variety of sources in order to develop their own materials for consumers based on the information they needed.

Ms. Mealer reported that the consumer assistance staff in Missouri used the FAQ document as their primary first source, and then supplemented with other sources such as the ones mentioned by Mr. Mitchell, as well as others. Ms. Nelson also noted that, when using documents from other organizations, state insurance department staff needed to factor in that organization’s perspective and potential bias, whereas the FAQ document had unique credibility given the participation of all of the divergent stakeholders, such as state insurance regulators, consumer groups, industry representatives and agent/broker groups. Timothy S. Jost (Washington and Lee University School of Law) noted that the FAQ document is unique in the type of material it covers and in its focus on answering specific questions that consumers may have, rather than simply providing a general review of the rules.

2. Discussed FAQs Posted on State Insurance Department Websites

Ms. Sheppard reported that Kansas had loaded the FAQ onto their website for consumers to access directly, making it interactive so that consumers could easily find the information they were looking for. She reported that feedback from consumers has been positive. Ms. Nelson noted that, in Missouri, the questions state insurance department staff selected to put on their website was typically driven by the volume of questions they had received from consumers on a particular topic. Mr. Wieske reported that Wisconsin noticed some differences between the types of information focused on in the FAQ document versus the information they found most useful to consumers. He noted that Wisconsin also posted information on their website, but broke out the information based on the target audience, such as agents, individual, small group, etc.
Mr. Mitchell asked whether the Subgroup could collect the links for the states that have posted the FAQ document on their website so that everyone could see what the states have done with it and what they have selected to include on their website. Ms. Nelson asked the states that had posted the FAQ document on their websites, and that would like to share that information with the Subgroup, to send a link to NAIC staff. The links will be compiled and distributed.

3. Discussed Topics to be Updated

Ms. Nelson reviewed that, on the last call, the Subgroup had identified several topics that needed to be updated, enhanced or modified in the FAQ document: 1) a high-level overview of the U.S. Department of Health and Human Services’ (HHS) transitional policy; 2) fraud — specifically information to help consumers distinguish real marketplace websites from fraudulent websites; 3) rules changes for the small employer market; 3) appeals processes for subsidy determinations; 4) retroactive tax credit for individuals who had trouble accessing state exchanges in certain states; 5) Marketplace eligibility for under age 65 Medicare-eligible due to disability; 6) ability to switch plans outside of open enrollment, including explanation of special enrollment periods; and 7) provider networks.

Additional feedback was included in the written feedback provided by state consumer assistance staff and will be considered for inclusion in the revisions. Ms. Nelson asked whether there were other issues that needed to be addressed.

Mr. Wieske noted that Wisconsin had been dealing with an issue relating to the Small Business Options Program (SHOP) exchange and noted that the federal SHOP exchange will calculate small group size differently than the outside market in Wisconsin. He said this is an important item to address in the FAQ document. Kathleen Gmeiner (Universal Health Care Action Network Ohio—UHCAN) asked whether this would be an issue in all of the states. Mr. Wieske said he thought this would affect most of the states because the federal government relies upon the definition of “full time equivalents” (FTEs) to calculate employees and most of the states would not use that same definition.

Mr. Wieske also suggested there should be information added for consumers about what to do regarding special enrollment periods, especially when it involves COBRA or a state continuation requirement.

Mr. Jost suggested that it might be helpful to start gathering questions about the re-enrollment period for 2015, as state insurance departments may soon begin receiving questions about that, and the answers for 2015 will be different than the information provided about the 2014 enrollment. He noted that the timing for when the states begin to receive these questions will likely coincide with the completion of this update. Mr. Wieske agreed and said that consumers are used to getting a premium notice about whether and how much their premiums would go up, without having to worry about doing anything else, and that may not be the case this year.

Ms. Mealer suggested that the Subgroup may want to consider adding information about dental plans that are not on a calendar year renewal schedule. Ms. Nelson said that the FAQ should also be updated to reflect changes included in the market standards regulation recently finalized by the U.S. Centers for Medicare & Medicaid Services (CMS). Some of the topics already discussed are included in that regulation, which will be reviewed.

4. Discussed Next Steps for Updating the FAQ Document

Ms. Nelson suggested that the Subgroup proceed with updating the FAQ document in two initial tracks. First, for technical updates, which include bringing the document up to date for accuracy and reflecting the most recent federal rules, Ms. Nelson suggested that NAIC staff be asked to making the first set of these revisions. Second, for new sections and new language to be added to the document, Ms. Nelson asked participants to begin the process of adding these sections to the document by submitting potential questions that should be added to the FAQ. Once the FAQ is updated for accuracy and potential new questions are compiled, the Subgroup can later proceed to begin drafting responses to the new questions.

Mr. Jost suggested that the Advisory Working Group members and others could assist NAIC staff in making technical corrections by submitting suggested draft language, but Mr. Mitchell expressed concern about duplication of effort. The Subgroup agreed to accept comments from Advisory Working Group members and others, and NAIC staff would make these comments available to other Subgroup and Advisory Working Group members and posted on the Subgroup’s website as they were submitted so that all parties would be aware of what language was already submitted.
Participants were asked to submit suggested language for technical corrections, and suggested questions for new sections, to NAIC staff by July 9. The Subgroup intends to hold its next conference call to review a draft by the end of July or early August.

5. Discussed Other Matters

David Korsh (Blue Cross and Blue Shield Association—BCBSA) asked whether the Subgroup should take any action to address the general public’s low level of health insurance literacy. He cited recent reports about consumers’ lack of understanding of concepts such as the definition of “deductible” or “coinsurance.” Ms. Sheppard noted that there were materials recently made available by HHS to address this issue. She said the information provided was valuable; however, in its current format, it would be overwhelming, so it would need additional work before it would be useful to consumers. Mr. Jost said that CMS had recently launched an effort called “Connecting to Care,” which explains to consumers how to access care, describes basic terminology and includes other useful information.

Ms. Jarrett said state insurance departments receive questions about basic insurance topics on a daily basis, and that state insurance department staff is trained and experienced in handling these types of questions. Brenda Cude (University of Georgia) suggested that the Subgroup may want to start compiling a list of resources that may be helpful to the states in handling these inquiries.

Ms. Nelson noted that this topic is outside their current task of updating the FAQ document. However, given the importance of the issue, she suggested that the Subgroup should pursue whether the NAIC should do more on this issue and what, if any, role the Subgroup should play in such an effort.

Having no further business, the Consumer Information (B) Subgroup adjourned.
HEALTH ACTUARIAL (B) TASK FORCE

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The Health Actuarial (B) Task Force met in Louisville, KY, Aug. 15, 2014. The following Task Force members participated: Jim L. Ridling, Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Katie Campbell (AK); Dave Jones represented by Perry Kipferman (CA); Thomas B. Leonard represented by Mary Ellen Breault (CT); Kevin M. McCarty represented by Eric Johnson (FL); Sandy Praeger represented by Mark Birdsall (KS); Sharon P. Clark represented by Maggie Woods (KY); Therese M. Goldsmith represented by Melissa Cain (MD); Annette E. Flood represented by Kevin Dyke (MI); Mike Rothman represented by Kristi Bohn (MN); Kenneth E. Kobylowski represented by Felix Schirripa (NJ); Benjamin M. Lawsky represented by Stephen Wiest (NY); Mary Taylor represented by Matt Elston (OH); Michael F. Consedine represented by Peter Camacci (PA); Raymond G. Farmer represented by Leslie Jones (SC); Julia Rathgeber represented by Jan Graeber (TX); and Todd E. Kiser represented by Jaak Sundberg (UT).

1. **Adopted its Aug. 1 Minutes**

Mr. Rink made a motion, seconded by Mr. Dyke, to adopt the Task Force’s Aug. 1 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Report of the Health Care Reform Actuarial (B) Working Group**

Mr. Dyke gave a report of the Health Care Reform Actuarial (B) Working Group’s recent activities. The Working Group met Aug. 15 (Attachment Two) and its Actuarial Value (B) Subgroup met June 19 (Attachment Two-A) and May 22 (Attachment Two-B). Mr. Dyke made a motion, seconded by Mr. Rink, to adopt the report of the Working Group. The motion passed unanimously.

3. **Heard an Update from the AAA/SOA Cancer Claim Cost Table Work Group**

Cindy MacDonald (Society of Actuaries—SOA) said the goal of the SOA relative to the joint AAA/SOA work group is to provide cancer insurance hospital confinement and first occurrence data to the AAA/SOA work group in order to produce updated claim cost tables to replace the 1985 NAIC Cancer Claim Cost Tables. She said data has been collected from 13 carriers, which represents approximately 65% of the market. She said the SOA has processed the data, and that approximately 25 million life-years of exposure will be included in the study. She said the hospital confinement data will be forwarded to the AAA by the end of August, and the first occurrence data will be forwarded to the AAA by mid-September. Brad Spenney (AFLAC Inc.) said the AAA has formed several subgroups to conduct analysis of specific issues, and that the AAA/SOA work group will be able to complete its analyses and provide the Task Force with replacement tables late in 2015. He said the AAA/SOA work group will compare the data provided by the SOA to all existing cancer insurance data including the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer to ensure data quality.

4. **Heard a Report from the SOA**

Ms. MacDonald referred to a list (Attachment Three) of SOA health research projects in progress and gave a presentation (Attachment Four) with updates on SOA experience studies in progress. Mr. Ostlund asked if the terminations in the long-term care claim termination study include terminations due to benefit exhaustion. Ms. MacDonald verified the terminations used exclude terminations due to benefit exhaustion.

5. **Heard a Presentation from the AAA Council on Professionalism**

Patricia Matson (Risk & Regulatory Consulting, LLC—RRC) said the ASB is seeking comments on its discussion draft, Determining Minimum Value and Actuarial Value under the Affordable Care Act, by Sept. 30. She said the ASB received 25 comments on its Medicaid Managed-Care Capitation Rate Development and Certification exposure draft, and she expects the Actuarial Standard of Practice (ASOP) based on the draft to be available at the ASB’s December meeting. She said a group has been formed to review ASOP No. 5, Incurred Health and Disability Claims, to determine if changes to the ASOP are needed. She said the ASB expects to receive a final version of an ASOP based on the Modeling exposure draft at its
September meeting. She said an updated version of ASOP 38, Using Models Outside the Actuary’s Area of Expertise (Property and Casualty), that expands the ASOP’s scope beyond only P/C insurance will be released at the September meeting. She said the ASB has issued a request for comment on public pension funding. She said the ASB is reviewing ASOP No. 21, Responding to or Assisting Auditors or Examiners in Connection with Financial Statements for All Practice Areas, to determine if changes to the ASOP are needed, and asked for volunteers to assist in the review. Mr. Ostlund said that actuaries should be aware they need to comply with the recently revised ASOP No. 8, Regulatory Filings for Health Plan Entities, which will be effective Sept. 1.

John Purple (RRC) said the Actuarial Board for Counseling and Discipline (ABCD) received 82 requests for guidance last year across all disciplines, and approximately 20 of these were related to health insurance. He said that, this year, there has been an average of 25 requests per quarter, with approximately 25% of the requests being related to health insurance. He said the ABCD is available to assist regulators with issues related to interpretation of ASOPs or provide mediation in actuarial disputes. Mr. Ostlund asked if the ABCD is willing to summarize guidance it has provided in the past. Mr. Purple said the ABCD provided detail on some of the issues it provided guidance on last year in its current annual report, and will do so in its next annual report.

Mary Miller (RRC) introduced a template (Attachment Five) drafted by the AAA to provide actuaries with a way to attest to how they meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (Qualification Standards) promulgated by the AAA. She said the template presents comprehensively and concisely what an actuary needs to do to meet the Qualification Standards. She said the AAA will post the template on its website, and intends to compile a database of voluntary responses from actuaries who complete the template that will be available for others to see the actuaries’ attestations. She said the AAA hopes to be able to link the template to its online TRACE tool, which is used to track actuaries’ continuing education (CE) efforts, so CE can also be viewed when viewing an attestation. She said the attestation also applies to demonstration of meeting the qualification standards for those signing a statement of actuarial opinion for NAIC annual financial statements. She said the draft template includes a link to submit comments on the draft to the AAA. Mr. Kupferman asked if the AAA would require all actuaries to complete the attestation. Ms. Miller said the attestation is intended to be voluntary at this time. Mr. Dyke said the NAIC could make submitting the attestation to the AAA a requirement for actuaries providing a statement of actuarial opinion for NAIC annual financial statements. He said the template should include specification of what discipline and to which function the attestation applies. Ms. Miller said a draft of the template that reflects changes based on comments received will be presented at the Fall National Meeting. She said the attestation draft is a first step toward providing a vehicle for AAA verification that an actuary is qualified to sign a statement of actuarial opinion, as requested by the Joint Qualified Actuary (A/B/C) Subgroup. Mr. Ostlund said, referring to a June 17 email (Attachment Six), that once the revised draft is available for review, the Joint Qualified Actuary (A/B/C) Subgroup may be reappointed by the Life Actuarial (A) Task Force, the Health Actuarial (B) Task Force and the Casualty Actuarial and Statistical (C) Task Force.

6. Heard a Report from the AAA Health Practice Council

Shari Westerfield (Blue Cross and Blue Shield Association—BCBSA) presented a list (Attachment Seven) of recent Health Practice Council publications, activities and webinars.

7. Discussed Appointing a Subgroup to Work on PBR for Health Insurance Reserves

Mr. Ostlund said he will be appointing a subgroup to work on health insurance principle-based reserving (PBR) issues and their inclusion in the Valuation Manual, and asked that volunteers for the subgroup contact Eric King (NAIC) at eking@naic.org.

8. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Mr. Kupferman said the Long-Term Care Actuarial (B) Working Group met Aug. 15 (Attachment Eight). The Long-Term Care Pricing (B) Subgroup met July 8 (Attachment Eight-A), July 1 (Attachment Eight-B), June 24 (Attachment Eight-C), June 10 (Attachment Eight-D), May 15 (Attachment Eight-E), May 8 (Attachment Eight-F) and May 1 (Attachment Eight-G). The Long-Term Care Valuation (B) Subgroup met May 22 (Attachment Eight-H) and in regulator-to-regulator session June 6 pursuant to paragraph 3 (specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis) of the NAIC Policy Statement on Open Meetings. During its Aug. 15 meeting, the Working Group heard updates from the AAA State Long-Term Care Terminations Work Group, the AAA Long-Term Care Principle-Based Work Group and the AAA Long-Term Care Credibility Monograph Work Group.
Mr. Kupferman made a motion, seconded by Mr. Sundberg, to adopt the report of the Long-Term Care Actuarial (B) Working Group. The motion passed unanimously.

9. Discussed Other Matters

Mr. Ostlund said that Illinois has requested to no longer serve as vice chair of the Task Force. He asked that anyone who is interested in serving as vice chair of the Task Force to contact him after discussing it with his or her commissioner. He said he would forward that expression of interest to the Executive (EX) Committee, which makes the appointment.

Having no further business, the Health Actuarial (B) Task Force adjourned.
The Health Actuarial (B) Task Force met via conference call Aug. 1, 2014. The following Task Force members participated: Jim L. Ridling, Chair, represented by Steve Ostlund (AL); Andrew Boron, Vice Chair, represented by Susan Christy (IL); Dave Jones represented by Perry Kupferman (CA); Thomas B. Leonardi represented by Mary Ellen Breault (CT); Kevin M. McCarty represented by Linda Ziegler (FL); Sharon P. Clark represented by Jill Mitchell (KY); Eric A. Cioppa represented by Sandra Darby (ME); Annette E. Flood represented by Kevin Dyke (MI); Mike Rothman represented by Julia Philips (MN); Bruce R. Range represented by John Rink (NE); Benjamin M. Lawsky represented by Frank Horn (NY); Mary Taylor represented by Matt Elston (OH); Michael F. Consedine represented by Peter Camacci (PA); Raymond G. Farmer represented by Leslie Jones (SC); and Todd E. Kiser represented by Jaak Sundberg (UT).

1. Reviewed the Summer National Meeting Agenda for the Health Actuarial (B) Task Force

Mr. Ostlund gave an overview of the agenda for the Task Force’s session at the Summer National Meeting.

2. Reviewed the Summer National Meeting Agenda for the Long-Term Care Actuarial (B) Working Group

Mr. Kupferman gave an overview of the agenda for the Working Group’s session at the Summer National Meeting.

3. Heard a Report from the AAA Individual Disability Table Work Group

Doug Taylor (Massachusetts Mutual Financial Group) gave an update (Attachment One-A) on the American Academy of Actuaries’ (AAA) Individual Disability Table Work Group’s activities related to work on the 2013 Individual Disability Valuation Table. He said the work group would hold a conference call Aug. 4 to discuss comments received by the Task Force on the table. Mr. Ostlund said the Task Force will form the Individual Disability Valuation Table Implementation (B) Subgroup to oversee adding references to the table to the Health Insurance Reserves Model Regulation (#10), developing an actuarial guideline to implement use of the table and methodologies for its use, and collaborating with the Statutory Accounting Principles (E) Working Group to add references to the table in the Accounting Practices and Procedures Manual. He asked that volunteers for the new Subgroup contact NAIC staff.

4. Adopted its 2015 Proposed Charges

Mr. Kupferman made a motion, seconded by Ms. Philips, to adopt the Task Force’s 2015 Proposed Charges (Attachment One-B). The motion passed unanimously.

Having no further business, the Health Actuarial (B) Task Force adjourned.
Status Update

- Proposed timeline
  - Comments received from industry (exposure period ended June 30, 2014) – comments received from 10 different sources
  - Subgroups develop proposed responses by 8/1
  - IDTWG discusses responses on 8/4
  - IDTWG compiles comments by 8/15
  - HATF has call with IDTWG and interested parties week of 9/1 – to allow time for commenters to discuss further
  - IDTWG final presentation via conference call to HATF by end of September

- Questions for HATF about next steps
  - Will HATF set up its own working group on this topic as it did for GLTD?
  - What are the steps after HATF adoption? What is the NAIC’s timeline?

Staff Contact Information

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The mission of the Health Actuarial (B) Task Force is to identify, investigate and develop solutions to actuarial problems in the health insurance industry.

**Ongoing Maintenance of NAIC Programs, Products, or Services:**

1. Work with the Society of Actuaries (SOA) and the American Academy of Actuaries (AAA) to develop a replacement for the 1985 Commissioners Individual Disability Income Table. Ensure the Health Insurance Reserves Model Regulation (#10) remains open to accommodate the new table.—**Important**

2. Work with the AAA and SOA to develop a replacement for the 1985 NAIC Cancer Claim Cost Tables as the basis for the valuation of individual cancer policies Request Model #10 be opened to accommodate the new table.—**Important**

3. Revise model rules for appropriate long-term care rates, rating practices and rate changes.—**Important**

4. Study the minimum standards applicable to statutory reserves for long-term care insurance. Ensure Model #10 remains open to accommodate any necessary changes to the standards. Begin developing a principle-based framework for a set of minimum standards.—**Important**

5. Review the Medicare supplement refund formula.—**Important**

6. Provide support for issues related to implementation of the federal Affordable Care Act (ACA).—**Essential**

7. Begin to develop health insurance reserving requirements (VM-25) using a PBR methodology. Long-term care should be a priority. Request Model #10 be opened to accommodate the new requirements.—**Important**

8. Submit VM-25 changes to the Life Actuarial (A) Task Force for publication in the Valuation Manual.—**Important**

9. Develop LTC experience reporting requirements in VM-50 and VM-51 of the Valuation Manual.—**Important**

10. Provide recommendations as appropriate to address issues and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.—**Important**
The Health Care Reform Actuarial (B) Working Group of the Health Actuarial (B) Task Force met in Louisville, KY, Aug. 15, 2014. The following Working Group members participated: Kevin Dyke, Chair (MI); Steve Ostlund (AL); Mark Birdsall (KS); Kristi Bohn (MN); Felix Schirripa (NJ); Stephen Wiest (NY); Matt Elston (OH); Leslie Jones (SC); Jan Graber (TX); and Jaak Sundberg (UT).

1. **Discussed the Working Group’s Recent Activities**

Mr. Dyke said the Working Group has two Subgroups that report to it: the State Rate Review (B) Subgroup and the Actuarial Value (B) Subgroup. He said the State Rate Review (B) Subgroup has not met since the Spring National Meeting. He said the Working Group is charged with providing support to the Health Actuarial (B) Task Force with regard to issues related to the implementation of the federal Affordable Care Act (ACA), developing a best practices document for the review of issuers’ non-standard ACA actuarial value (AV) calculations, and monitoring American Academy of Actuaries (Academy) and Actuarial Standards Board (ASB) activities related to AV and minimum value (MV).

Mr. Dyke said the Actuarial Value (B) Subgroup was formed in March at the request of the federal Center for Consumer Information and Insurance Oversight (CCIIO) to address the review of non-standard AV calculations. He said he expects the Subgroup will complete its work by the end of the year, and the Subgroup will likely be disbanded, but it can be reappointed in the event that AV or MV issues arise in the future. He said the Subgroup met via June 19 and May 22 to develop its charges and to discuss development of a best practices document for the review of issuers’ non-standard AV calculations. He said the Subgroup identified the Academy’s *Minimum Value and Actuarial Value Determinations Under the Affordable Care Act* practice note and the ASB’s discussion draft, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*, as starting points to use in developing its best practices document. He said the ASB has asked for comments on its discussion draft by Sept. 30, and the Subgroup has started to draft comments to submit to the ASB. He said the Subgroup will review a document written by INS Consultants, *Best Practices for Reviewing Alternative Actuarial Value Calculations of the Affordable Care Act*, to determine if it can be used for development of its best practices document. He said the Subgroup will meet via conference call to continue discussion of the comments it will provide on the ASB’s discussion draft.

Mr. Dyke said the State Rate Review (B) Subgroup will likely meet via conference call after the states have completed their reviews of ACA rate filings.

2. **Adopted the Actuarial Value (B) Subgroup’s June 19 and May 22 Minutes**

Ms. Jones made a motion, seconded by Mr. Ostlund, to adopt the June 19 (Attachment Two-A) and May 22 (Attachment Two-B) minutes of the Actuarial Value (B) Subgroup. The motion passed unanimously.

Having no further business, the Health Care Reform Actuarial (B) Working Group adjourned.

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The Actuarial Value (B) Subgroup of the Health Care Reform Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call June 19, 2014. The following Subgroup members participated: Kevin Dyke, Chair (MI); Marti Hooper (ME); Matt Elston (OH); and Shari Miles (SC).

1. Discussed Comments on ASB Minimum Value and Actuarial Value Discussion Draft

Mr. Dyke gave an overview of comments received (Attachment Two-A1) from Subgroup members concerning the Actuarial Standards Board’s (ASB) discussion draft, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*. Mr. Dyke said the Subgroup will ask for clarification if “health plan” in the context of the discussion draft applies only to plans that are subject to the federal Affordable Care Act (ACA) or if a broader definition is intended. Bill Weller (America’s Health Insurance Plans—AHIP) said he is concerned that if an Actuarial Standard of Practice (ASOP) is developed based on the discussion draft, the ASOP may not be easily updated to reflect changes in regulations governing the calculation of minimum value and actuarial value. Mr. Dyke said the Subgroup will consider including this concern in its comments.

2. Discussed Development of a Best Practices Document

Mr. Dyke presented a document (Attachment Two-A2) about best practices for reviewing alternative ACA actuarial value calculations that INS Consultants wrote. He asked call participants to review the document to determine if it could be used to assist in developing the Subgroup’s best practices document. Mr. Elston said he reviewed the document and that it appears to be useful for the Subgroup’s efforts to develop its best practices document, particularly in its discussion of reporting to substantiate alternative actuarial value calculations.

Having no further business, the Actuarial Value (B) Subgroup adjourned.
Virginia (David Shea)
At first blush, there may not be enough meat on the topic of AV/MV as defined by the ACA to warrant an ASOP. For example, one item in the ASOP describes when to use the AV calculator and when to use the MV calculator; I know this is helpful, especially to actuaries new to the ACA, but to me it doesn’t rise to the level of needing to be in an ASOP.

Maine (Marti Hooper)
1. Yes, we think an ASOP is necessary especially for nonstandard or unique plan designs. We would like to have detail about what should be provided in the rate filing when the plan is unique for the regulator.
2. Section 2.1 second paragraph, insert “standard” before population for consistency. What happens when the calculator changes (possible state population, etc.)?
3. Section 2.5 Definition of Health Plan should exclude limited benefit policies by including only expense-incurred and/or list the limited policies that are excluded?
4. Section 2.7 Should the wording of MV Calculator be consistently worded as AV Calculator definition?
5. Section 2.8 Should the title be Unique or Non-Standard Plan Designs?
6. Section 3.1.2 should require they provide a statement of what was modified and a list to include a screenshot, certification, etc.
7. Section 3.1.5 Would more examples be for reference based pricing or out-of-network coverage?
8. Section 3.2 We were confused about when this would be appropriate. Could there be an example?

Ohio (Matt Elston)
1. In the Purpose of the discussion, it mentions the guidance may be used for other purposes which may address Maine’s concerns around the Definition of Health Plan needing to exclude limited benefit policies.
2. Section 2.4 defines EHBs. This definition needs to be reworked to reflect that EHBs may change in 2016. The definition could just not directly define the EHBs and could instead reference EHBs as defined in the ACA and applicable regulations.
3. Section 3.1.1 mentions that HHS excludes grandfathered plans from the AV calculator. It should also exclude transitional or grandfathered plans.
BEST PRACTICES FOR REVIEWING ALTERNATIVE ACTUARIAL VALUE CALCULATIONS OF THE AFFORDABLE CARE ACT

This document details the best practices for reviewing an issuer’s rate filing, which contains an Alternative Actuarial Value (AV) calculation, permitted under 45 CFR 156.135(b). Below is the code from 45 CFR 135(a) and 45 CFR 135 (b):

(a) Calculation of AV. Subject to paragraph (b) of this section, to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS.

(b) Exception to the use of the AV Calculator. If a health plan’s design is not compatible with the AV Calculator, the issuer must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in paragraphs (b)(2) and (b)(3) of this section: (2) Calculate the plan’s AV by: (i) Estimating a fit of its plan design into the parameters of the AV Calculator; and (ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(3) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator.

(4) The calculation methods described in paragraphs (b)(2) and (3) of this section may include only in-network cost-sharing, including multi-tier networks.

The relevant sources which are used in preparation of this document are the following:

- Minimum Value and Actuarial Value Determinations under the Affordable Care Act, April, 2014, American Academy of Actuaries

- Actuarial Value Calculator Methodology - 2015, Department of Health and Human Services
Actuarial Value – General

The determination of the final 2015 AV Calculator was discussed in the 2015 Final Rule for Benefit Payment Parameters for the Affordable Care Act (Federal Register, Volume 79, Number 47, March 11, 2014). One change was made to the 2014 AV Calculator to account for the updated 2015 annual limit on cost sharing (as known as the Maximum Out-of-Pocket or the MOOP limit) and the related functions in the AV Calculator. Similar to the 2014 AV Calculator, the final 2015 AV Calculator includes an estimated MOOP limit to allow versatility of the AV Calculator. Specifically, the MOOP limit in the 2014 AV Calculator was increased from $6,500 to $6,850 for the 2015 AV Calculator to account for the estimated 2015 annual limit on cost-sharing. Plan designs must not exceed the annual MOOP limit that is established in regulation regardless of the limit included in the AV Calculator. In future years when the AV Calculator is updated through implementation of the parameters set forth in the final rule, this limit will be likely finalized in the annual HHS notice of benefit and payment parameters, after the final AV Calculator is released.

In the individual and insured small-group markets, the metal AV is defined as the ratio of (i) total expected payments by the plan for essential health benefits (EHBs) computed in accordance with the plan's cost-sharing provisions for a standard population over (ii) the total costs for the EHB that the standard population is expected to incur. Benefits that are not considered part of EHB are not included in the AV calculation. The AV calculator begins with a standardized population that is applied across all geographic locations. While the set of specific services included in the EHB set may vary by state, the AV calculator assumes that the difference between EHBs would not have a material impact. (Beginning in 2015, a state may elect to utilize state-specific tables in the AV Calculator, with HHS pre-approval). The AV calculator then takes into account cost-sharing parameters, and also for induced demand in the underlying assumptions. Cost-sharing parameters include those related to deductibles, co-insurance, copays, and out-of-pocket limits. Only in-network cost sharing will be considered for the AV calculation, since out-of-network coverage typically comprises a small proportion of overall use (cost sharing for a tier in multi-tier network products are
considered if the providers in that tier are in-network). Induced demand can occur when cost-sharing elements affect utilization behavior. For example, it generally is assumed that individuals in plans with lower cost-sharing requirements will use more services, even after controlling for differences in health status. The metal AV incorporates induced demand by establishing different continuance tables for each of the four metal tiers (i.e., platinum, gold, silver and bronze.) These continuance tables are each based on a standard population, but the utilization will reflect the relative plan generosity of the particular metal tier. The AV Calculator does not adjust for induced demand within a metal tier.

**Plan Designs Not Accommodated by the AV and MV Calculators/Material Effect**

In accordance with 45 CFR 156.135, there will be various situations in which the actuary will need to consider adjusting inputs to the AV Calculator or making an actuarial adjustment to the result from the calculator. These may be due to limitations associated with the calculator or to features of unique or innovative plan designs that are expected to have a Material Effect on the plan’s AV. These situations are referred to as non-standard plan designs.

Whenever an adjustment for a non-standard plan design is made, the actuary will need to consider whether the adjustment should be made to the input or the output. In most cases, it should be clear from a calculation perspective whether to adjust the input or the output. It is probably less likely that an actuary would be in a situation in which he or she could choose between calculating an adjustment to the input or to the output.

A non-standard plan design feature has a Material Effect if it changes the metal tier. Therefore, when considering whether a particular plan design feature(s) would have a material effect on the AV calculation, the actuary would likely consider both the potential magnitude of the impact to AV and the location of that particular plan within the de minimis range for AV. For example, if a plan design feature not accommodated by the AV Calculator is deemed to change the AV by 0.5 percent and the unadjusted AV of the plan is 70 percent, then that particular feature could be considered immaterial with no adjustments required. However, if the unadjusted AV of the plan is 68 percent, a feature that would
lower the AV by 0.1 percent could put the plan out of the de minimis 2 percent range for AV purposes. As such, it would be considered material and would require adjustments to the AV calculator’s result.

Data Assumptions

In general, since an underlying assumption of the AV calculators’ process is to reflect a standard population, the actuary would be prudent to attempt to use data and assumptions that are consistent with the AV calculator as much as possible when making adjustments for non-standard plan designs. In some cases, though, this will not be possible and the actuary will need to consider alternate sources of data or assumptions, such as carrier-specific data or market data (e.g., external data from consultants). When determining which data sources to use if assumptions cannot be drawn directly from the calculator, the actuary should attempt to use data that most closely resembles the AV Calculator continuance tables. When selecting other data sources the actuary should apply appropriate actuarial judgment and apply the following considerations.

1. Consistency of the covered population with the “standard” population
2. Current Data - More recent data is better than older data
3. The number of covered lives
4. Plan network design (i.e., HMO, PPO, POS)
5. Plan coverage features (e.g., deductible, coinsurance, copay)
6. Covered services alignment

In general, the actuary would consider the materiality of the plan design feature when judging the importance of using a different data source. The more material the feature and the larger the adjustment to AV it will require, the more important it is to use data closer to the calculator’s continuance tables. Features that are less material could be valued using data sources lower in the hierarchy. Further, the sensitivity of the value of that feature to the underlying data source...
being used would be taken into account. Materiality would, of course, be balanced against the availability of various data sources.

When normalizing data to a standard population, one goal should be to try to mimic the assumptions behind the data in the AV Calculator continuance tables as closely as possible. Considerations for AV in the early years, taken from the AV methodology document, should include: coverage of all essential health benefits, metal tier-specific induced demand, expected individual and small group national population including high-risk pool members, and including only continuously enrolled members.

When normalized market or carrier-specific data is not available, the actuary will need to use professional judgment to adjust other data for appropriate AV calculation purposes. The actuary typically would disclose what type of data was used and what adjustments were made. Credibility provisions are applicable and due care needs to be exercised. Materiality would need to be considered when making adjustments for standardization. If the plan feature has a material effect, then it is important to consider these adjustments. An actuary would use his or her best judgment to determine the relative importance of making adjustments for any of the considerations listed above. In the end, the data could be considered adequately “standardized” if all of the considerations listed above are incorporated to the extent possible.

Although value-based plan designs present a slightly different complication in design that the standard AV Calculators may not address, approaches to determining the adjustments to AV results produced by the calculator should follow the general considerations underlying the AV determination. The following are examples of value-based plan designs that will require the actuary to modify the calculator’s results if material:

-Condition-based plan provisions (e.g., reduced cost sharing to encourage diabetes monitoring/treatment);

-Treatment decisions by insured (e.g., place of service) impacting benefit levels; or
-Wellness incentives in plan design, including employer contributions to health reimbursement accounts (HRAs) or health savings accounts (HSAs) that vary based on member involvement in a wellness program.

For most of the value-based plan design benefits, the actual cost-sharing provisions that apply to a medical service will depend on actions or conditions of the insured. The actuary will need to determine the expected portion of the claimant population to which each benefit variation will apply, so those programs that have more strict requirements may result in smaller populations than others. Ideally, the various expected portions of the claimant population would be determined based on a standardized population; otherwise, they would be determined using data in accordance with the materiality and data hierarchy rules. The underlying utilization rates in the continuance tables do not change. For the above examples:

-For condition-based provisions, both the prevalence of the condition and the expected rate of compliance with requirements for reduced cost sharing could be based on a standardized population or based on data in accordance with the data hierarchy.

-When benefit levels vary by place of service, the weights that are used to blend the different benefit levels would be based on a standardized population, or based on data in accordance with the data hierarchy.

-For wellness incentives plans, insignificant benefit differentials or excessive hurdles in wellness programs likely would result in standard/normal member cost sharing to be applied more often. In determining the adjusted HRA/HSA amount, for benefits varying by member involvement in a wellness program, the take-up rate of the wellness incentives would be based on a standardized population or based on data in accordance to the materiality and data hierarchy rules.

**Actuarial Reports**

For AV, issuers can either fit the plan design into the calculator and an actuary can certify that the design was fit appropriately, or they may use the AV Calculator for all major plan provisions and then make adjustments for certain other plan
provisions in accordance with relevant Actuarial Standards of Practice (ASOPs). Reports that communicate Actuarial Value should be considered actuarial communications. Such reports should be prepared in accordance with ASOP No. 41, Actuarial Communications.

The AAA Working Group who prepared the Minimum Value and Actuarial Value Determinations under the Affordable Care Act, April, 2014 document expects the following to be included in the AV Report:

- The option the actuary is using in the certification.

- The basis for selecting the option chosen, including a brief summary on the methodology employed in determining the AV and issues that were addressed in determining AV.

- When adjustments are applied, confirmation as to whether only permitted factors were used. For example, provider discounts and the plan’s own projected demographic changes would not be considered in the calculation.

- In the event the calculator does not contain all of the data required for an adjustment, and alternative data other than the HHS/IRS/state’s standard population data is used to calculate those adjustments, the basis for using the selected data and, when applicable, a description of the methodology used to normalize the data to a standard population.

- The certifying actuary should state his or her assumptions regarding what services go into the core benefit categories and what services are not included. The certifying actuary would need to use outside data sources and sensitivity testing to set assumptions.

- A summary of the plan provisions. The actuary would highlight those plan provisions that do not fit into the calculator and are deemed to have a significant impact on the calculation.

- If the plan offers an EHB outside the parameters of the MV Calculator, and the actuary adds the value of that benefit to the result derived from MV, a statement of what benefits were added.
AV Best Practices Comments from INS Consultants – 6/18/2014

- A description of actuarial assumptions, methods, or data used to arrive at the actuarial adjustments and actuarial value in sufficient clarity and detail that another qualified health actuary can make an objective appraisal of them. The certifying actuary usually would address the reasonableness or appropriateness of such assumptions and methodology.

- In cases in which it is appropriate, the details on the scope of engagement, any sensitivity analysis performed, and any proprietary data/model used to estimate utilization and claims.

- Any additional work papers relevant to the work product.

- The final actuarial value for each of the plans evaluated.

Certification Language

AV certification is required for non-grandfathered health plans offered in the individual and small-group markets when the plan design is not compatible with the AV calculator.

The certification should include the following:

- The purpose of the certification that states the certification is for plans offered in the individual and small-group markets as required by 45 CFR Section 156.135.

- For each applicable plan, the alternative methodology the certification pertains to, the basis for selecting that alternative, and a description of the process that was used to develop the AV.

- A certification that the plan meets the AV requirements in the metal tiers.

- Disclosure of the actuary’s relationship to the issuer or the employer.

- A statement that the actuary is a member of the American Academy of Actuaries, meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries, and has the education and experience necessary to perform the work.
- A statement regarding the time period for which the AV certification applies.

- A statement that the AV was determined based on the plan’s benefits and coverage data, the standard population, utilization and continuance tables published by HHS/state (or in consultation with the U.S. Department of the Treasury) for purposes of the valuation of AV. The actuarial analysis is not appropriate for any other purpose. Other data sources used should be specified when applicable.

- A statement that the AV was determined in accordance with the Actuarial Standards of Practice (ASOPs) established by the Actuarial Standards Board (ASB) and with applicable laws and regulations.

- Disclosure of the assumptions and/or type of data other than those provided by HHS/state (or in consultation with U.S. Department of Treasury), and the extent of verification for reasonableness or consistency of the data.

- Disclosure of other limitations, if any.

- Any other disclosure as required by any future guidance/regulations.

The actuary would be prudent to maintain documentation of the certification, demonstrations that he or she is a member of the American Academy of Actuaries, and that he or she meets the qualifications for performing such a certification. Documentation would be retained for the period as required by applicable laws and regulations.

**Qualifications**

Certification of the metal AV for the individual and insured small-group health market is a statement of actuarial opinion. As such, the signing actuary is subject to the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (including continuing education requirements) promulgated by the American Academy of Actuaries. Under the U.S. Qualification Standards (as may be revised or amended periodically), the actuary must satisfy requirements for basic education, experience, and continuing education in the practice area related to the statement of actuarial opinion before issuing a
AV Best Practices Comments from INS Consultants – 6/18/2014

statement of actuarial opinion. Since AV analysis as prescribed in the law and regulations is considered health benefit pricing analysis, the actuary's work experience and continuing education should include health benefit system pricing and analysis.
The Actuarial Value (B) Subgroup of the Health Care Reform Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call May 22, 2014. The following Subgroup members participated: Kevin Dyke, Chair (MI); Marti Hooper (ME); Matt Elston (OH); Shari Miles (SC); and David Shea (VA).

1. Adopted its Charges

Mr. Dyke said the Subgroup was formed at the request of the federal Center for Consumer Information and Insurance Oversight (CCIIO) to determine the best approach for reviewing actuarial value calculations that use methods other than the CCIIO actuarial value (AV) calculator.

Mr. Dyke said the Subgroup needs to determine if the document it may develop to outline best practices for the review of AV calculations performed outside of the AV calculator should be limited to references to existing actuarial guidance on the topic, or if it should be something more detailed. He said the Subgroup should also monitor and provide comments on the Actuarial Standards Board’s (ASB) discussion draft, Determining Minimum Value and Actuarial Value under the Affordable Care Act.

Mr. Shea made a motion, seconded by Ms. Hooper, that the Subgroup adopt as its charges: 1) develop a document outlining best practices for reviewing issuer’s alternative AV calculations as permitted under 45 CFR 156.135(b); and 2) monitor and provide comments as appropriate on the ASB’s discussion draft on minimum value/AV. The motion passed.

2. Discussed Development of Best Practices Document

Mr. Dyke said he thinks the ASB’s discussion draft and the American Academy of Actuaries’ (AAA) Minimum Value and Actuarial Value Determinations Under the Affordable Care Act practice note should be reviewed and possibly used as starting points for developing the Subgroup’s best practices document. Mr. Elston said he will review the ASB’s discussion draft for the purpose of developing the Subgroup’s best practices document, and Mr. Shea said he will review it for the purpose of developing comments to the ASB. Ms. Hooper and Mr. Dyke said they will review the ASB’s discussion draft and the AAA practice note. Mr. Dyke said the Subgroup will discuss any issues found in the review of the ASB’s discussion draft and the AAA’s practice note on its June 5 conference call. Mr. Dyke asked interested regulators and interested parties to also review these two documents and present any issues to the Subgroup. Mr. Dyke said he would survey interested regulators to determine if state insurance departments have developed any guidelines on or processes for the review of AV calculations.

Having no further business, the Actuarial Value (B) Subgroup adjourned.
### SOA HEALTH RESEARCH IN PROGRESS - July 2014

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint SOA/AAA Long-Term Care Policy Termination</td>
<td>Examine long term care mortality and policy terminations in experience data from 1984-2007 under the direction of a Joint SOA/Academy Work Group.</td>
<td>9/30/2014</td>
</tr>
<tr>
<td>Long-Term Care Policy Termination Study</td>
<td>Examine long term care mortality and policy terminations in experience data from 2000-2011 under a Joint SOA/LIMRA project.</td>
<td>9/30/2014</td>
</tr>
<tr>
<td>Long-Term Care Experience Study</td>
<td>Develop experience basic tables for Long-Term Care claim termination, incidence and utilization based on experience from 2000-2011.</td>
<td>4/1/2015</td>
</tr>
<tr>
<td>Cancer Claim Cost Study</td>
<td>Develop valuation tables for first occurrence and hospitalization benefits from cancer policies, utilizing experience data from 2001-2010.</td>
<td>9/30/2015</td>
</tr>
<tr>
<td>Group LTD Claim Termination Study</td>
<td>Complete a study of termination experience under group long-term disability claims.</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>Group LTD Incidence Study</td>
<td>Study the incidence of claims under group long-term disability benefits.</td>
<td>12/31/2016</td>
</tr>
</tbody>
</table>
## SOA HEALTH RESEARCH IN PROGRESS - July 2014

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Low Interest Rates</td>
<td>Examine the risks related to a sustained low interest rate environment on a variety of insurance and financial products.</td>
<td>Completed. On SOA website. *</td>
</tr>
<tr>
<td>Understanding the Volatility of Experience &amp; Pricing Assumptions in LTC Insurance</td>
<td>Analyze risk associated with LTC insurance by running stochastic simulation models with a variety of product designs and morbidity assumptions.</td>
<td>7/15/2014. First report on SOA website. +</td>
</tr>
<tr>
<td>Health Section/Financial Reporting Survey</td>
<td>Survey how companies are preparing to report on the new assets and liabilities created by the Affordable Care Act.</td>
<td>9/15/2014</td>
</tr>
<tr>
<td>Modeling US Provider Payment Reform</td>
<td>Research provider payment reform designs and developing models.</td>
<td>9/30/2014</td>
</tr>
<tr>
<td>LTC Morbidity Improvement Study</td>
<td>Analyze changes in LTC morbidity and the impact of those changes on lifetime disability</td>
<td>10/1/2014</td>
</tr>
<tr>
<td>Conceptual Actuarial Model for Wellness</td>
<td>Develop the framework for an actuarial model for wellness through a literature search, survey and interviews with experts.</td>
<td>10/1/2014</td>
</tr>
<tr>
<td>Managing the Impact of LTC Needs &amp; Expense on Massachusetts Connector Project</td>
<td>Examine the Massachusetts health market and lessons learned from it.</td>
<td>10/30/2014</td>
</tr>
<tr>
<td>Statistical Tools for Health Actuaries</td>
<td>Develop a guide for credibility methods for medical coverages.</td>
<td>12/1/2014</td>
</tr>
<tr>
<td>Provider Payment</td>
<td>Develop a report that will highlight, through specific examples, numbers, and illustrations, the practical issues of understanding value based arrangements.</td>
<td>12/31/2014</td>
</tr>
<tr>
<td>Potential Sources of Bias in Small Group &amp; Individual Market Risk Adjustment</td>
<td>Research and develop a framework for actuaries and others to understand the sources and consequences of bias in risk adjustment.</td>
<td>4/1/2015</td>
</tr>
<tr>
<td>Getzen Model Update</td>
<td>Update a model that estimates future long-term healthcare trends.</td>
<td>7/1/2015</td>
</tr>
</tbody>
</table>


+ [https://www.soa.org/research/research-projects/ltc/research-2014-understanding-volatility.aspx](https://www.soa.org/research/research-projects/ltc/research-2014-understanding-volatility.aspx)
SOA Experience Studies

Update to HATF – 8/2014

Long Term Care Study
Cancer Claim Cost Study
Volatility in LTC Assumptions
Upcoming Studies

SOA LTC Study-Goal

- Compile and analyze* industry Long Term Care ("LTC") experience and create experience basic tables for:
  - Claim terminations
  - Claim incidence
  - Claim utilization/salvage
- Develop* a database of LTC experience data

*In accordance with the terms and conditions specified in an engagement agreement dated January 14, 2014, the Society of Actuaries ("SOA") engaged Towers Watson

SOA LTC Study-Data

- Incidence, policy termination, claim termination, salvage experience
- Experience data from 2000-2011
- 22 carriers participated
- 81% of the industry

SOA LTC Study-Process

- To Date
  - Data collection: June-Dec 2013
  - Data cleansing and validation: Jan-April 2014
  - Claim termination study: May-July 2014
- Future
  - Claim incidence and utilization study: 8/14-9/14
  - Create experience basic tables: 10/14-3/15
- TBD
  - experience report and valuation tables
LTC Claim Termination Study - Data

- Claims count = 213,796
- Terminations count = 139,080
- Death count = 104,317

Splits by
  - Gender, claim age, claim type, benefit years, inflation feature, elimination period, region

Cancer Claim Cost Study

- SOA Goal
  - Deliver Hospital Confinement and First Occurrence data to Joint SOA/AAA WG to produce claim cost tables

- Data collected
  - 13 carriers, 65% market
  - 60% market in study

- Process
  - Hospital data - to WG w/in a week
  - First occurrence data – to WG in 9/14

Volatility in LTC Assumptions

- Objective - analyze risk utilizing stochastic modeling
  - How risky is a typical LTCI block of business?
  - Poor experience from inherent volatility vs incorrect assumptions
  - Product designs for risk mitigation
  - Implications for pricing margins and triggers for rate increases

- Actuarial Resource Corporation report recently published

Other SOA work

- Group LTD Study
  - 2004-2012 termination study is underway
  - Claim incidence study to follow – begin in 2016

- Individual Disability Study
  - Valuation work to finish in 2014
  - Next round to begin in 2015
U.S. Qualification Standards Attestation for 2014

The purpose of this form is to aid actuaries’ understanding of the “Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States” (promulgated by the American Academy of Actuaries, effective January 1, 2008) and to provide a means to attest how these standards are satisfied. Complete the following to demonstrate how you are qualified to issue, during 2014, Statements of Actuarial Opinion (SAOs) in your area of expertise.

Part 1: General Qualification Standards

1) Basic education and experience, General Qualification Standard

The US Qualification Standards require actuaries to meet basic education and experience requirements, as well as continuing education requirements. In terms of basic education and experience, to be qualified to issue a SAO, actuaries must meet the following criteria. Please indicate if you have satisfied each condition:

- Yes  No
  I am a Member of the Academy, a Fellow or Associate of the SOA or the CAS, a Fellow of the CCA, a Member or Fellow of ASPPA, or a fully qualified member of another IAA-member organization; and

- Yes  No
  I have three years of responsible actuarial experience, which is defined as work that requires knowledge and skill in solving actuarial problems; and

- Yes  No
  I am knowledgeable, through examination or documented professional development, of the Law applicable to the SAO. “Law” is defined in the Code of Professional Conduct.

2) Basic education and experience, additional rule for opinions in an area covered by specialty tracks

The US Qualification Standards have additional requirements for SAOs issued in the subject area of a specialty track offered by the SOA, or an area of practice covered by the exams of the CAS or ASPPA. For such SAOs, you must meet one of the following criteria. Please indicate which method you satisfy:

- I have obtained the highest designation in my specialty track (e.g., FCAS, FSA or FSPA).
- I have obtained the highest designation in another track, and I have at least one year of responsible actuarial experience in the area of the SAO under the supervision of an actuary qualified in the area of the SAO.
- I have three years of responsible actuarial experience in the area of the SAO under the supervision of an actuary qualified in the area of the SAO.
3) Continuing education

Generally, actuaries need 30 hours of relevant continuing education in the prior calendar year to issue a SAO in the current calendar year. See the Appendix to this Attestation if you need more information. Please indicate if you satisfy each of the following criteria:

☐ Yes ☐ No I completed 30 credit hours of relevant continuing education during 2013.
☐ Yes ☐ No Of those hours, at least three credit hours are considered "professionalism" hours.
☐ Yes ☐ No Of those hours, at least six credit hours are considered from "organized" activities.
☐ Yes ☐ No Of those hours, no more than three credit hours were spent on general business courses and educational materials. [Note: general business courses are not required, but if taken, are limited to no more than three]

4) Continuing education, documentation

The Qualification Standards require documentation of your continuing education activities.

Supporting documentation for your credits listed in (3) above. Note, in most cases, this support will be comprised of a list of the credits you have maintained on your own documentation of your continuing education activities. (For example, see TRACE for a useful format.)

☐ Yes ☐ No I have attached documentation of my continuing education credits in Attachment 2.

Part 2: Specific Qualification Standards

5) Basic education and experience, Specific Qualification Standards

In addition to meeting the above basic education, continuing education, and experience requirements of the General Qualification Standards, an actuary must meet additional specific requirements in order to issue a Statement of Actuarial Opinion for an NAIC Annual Statement.

Please indicate which of the additional specific requirements below you have satisfied.

☐ Yes ☐ No I have successfully completed the required topic-specific* examinations administered by the American Academy of Actuaries or the Society of Actuaries to complete an SAO for NAIC Life and A&H Annual Statement.

☐ Yes ☐ No I have successfully completed the required topic-specific** examinations administered by the American Academy of Actuaries or the Casualty Actuarial Society to complete an SAO for NAIC Property and Casualty Annual Statement.

☐ Yes ☐ No I have successfully completed the required topic-specific*** examinations administered by the American Academy of Actuaries, the Casualty Actuarial Society, or the Society of Actuaries to complete an SAO for NAIC Health Annual Statement.

Alternative basic education, Specific Qualification Standards

If none of the above examination criteria have been satisfied, can you attest that

☐ Yes ☐ No I have acquired comprehensive knowledge of the applicable topics through responsible work and/or self-study, and a signed statement from an actuary familiar with my professional history and alternative education, and who is qualified to issue NAIC Annual Statement SAOs in my specific specialization, is attached in Attachment 3.

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Regulators: Submit your comments on this draft at http://www.actuary.org/content/suggestions-usqs-attestation-2014.

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6) Experience requirement, Specific Qualification Standards

☐ Yes ☐ No I have three years of responsible experience relevant to the subject of the NAIC Annual Statement SAO under review by an actuary who was qualified to issue the NAIC Annual Statement SAO at that time.

7) Continuing education requirement, Specific Qualification Standards

To satisfy the Specific Qualification Standards, actuaries need 15 hours of continuing education per calendar year that is directly relevant to the topics in the NAIC Annual Statement related to the examinations completed in (5) above. Please indicate if you satisfy each of the following criteria:

☐ Yes ☐ No I completed 15 credit hours of topic-specific continuing education during 2014.

☐ Yes ☐ No Of those hours, at least six credit hours were obtained through experiences that involved interactions with outside actuaries or professionals.

8) Continuing education, documentation, Specific Qualification Standards

The Specific Qualification Standards require documentation of your continuing education activities.

Supporting documentation for your credits listed in (7) above. Note, in most cases, this support will be comprised of a list of the credits you have maintained on your own documentation of your continuing education activities.

☐ Yes ☐ No I have attached documentation of my specific qualification standards continuing education credits in Attachment 4.

9) Attestation

I have completed all the sections above and attest that I meet the requirements in the US Qualification Standards.

Name ____________________________ Date __________________

If you are unable to attest because you do not satisfy all of the above listed requirements, but believe you are qualified to issue NAIC Annual Statement SAOs, please document your reasoning in an attachment.

☐ Yes ☐ No I have attached documentation to support my belief that I am qualified to issue NAIC Annual Statement SAOs in Attachment 5.

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Appendix to Attestation

Definitions
The following information from the US Qualification Standards is provided for your convenience.

Continuing education is "relevant" if: (1) it broadens or deepens an actuary’s understanding of one or more aspects of the work an actuary does; (2) the material expands an actuary’s knowledge of practice in related disciplines that bear directly on an actuary’s work; or (3) it facilitates an actuary’s entry into a new area of practice.

Examples of professionalism topics include, but are not limited to, studying, reviewing, or providing input on an Exposure Draft of an ASOP; studying or reviewing the Code of Professional Conduct; and serving on the ASB or a professionalism committee.

"Organized activities" involve interaction with actuaries or other professionals working for different organizations and include, but are not limited to, conferences, seminars, webcasts, in-person or online committee work that is directly relevant to the area of practice of the subject of the SAO.

Examples of business and consulting skills topics include, but are not limited to, client relationship management, presentation skills, communication skills, project management, and personnel management.

"Law" is defined as statutes, regulations, judicial decisions, and other statements having legally binding authority.

Examination Topics, Specific Qualification Standards

* NAIC Life and A&H Annual Statement examination topics: (a) policy forms and coverages, (b) dividends and reinsurance, (c) investments and valuations of assets, and the relationship between cash flows from assets and related liabilities, (d) statutory insurance accounting, (e) valuation of liabilities, and (f) valuation and nonforfeiture laws.

** NAIC Property and Casualty Annual Statement examination topics: (a) policy forms and coverages, underwriting, and marketing; (b) principles of ratemaking; (c) statutory insurance accounting and expense analysis; (d) premium, loss, and expense reserves; and (e) reinsurance.

*** NAIC Health Annual Statement examination topics: (a) principles of insurance and underwriting; (b) principles of ratemaking; (c) statutory insurance accounting and expense analysis; (d) premium, loss, expense, and contingency reserves; and (e) social insurance.
Attachments to Attestation

[Please provide any relevant documents referred to in the Attestation and identify which numbered Attachment each pertains to.]

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Regulators: Submit your comments on this draft at http://www.actuary.org/content/suggestions-usqs-attestation-2014.

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This message is being sent to the Members, Interested Regulators and Interested Parties of the Health Actuarial (B) Task Force on behalf of Steve Ostlund (AL), Chair of the Health Actuarial (B) Task Force (HATF).

To HATF:

On June 10, the Casualty Actuarial and Statistical (C) Task Force (CASTF) disbanded the Joint Qualified Actuary (A/B/C) Subgroup (JQASG). This was done upon the recommendation of its Chair, Rich Piazza, who had consulted with the other Actuarial Task Force (ATF) Chairs. The JQASG’s diligent efforts have resulted in a proposed definition that each ATF has received. In consultation with the Chairs of the other ATF’s, I believe the definition provides a framework upon which we can build, if not accept as is. One element of the definition is the phrase “…validated in compliance with the Academy’s verification process….” The American Academy of Actuaries (AAA) is currently reviewing their processes and we anticipate they will present to the ATFs a description of a presumably enhanced “verification process”. The Chairs believe it is better to disband the JQASG at this time until the AAA has completed its review and recommendations. Then, if needed, we can reconstitute the subgroup or take other appropriate action. At such time, we can consider if other elements of the definition deserve attention. For now, it seems best to wait for a response from the Academy before acting.

Steven Ostlund

L and H Actuary

Alabama Department of Insurance

Rates and Forms Division

Email steven.ostlund@insurance.alabama.gov

Ph 334-240-4424
The following is a list of important publications and webinars that the American Academy of Actuaries' Health Practice Council has released over the past few months.

**Affordable Care Act**

Health Practice Financial Reporting Committee comments to the NAIC on new accounting proposals for the risk-sharing programs of the Affordable Care Act (ACA). (June 20, 2014)
http://actuary.org/files/HPFRC_letter_SAPWG_3RsACA_AcctProposal_June20_0.pdf

Senior Health Fellow testimony to the U.S. House Oversight and Government Reform Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs hearing on the ACA’s risk-sharing mechanisms, also known as the 3Rs. (June 18, 2014)
http://actuary.org/files/Acad_testimony_on_3Rs_061814.pdf

Health Practice Council issue brief providing an overview of the factors underlying general premium rate setting and highlighting the major drivers behind why 2015 premiums could differ from those in 2014 under the ACA. (June 4, 2014)

Practice note by the Minimum Value Practice Note Work Group on the calculation of minimum value and actuarial value under the ACA, which includes a discussion of plan designs not accommodated by the calculators. (April 24, 2014)

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1 The American Academy of Actuaries is an 18,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.
Risk Sharing Work Group letter to CCIIO with comments on a proposed rule related to exchanges and market reforms for 2015, specifically addressing ACA risk-sharing mechanisms. (April 21, 2014) http://actuary.org/files/AAA_cmts_on_market_stds_prop_rule_on_3Rs_042114.pdf

Medicare/Medicaid

Medicare Steering Committee issue brief offering an actuarial perspective on Medicare's financial condition and outlining the public policy options to address the program's long-term financial challenges. (July 31, 2014) http://actuary.org/files/Medicare_Trustees_2014_FINAL_073114.pdf


Briefings/Webinars

May 29 webinar on the progress of state-run health insurance exchanges, which included topics such as the current status of state-run health exchanges, notable successes that exchanges have had, and challenges that exchanges are facing and issues that may arise in the coming months.


May 15 webinar on the newly approved group long-term disability valuation table and actuarial guideline which replaces the 1987 Commissioner’s Group Disability Table and is based off of the Group Long-Term Disability 2008 Experience Table.

Webinar Slides- http://www.actuary.org/files/GLTD_May15_Webinar_Slides_0.pdf

April 7 Hill briefing on the newly released paper, “New Models of Care Delivery,” the first in a series of papers that will focus on specific issues related to the issue of health care cost growth and explores options to reduce long-term spending growth and promote high-quality care.


The Long-Term Care Actuarial (B) Working Group met in Louisville, KY, Aug. 15, 2014. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Eric Johnson (FL); Mark Birdsall (KS); James Mills (OK); Peter Camacci (PA); Leslie Jones (SC); Jan Graeber (TX); and Tomasz Serbinowski (UT). Also participating were: Robert Wake (ME); and John Rink and Rhonda Ahrens (NE).

1. **Adopted its Subgroups’ Minutes**

Ms. Jones made a motion, seconded by Mr. Ostlund, to adopt the Long-Term Care Pricing (B) Subgroup’s July 8 (Attachment Eight-A), July 1 (Attachment Eight-B), June 24 (Attachment Eight-C), June 10 (Attachment Eight-D), May 15 (Attachment Eight-E), May 8 (Attachment Eight-F) and May 1 (Attachment Eight-G) minutes; and the Long-Term Care Valuation (B) Subgroup’s May 22 (Attachment Eight-H) minutes. The Long-Term Care Valuation (B) Subgroup met in regulator-to-regulator session June 6 pursuant to paragraph 3 (specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis) of the NAIC Policy Statement on Open Meetings. The motion passed unanimously.

2. **Received a Report from the Long-Term Care Pricing (B) Subgroup**

Ms. Graeber said that, since the Spring National Meeting, the Subgroup has continued to work on recommendations for changes to the NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation (LTC Manual) to address issues related to existing policies.

Ms. Graeber said the Subgroup’s main focus has been discussion of an optional rate increase review process that Kansas proposed. She said allowing the use of the optional process will be at the discretion of each state, that use of the optional process in states that will allow use of it will not be mandatory for insurers filing rate increase requests, and that the maximum increase allowed under the optional process will not be used to set a maximum allowed rate increase for insurers that do not choose to use the optional process. She said the Subgroup exposed the optional rate increase review process for comment during its July 8 conference call and requested comments be submitted by Aug. 4. Mr. Birdsall said there has been a mix of reactions from regulators, industry and interested parties to the optional proposal. He said that given the opposition by some regulators, interested parties and industry, he will withdraw the proposal and request that it no longer be discussed by the Subgroup.

Mr. Serbinowski said he thinks it is important to incorporate criteria other than meeting loss ratio requirements for rate increases, especially for small blocks of policies that are no longer being sold, and that he thinks parts of the optional rate review process proposal accomplish this goal. Mr. Johnson said that the purpose of the LTC Manual is to provide guidance related to long-term care (LTC) insurance regulations, and because the optional rate review process will not be incorporated into regulations, referring to it in the LTC Manual is not appropriate. He said that states could choose to offer the optional rate review process whether it is included in the LTC Manual. Ms. Graeber asked if it makes sense to include guidance in the LTC Manual that will help in situations where strict application of the regulations produce results that seem unreasonable. Mr. Johnson said he thinks this is a public policy decision and is not something that should be addressed in the LTC Manual. Ms. Graeber said she thinks that the LTC Manual should be used to address unintended consequences of existing regulations as they apply to existing policies and that recent changes to regulations pertain only to policies issued after the effective date of the changes. Mr. Rink said he does not think the LTC Manual is an appropriate place to place the optional rate review process, but there may be another place to publish the process so that regulators can use it. Mr. Johnson suggested the optional rate review process could be the topic of an NAIC white paper. Mr. Kupferman said it may be appropriate to include the optional rate review process in the NAIC Product Filing Review Handbook.
Ms. Ahrens said that many states have guidelines in addition to current regulations that must be met in order for a rate increase to be granted, and that it would be helpful to have a list of these that other regulators could use for guidance. Mr. Wake said regulators have a responsibility to protect insurers against adverse deviation, but they do not have a responsibility to ensure insurers meet a target loss ratio for the life of the contract. He asked if it is possible to isolate what part of a block’s adverse experience is the result of dwindling numbers of policyholders, and to not allow rate increases that are the result of the shrinking of the block size. Mr. Johnson said he thinks this has been addressed somewhat by recent changes to regulations that prohibit recouping past losses through rate increases for newly issued policies. Ms. Graeber said she would like to add a set of items to the LTC Manual for regulators to consider to address problems with rate increases for existing policies.

Mr. Serbinowski said he is interested in what contingent benefit upon lapse terms are being offered to policyholders at the time of a rate increase. Mr. Kupferman asked Bill Weller (America’s Health Insurance Plans—AHIP) to determine if AHIP member companies can provide this information.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ does not support an optional rate review process. He said the issues the optional proposal addresses should be addressed with mandatory measures, not optional ones.

Ms. Graeber said Mr. Rink has developed sample annual actuarial certifications for each of the products that are no longer marketed and products that are currently being marketed. She said Mr. Rink will introduce any actuarial recommendations from the Subgroup to the Long-Term Care Guidance Manual (B) Joint Subgroup that reports to the Health Actuarial (B) Task Force and the Senior Issues (B) Task Force. She said Mr. Serbinowski has done some initial work on standardized actuarial assumptions templates to be used with initial LTC insurance rate filings and rate increase request filings. She said the Subgroup will continue to discuss the actuarial certification and assumptions templates.

3. **Heard a Status Report from the Academy’s State Long-Term Care Terminations Work Group**

Warren Jones (Genworth Financial) gave a presentation (Attachment Eight-I) to update the Working Group on the American Academy of Actuaries (Academy) State Long-Term Care Terminations Work Group’s efforts to study LTC mortality. He said the Working Group plans to provide an update on its study of voluntary terminations to the Working Group at the Fall National Meeting, and to draft a report on both mortality and voluntary terminations in 2015. Ms. Ahrens asked how the Working Group determined that the nine LTC insurers used in the study were confident in the accuracy of the data on policyholder deaths they reported. Mr. Jones said the Work Group reviewed summary data and compared actual deaths to expected deaths, and found that the larger companies’ actual-to-expected ratios were closer to one than the smaller companies’. He also said that in early experience years, most companies’ data was not reported as well as in later years, so earlier experience years’ data was excluded from the study. Ms. Ahrens asked if only policies that had active claims were included in the study. Mr. Jones said both policies with and without an active claim were included. Mr. Jones said the study was conducted to inform decisions about standards for active life reserves, so the intent is to use an all-policyholder approach for the study, which is comparable to the standard currently used, which uses an all-policyholder approach. Mr. Serbinowski asked if it should be expected that there is more accurate reporting of deaths for post-rate stability policies compared to pre-rate stability policies, given there are provisions for the insurer to contact policyholders who have not paid a premium for post-rate stability policies. Ms. Ahrens said she expects this, but because pricing is based on total terminations (both voluntary lapses and deaths), any increase in reported deaths will be offset by a decrease in voluntary lapses. Mr. Jones said the Work Group plans to start with total terminations and subtract expected deaths to arrive at voluntary lapses.

4. **Heard a Status Report from the Academy’s Long-Term Care Principle-Based Work Group**

Al Schmitz (Milliman, Inc.) gave a presentation (Attachment Eight-J) to update the Working Group on the Academy’s Long-Term Care Principle-Based Work Group’s study of principles-based reserving (PBR) for LTC insurance. He said the Work Group expects to complete sensitivity tests and summarize the results of the tests by the end of September, run the 20,000 policy block through the model and analyze the results by the end of October, and complete a draft of a report that summarizes the results of all modeling by the end of November. Mr. Kupferman asked if Mr. Schmitz thinks stochastic analysis of LTC insurance liabilities is appropriate. Mr. Schmitz said he thinks it helps to inform about the variability of the liabilities given a set of initial assumptions, but there are limitations to a stochastic approach that are driven by the accuracy...
of the initial assumptions used in modeling the liabilities. Mr. Kupferman said the Working Group will continue to examine PBR for LTC insurance, and that a charge has been sent to the Academy requesting assistance in developing data elements for insurer experience reporting requirements.

5. **Heard a Status Report from the Academy’s Long-Term Care Credibility Monograph Work Group**

Karl Volkmar (United Health Actuarial Services, Inc.) gave a presentation (Attachment Eight-K) to update the Working Group on the Academy’s Long-Term Care Credibility Monograph Work Group’s progress towards completing its monograph. Mr. Kupferman asked Mr. Volkmar to make a draft of the Long-Term Care Credibility Monograph Work Group’s final report available to the Working Group for review by Oct. 16.

6. **Received a Report from the Long-Term Care Valuation (B) Subgroup**

Mr. Kupferman said he requested insurers filing annual statements for 2013 with the California Department of Insurance that sell or have any in-force LTC insurance business to give details of their premium deficiency reserve (PDR) calculations for LTC care insurance in order to assist the Subgroup with its analysis of PDR standards. He said he will send details of the approximately 48 responses received to the Subgroup and schedule a conference call to discuss the responses and next steps. He said he asked the insurers what mortality basis was used, how long it takes to reach ultimate lapse levels, what ultimate lapse rate was used, how many projection years were used, and what discount rate was used to calculate the PDR. He said that, of the 40 answers received to the mortality basis question, about half of the respondents indicated they used the 1994 Group Annuity Mortality table, and the balance used the 1983 Group Annuity Mortality table, the 1983 Individual Annuity Mortality table, the 1984 Society of Actuaries Intercompany Study, the 2000 Individual Annuity Mortality table, the 1990–1995 Society of Actuaries Intercompany Study, or their own company experience. He said that of the respondents that indicated use of the 1994 Group Annuity Mortality table, four used it without modifications, and 17 used selection factors, mortality improvements or both. He said three companies refused to answer the mortality basis question. He said that, of the 47 answers received concerning time to reach ultimate lapse rates, 20 of the respondents said they reached ultimate lapse levels within 10 years, 10 within 15 years and four within 16 years, while 13 would not provide this information. He said that 27 respondents used an ultimate lapse rate less than 1%, nine between 1% and 2%, and seven higher than 2%. He said five respondents said they projected 40 years or less, and 23 projected 60 or more years. He said nine respondents used a discount rate between 3.5% and 5%, 15 between 5% and 6%, seven between 6% and 7%, one between 7% and 8%, and one used 8.5%. Mr. Serbinowski asked if the respondents used future rate increase assumptions in their PDR calculations. Mr. Kupferman said he received that information, but he still needs to summarize it.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

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The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call July 8, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Eric Johnson (FL); Mark Birdsall (KS); Fred Andersen (MN); William Leung (MO); John Rink (NE); Frank Horn (NY); Matt Elston (OH); Jeannette Holman (OR); Leslie Jones (SC); and Tomasz Serbinowski (UT).

1. Discussed a Revised Optional Long-Term Care Insurance Rate Increase Review Proposal

The Subgroup continued discussion of the revised optional long-term care insurance rate increase review proposal from its July 1 conference call. Mr. Birdsall said the proposal has been revised to clarify that the optional process will only be applicable to policies issued prior to the effective date of the 2014 amendments to the Long-Term Care Insurance Model Regulation (#641), and to indicate that allowing companies to use the optional process would be at the discretion of each state. He said the states that do choose to use the optional process should not give preferential treatment to companies that submit rate increase requests under the optional process. He said the proposal has also been revised to clarify that the requirement to perform sensitivity testing only applies to policies that are subject to rate stabilization requirements in Model #641. He said the proposal includes a revision that references Appendix 4B, which illustrates a method to address application of the optional rate increase review procedure when there are rate increases subsequent to an initial rate increase. He said the proposal requires regulators to determine that a rate increase is actuarially justified, just as they currently do within existing rate review processes. He said the proposal allows for a commissioner to approve a rate increase greater than indicated by the cost-sharing exhibit in case there are concerns about the company’s solvency, and allows a commissioner to implement policy-level caps on rate increases.

Mr. Kupferman asked why a company cost-sharing requirement of 60% is more appropriate than 75%. Mr. Birdsall said that when expenses associated with policy maintenance are considered, the effective portion of the rate increase shared by the company using a 60% cost-sharing parameter is closer to 50%, resulting in closer to an equal share of the increase for the company and the policyholder. He said the percentage was determined using judgment, and was not actuarially determined. Mr. Johnson said it should be made clear that the initially requested rate increase is actuarially justified, although the percentages shared by the company and the policyholder are based on judgment.

Mr. Birdsall said some companies that have chosen to use the optional review process in Kansas have said they appreciate being able to inform consumers that the company will reduce the policyholder’s portion of the needed rate increase by participating in cost-sharing. He said Kansas Insurance Department employees have said that being able to explain to policyholders that are upset about rate increases that the company is absorbing part of the rate increase has helped diffuse the policyholders’ anger.

Mr. Rink said he is concerned that, even though the proposed process is intended to be optional, some states may make it mandatory. He said having an optional review process is contrary to the goal of consistency in rate reviews between the states. Mr. Birdsall said language will be added to the proposal, as presented during the Subgroup’s July 1 conference call, clarifying that the process is to be optional and should not be made mandatory.

Birny Birnbaum (Center for Economic Justice—CEJ) said the proposal does not appear to provide a more objective review than those currently in use, as the cost-sharing percentages are determined subjectively. He said a subjective process should not be codified in the NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation. He said the proposal has been revised based on what the industry is willing to accept, which he thinks is poor regulatory policy. He said rate increases for small, closed blocks of business should not be allowed, as this rewards insurers for closing blocks of business and creates “death spirals.” He said insurance departments using explanations of cost-sharing as a way to mollify policyholders amounts to the departments shilling for the insurance companies. Mr. Birdsall said that informing policyholders that they are not bearing the entire cost of an appropriate, actuarially justified rate increase is not “shilling for the insurance companies.” He said that the rate increases are actuarially justified under the proposal and are not subjective, and that it is only the cost-sharing percentages required by the proposal that were determined using judgment.
Mr. Serbinowski asked if actual experience will be compared to expected experience plus pricing margins when tracking future experience under the proposal. Mr. Birdsdall said best-estimate expected experience without pricing margins will be used, and he will clarify this in the revised proposal.

2. Voted to Expose the Revised Optional Long-Term Care Insurance Rate Increase Review Proposal

Mr. Birdsdall made a motion to expose the revised optional rate increase review proposal for a public comment period ending Aug. 4. Mr. Kupferman seconded the motion. The motion passed, with Minnesota and Nebraska voting against the motion, and New York and Ohio abstaining.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.

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The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call July 1, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Eric Johnson (FL); Mark Birdsall (KS); Fred Andersen (MN); Leslie Jones (SC); and Tomasz Serbinowski (UT).

1. **Discussed an Optional Long-Term Care Insurance Rate Increase Review Proposal**

Ms. Graeber said the optional rate increase review proposal has been revised to remove the minimum 85% prospective loss ratio requirement, change the 75% cost-sharing requirement to 60% and change the five-year, 15% margin for adverse experience restriction on rate increases subsequent to an initial rate increase to a three-year, 10% margin requirement. She proposed the following language be included with the proposal to clarify that the requirements are optional:

> “The methodology described below provides an optional rate review process for use in reviewing rate increases on existing business. The methodology described is intended as guidance only. A company’s use of the methodology is optional and this guidance should not be interpreted as a mandatory approach for determining the amount of rate increase a state is willing to approve.”

Mr. Serbinowski gave a summary of an example (Attachment Eight-B1) that illustrates a method to address application of the optional rate increase review procedure when there are rate increases subsequent to an initial rate increase. Mr. Birdsall said this example will be incorporated into the optional rate increase review proposal.

Mr. Birdsall said that to test the effect of removing the 85% prospective loss ratio requirement and changing the proposal’s cost-sharing percentage, he applied the prior 85% loss ratio requirement and 75% cost-sharing parameter to 33 long-term care insurance rate increase filings received by the Kansas Insurance Department, which produced an allowed arithmetic average rate increase of 41%. He said he tested the same 33 rate increase filings with the 85% loss ratio requirement removed and used the revised 60% cost-sharing parameter, which produced an arithmetic average allowed rate increase of 44%, and that 14 of the 33 increase requests were not reduced by use of the optional rate increase review structure. He said the arithmetic average of the rate increase requested by the filers is 70%, and noted that these filings were submitted without use of the optional rate increase review structure.

Ms. Graeber asked if the revised optional rate increase review proposal could be used for both pre- and post-rate stabilization policies. Mr. Birdsall said he intended it to be available for use with either type of policy, but he is open to guidance from the Subgroup. Mr. Johnson asked if the proposal is intended to be used for new and existing policies. Mr. Birdsall said that it is, but he would not object to it only being available for use with existing policies.

Mr. Kupferman asked if the revised optional rate increase review proposal would replace what is currently in the *NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* (LTC Manual). Mr. Birdsall said it would be in addition to what is currently in the LTC Manual.

Bill Weller (America’s Health Insurance Plans—AHIP) asked whether, if a company does not choose to use the optional rate increase review procedure, it will nevertheless have its approved rate increase limited to what the optional procedure would have produced, and whether the rate increase review be conducted in a timely manner. Ms. Graeber said there will not be discrimination against an insurer that does not use the optional process.

Ms. Graeber said the Subgroup will continue discussion of the revised proposal on its July 8 conference call.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
## Appendix 4B
Calculation Example for Subsequent Future Rate Increases

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<th>Etc.</th>
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### Original pricing projection

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<th>Claims</th>
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<tr>
<td>1-10</td>
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<tr>
<td>11-13</td>
<td>20</td>
<td>10</td>
<td>50%</td>
</tr>
<tr>
<td>14+</td>
<td>80</td>
<td>90</td>
<td>113%</td>
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<tr>
<td>Total</td>
<td>200</td>
<td>120</td>
<td>60%</td>
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### Actual and projected after 10 years prior to any rate increase

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<th>Claims</th>
<th>LR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
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<tr>
<td>11-13</td>
<td>35</td>
<td>20</td>
<td>58%</td>
</tr>
<tr>
<td>14+</td>
<td>138</td>
<td>160</td>
<td>116%</td>
</tr>
<tr>
<td>Total</td>
<td>273</td>
<td>230</td>
<td>84%</td>
</tr>
</tbody>
</table>

The company files for 73% rate increase.

Additional premiums required to restore lifetime LR to 60% equals 183.

73% rate increase results in policyholders paying 73 more over years 11+.

Rate increase is close to maximum that could be requested under 60% cost sharing requirement.

### Actual and projected after 10 years following rate increase of 73%

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<th>LR</th>
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<tr>
<td>1-10</td>
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<td>14+</td>
<td>138</td>
<td>160</td>
<td>116%</td>
</tr>
<tr>
<td>Total</td>
<td>273</td>
<td>230</td>
<td>84%</td>
</tr>
</tbody>
</table>

### Actual and projected after 13 years prior to the second rate increase

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<tr>
<td>Total</td>
<td>273</td>
<td>255</td>
<td>93%</td>
</tr>
</tbody>
</table>

Three years passed from the first increase and claims for years 11+ are 14% higher than previously projected.

Total premium required to restore lifetime LR of 60% is 425. Total lifetime original premium is 200 (see "Original pricing projection"). Total additional premium is 225.

Policyholder share of total additional premium is 90 (40% of 225). Total policyholder premium should therefore be 290. 135 was already collected, so future premium should be 155, which corresponds to a 12% rate increase (155/138 - 1).
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call June 24, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Eric Johnson (FL); Mark Birdsall (KS); William Leung (MO); Bob Potter (NC); David Ball (OR); Leslie Jones (SC); and Tomasz Serbinowski (UT).

1. Discussed an Optional Long-Term Care Insurance Rate Increase Review Proposal

Ms. Graeber introduced comments that were received concerning the optional rate increase review proposal discussed on the Subgroup’s May 15 conference call and asked those who submitted the comments to give a summary of their observations.

Bill Weller (America’s Health Insurance Plans—AHIP) gave a summary of the comments (Attachment Eight-C1) AHIP and the American Council of Life Insurers (ACLI) submitted. Mr. Birdsall asked why AHIP and ACLI are opposed to an optional process that would not be incumbent upon companies to implement. Mr. Weller said there is a concern that the proposal may come to be considered mandatory in some states rather than optional. Mr. Birdsall said that if a regulator attempted to make the process mandatory, legal challenges would be made to the regulator. Mr. Weller said there is also concern that even if a company declined to use the optional process, a regulator may use concepts from the optional process to limit the rate increase it will allow for a company. He said he thinks that given the proposal’s current factors for determining an allowable rate increase, few companies would find this to be a viable option in the future. Ms. Graeber asked if it would be helpful to add language to the proposal that would be added to the NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation (LTC Manual) that clarifies that the proposal can be used at the option of the filing company, and that it is not to be considered mandatory by regulators. Mr. Weller said he thinks this may be acceptable, depending on how the clarification is worded.

Mr. Birdsall said that the proposal’s third guardrail, which requires companies to absorb a portion of the requested rate increase, is intended to address the scenario where a company is currently not experiencing adverse long-term care experience, but expects future experience to deteriorate in a way that will cause hardship for the company.

David Plumb (John Hancock Life Insurance Company) gave a summary of his comments (Attachment Eight-C2), and said he agrees with the comments that AHIP and ACLI provided. He said he is concerned that the optional proposal effectively changes a guaranteed renewable product into a noncancellable product for insurers with small or closed blocks of business. Mr. Johnson said that Florida surveys insurers for rates for closed blocks of business and uses these rates to establish rate increase caps for closed blocks of business.

Kim Tillmann (Thrivent Financial) gave a summary of her comments (Attachment Eight-C3). She said that an insurer share of rate increases less than the proposed 75% may be more likely to be used when offered as an optional method intended to simplify the state review process. However, she said that if the concept of rate increase cost-sharing becomes mandatory, it will deter insurers from offering long-term care insurance. She expressed a desire to have rate increase standards that are uniform across all states, similar to those the IIPRC uses. Mr. Birdsall said he is willing to consider adjustments to the proposal that Ms. Tillmann suggested.

Mr. Serbinowski asked if insurers are willing to discuss what the appropriate amount of time is for experience to develop to have a meaningful basis to determine if a rate increase is justified. Mr. Weller said if the full requested rate increase is approved, he agrees that there should be no further rate increases approved for three years, but three years may not be appropriate for a rate increase that is implemented over a period longer than one year.

Ms. Graeber asked Mr. Birdsall how he would like the Subgroup to proceed with the optional rate increase review proposal. Mr. Birdsall said he wants to retain the proposal’s guardrail for small blocks of business. He said he will consider modifying the cost-sharing percentage requirements for the third guardrail. He said the Subgroup should decide if it wants to proceed with modifying the proposal and continuing discussion. No member of the Subgroup objected to Mr. Birdsall’s suggested course of action. Ms. Graeber said the Subgroup will continue discussion of the proposal on its July 1 conference call.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.

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June 16, 2014

Jan Graeber, Chair, NAIC LTC (B) Pricing Subgroup
Texas Department of Insurance
333 Guadalupe
Austin, Texas 78701

Re: Proposed Changes to NAIC LTC Guidance Manual – Optional Rate Review Election Exposure

Dear Jan:

America’s Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI) appreciate the opportunity to provide comments on the proposed changes to the LTC Guidance Manual exposed on May 15th. The exposed changes to Section VI would add a subsection D titled “Optional Rate Review Election.”

We note that this “Optional” process is being advanced based on a document created by the Kansas Insurance Department, referred to as the “Kansas Principles” document. We believe that the inclusion of this option in the LTC Guidance Manual is inappropriate for the following reasons:

- We believe that both the ad hoc company cost sharing requirement and the guardrails generally are not sustainable since, under certain circumstances, they will not allow sufficient rate increases necessary to effectively mitigate emerging LTC financial and enterprise risk to individual companies and, in aggregate, to the insurance market generally. The type of cost-sharing arrangements contemplated by this “optional” process¹ is not related to the NAIC enacted Model Laws and Regulations governing long term care rate increases. We have many concerns with details of the operation and effect of the application of the spreadsheet as well.

¹ In fact, we note that when this proposal was being discussed by the Subgroup, it was specifically expressed that this would be applied to filings that were already reviewed and found to be in compliance with existing laws and regulations. That is, these “principles” are specifically intended to be applied outside the confines of adopted NAIC Model Laws and Regulations.
The approach would be applied retroactively to policies that were priced and sold under “different” regulations creating very different results based on past experience with rate increase requests.

We do not believe it is appropriate to include “options” of any kind into a Guidance Manual addressing any NAIC Models. Adoption of this process at the NAIC for creating “options” through changes to the LTC Guidance Manual would empower Insurance Departments freely to adopt new standards at any time without regard to statutes or regulations and retroactively apply those standards to policies that were priced under prior regulations. The NAIC processes should be used to encourage and increase consistency in how the states address rate increase requests.

We recommend that the LTC Pricing Subgroup limit its changes to the LTC Guidance Manual to ones that (i) interpret Model language, (ii) provide examples of how provisions of the Models might be implemented and (iii) address ways in which use of the Models can enhance consistency of regulation across the country. We question whether including an “option” within the LTC Guidance manual would achieve the goal of the NAIC to have uniformity and consistency in the states.

Explanation of Our Recommendations

Interpretation of Model Language

The existing LTC Guidance Manual has many sections with explanations of the Model Regulation language and what it means. Some of this is in general explanatory paragraph format while others are in a question and answer format. This is done in part to provide background for the Model wording and to be of assistance to those regulators and company personnel who may have limited background of how the Model language was developed.

For example, in the Model Regulation Section VI.A.(4) provides considerable detail into what a regulator should expect to see in an actuarial memorandum filed with a rate increase request. This area is further amplified in the questions in subsection D.

Certain proposed changes in 2014 to the LTC Model Regulation language (as well as the new NAIC Model Bulletin) could benefit from similar explanation. For example, the new Model Regulation Section 10.B.(2)(d)(ii) says:

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2 Changes to the LTC Guidance Manual would address only changes to any of these three NAIC Models:
1. NAIC Long-Term Care Model Act
2. NAIC Long-Term Care Model Regulation
3. NAIC Long-Term Care Model Bulletin
“A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.”

Interpretation of the actual process to make the phrases “uncommon circumstances,” “full justification” and “monitor developing experience” have a consistent meaning would be an appropriate addition to the LTC Guidance Manual.

Providing Examples of How Provisions of the Models Might Be Implemented

The LTC Guidance Manual already contains numerous examples – e.g. rate increase history, actuarial certification language, etc.

The LTC Model Bulletin provides for disclosure in any notification to policyholders of rate increases. Draft sample paragraphs addressing these items would be helpful to regulators and companies and probably should be considered for inclusion in the LTC Guidance Manual.

There are other changes proposed in 2014 to the LTC Model language that could benefit from such examples. For example, the new LTC Model Regulation Section 15.I. provides for an annual actuarial certification with respect to rates for existing business and in circumstances where such a certification cannot be provided, the notice by the company of its “plan of action” and “time frame for re-establishment of adequate margins.” Draft examples of acceptable wording should be considered for inclusion in the LTC Guidance Manual.

Enhancing Consistency and Uniformity of the Use of the Models

NAIC Models are intended to allow states to regulate insurance written on a national level. Having different rules, written and unwritten, in many states adds to the costs to policyholders in an unnecessary way. While the NAIC cannot impose common rules and regulations on the states, the Models have been an effective way to encourage consistency and uniformity. The Interstate Insurance Product Regulation Commission is another way to increase consistency and uniformity and reduce unnecessary costs of variations. The LTC Guidance Manual should focus on the Model language in order to support this goal of enhancing consistency and uniformity.

We have noted an increase in the variations in rules states are applying to LTC rate increases. In some cases, it appears that some states are limiting their actions based on what or how many other states have done. We hope that the NAIC responds to these inappropriate limits which delay or lower rate increase requests, not based on an actuarial review of the experience and projected results, but some arbitrary relationship of the results of other states’ actions. An addition to the Guidance Manual on this topic should also be considered.

In summary, the aforementioned examples are just more information on what we recommend to be included in the LTC Guidance Manual. Currently, we do not believe that “options”, be it
options for rate review elections or other “options,” should be in guidance manuals addressing adopted NAIC Models.

We appreciate the opportunity to provide comments on the exposure and are available to address any questions you and your subgroup may have.

Sincerely,

William C. Weller
Consultant to AHIP

Sincerely,

Steve Clayburn
ACLI

cc: Perry Kupferman
    Eric King
    Mark Birdsall
June 13, 2014

Jan Graeber, Chair, NAIC LTC (B) Pricing Subgroup
Texas Department of Insurance
333 Guadalupe
Austin, Texas 78701

Re: Proposed Changes to NAIC LTC Guidance Manual – Optional Rate Review Election Exposure

Dear Jan:

I would like to thank you and the NAIC for the opportunity to opine on proposed changes to the LTC Guidance Manual as exposed for comment on May 15th. In addition, I wish to extend my appreciation of all the good work your group has done to date as it relates to the NAIC LTC Bulletin and current proposed changes to the NAIC LTC Model Regulation.

However, I would like to relay my serious reservations regarding the inclusion in the Guidance Manual of the proposed optional process which is not reflective of existing regulation and could be applied to products priced under different standards.

As additional support as to why I do not believe the optional rate review election should be included in the Guidance Manual, I would like to submit the following technical comments.

With respect to Appendix 4A, "Long-Term Care Cost-Sharing Exhibit":

- I believe the 75% cost sharing requirement is overly punitive. This results in rate increases as low as just 25% of what the NAIC LTC Model Regulation would allow, thus significantly increasing the risk for carriers which currently write LTC insurance and those carriers who may wish to return to or enter the market. While this is a optional election, inclusion in the Guidance Manual may unintentionally infer to regulators that this election may extend to a mandatory process that carriers would be forced to follow. I believe the recently adopted revisions to the NAIC LTC Model Regulation (as approved by the NAIC Senior Issues Task Force and B Committee) are rigorous enough to encourage companies to price LTC insurance appropriately. Any further pullback by insurance companies away from this important product will result in more people losing their hard-earned assets and relying on Medicaid.

- I believe the 85% minimum future loss ratio is overly punitive and should be a weighting of
  - The greater of the original pricing loss ratio and 58% applied to the original premiums, and
• 85% applied to the premium increase

With respect to Section D.8 of the proposal:

To provide an adequate period for future experience to indicate a significant deviation from prior expectations, Section D.8 of the proposal requires the company to agree that no future rate increases will be submitted for at least five years and not unless experience deteriorates at least 15% from the expectations from the prior filing. In addition to actual past experience, rate increases are driven by changes to future expectations (which are informed by past experience). Future expectations at older attained ages and later policy durations can change with new company experience. That experience deviation might not stand out if one is just looking at past experience, because there might be a small portion of the business at those older attained ages and later policy durations. Five years might not even be enough to see the deterioration in past experience, but companies should act as soon as the need for an increase is evident in order to keep the amount of the increase needed as small and manageable as possible. A five year limitation works against this goal.

I think the requirement of a 15% deterioration is problematic because it also doesn’t allow companies to act quickly and keep the increases smaller and manageable. This would likely force companies to raise premiums even more, in order to be able to withstand a further deterioration of up to 15%.

I appreciate the opportunity to provide comments on the exposure and would be happy to address any questions you may have.

Sincerely,

David Plumb
John Hancock Life Insurance Company

Copy to: Eric King, Mark Birdsall
I’d like to submit the following three comments from Thrivent.

1. The formulas in rows 44-46 are not correct if the requested increase is less than the 25/72 cost sharing guardrail.
2. The 75% company portion of the cost sharing guardrail seems very high. If it was lower – say in the 60-70% range, more companies may be able/willing to use this rate filing method.
3. It would be great if IIPRC would be willing/able to review and approve increases greater than their current 15% limit using this method. Since it is a more objective method, it seems well suited to be included in the IIPRC uniform code.

And then one comment about LTCI rate increase filings in general for the subgroup:

1. Most of the rate review discussion seems to stem from the assumption that rate increases are primarily a result of incorrect or aggressive pricing by insurance companies. This is not necessarily the case. LTCI assumptions – particularly the morbidity assumption – is very hard to predict. Past experience on insured lives, which is just starting to become available, may not be indicative of future experience as the types of care available and people’s attitudes towards paid care change over time. If a high level of cost sharing becomes the rule, rather than an option, companies will be discouraged from providing this important coverage.

Thanks for your consideration and please commend the subgroup for their work on this difficult topic.

Kim H Tillmann, FSA, MAAA
Senior Staff Actuary
Pricing and Financial Evaluation
625 Fourth Ave. S., Minneapolis, MN 55415-1665
Direct: 612-844-8225
Fax: 612-844-5040
Toll-free: 800-847-4836, "Directory," ext. 38225
Email: kim.tillmann@thrivent.com
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call June 10, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Mark Birdsall (KS); Julia Philips and Fred Andersen (MN); William Leung (MO); Bob Potter (NC); John Rink (NE); Felix Schirripa (NJ); Jeannette Holman (OR); and Tomasz Serbinowski (UT). Also participating were: Kerry Krantz (FL); and Jim Laverty (PA).

1. Discussed Developing a Long-Term Care Insurance Pricing Assumptions Template

The Subgroup discussed a document (Attachment Eight-D1) that examines the possible use of experience data from the Society of Actuaries 1984–2007 Long-Term Care Intercompany Report for evaluating pricing assumptions used in long-term care rate filings. Ms. Graeber said Mr. Serbinowski is working to determine if some of the elements of the report can be used to develop a template to be used by insurers to report their pricing assumptions in a standard format. Mr. Serbinowski asked if the primary purpose of the template should be the analysis of assumptions to determine the appropriateness of the filed rates, or to act as a benchmark for expected results when comparing actual experience to expected experience in the future. Ms. Graeber asked if such a template can be used for both purposes. Mr. Serbinowski said he believes it can.

Mr. Krantz suggested that the template should use best-estimate assumptions and disclosure of the amount of margin for moderately adverse experience to be added to each best-estimate assumption. Mr. Serbinowski said comparing actual results to expected results that include margins may result in actual-to-expected ratios less than 1.00. Mr. Krantz said comparing actual experience to expected experience includes margins would allow regulators to determine if experience is worse than assumed under moderately adverse conditions, which will assist in determining if a rate increase is appropriate. Ms. Philips said she is concerned that allowing the insurer to determine what qualifies as “moderately adverse experience” may result in understated moderately adverse margins that could result in more frequent rate increases. Mr. Krantz said that the best-estimate assumptions and margins for moderately adverse experience will have to be supported by data. He said that if an insurer files a rate that is less than the rate with an appropriate margin for adverse experience, perhaps the insurer should be required to hold a reserve to account for the difference between the two rates. Mr. Potter said using the template as a means to compare actual experience to expected experience would be valuable.

Mr. Serbinowski asked participants if, when evaluating a rate increase request, it matters whether the cause of actual experience deviating from expected experience is due to inappropriate initial pricing assumptions or due to statistical volatility. Bill Weller (America’s Health Insurance Plans—AHIP) said he believes that projected adverse experience beyond the initially priced moderately adverse level is a valid reason for requesting a rate increase. He said it is important for regulators to consider the statistical credibility of the projected future actual-to-expected ratio when evaluating a rate increase request. David Hippen (Risk & Regulatory Consulting, LLC) said it is fair for regulators to require a demonstration that the assumptions used to develop a rate increase are more appropriate than the assumptions used for initial pricing.

Mr. Potter suggested including claim incidence and continuance information that varies by benefit period in the template.

Mr. Serbinowski said he would use the results of the discussion to continue work on developing the template.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
I have reviewed the latest SOA LTC Experience Report (http://www.soa.org/Research/Experience-Study/ltc/research-ltc-study-1984-report.aspx) to check the level of detail/granularity at which experience is collected and analyzed.

I have assumed that for the purpose of the new business assumption setting, we would only look at assumptions that are relevant to pricing. For example, distribution of business between males and females is important because the cost varies by gender and the actuary does not know a priori what that distribution will be. On the other hand, even though SOA experience is analyzed by the issue era, issue era is not an assumption that the actuary would need to make when pricing new business.

SOA data has some experience analyzed based on the Geographic Region (Midwest, Northeast, South, and West). In the past, the companies neither varied the rates nor assumed any cost difference between various Regions. To the extent that the evidence of differences in incidence rates, terminations rates, lapses, mortality, etc. by Geographic Region emerge, and to the extent that these differences are not reflected in rates (that is some cross subsidies exist between different Regions), it may become necessary to assume a particular distribution of business between Geographic Regions in pricing.

On the flip side, to the extent that insurers move away from unisex rates and adopt rates that reflect actual male/female cost differential, the importance of the assumed male/female split will lessen.

SOA study has some claim experience by diagnosis. I have decided that this information would not be relevant at the initial rate review unless the company varied benefits by diagnosis. To the extent that the actuary believes that a particular underwriting tool would influence future composition of claims by diagnosis, it may inform the choice of incidence and claim termination rates, but that would be covered by type and quality of underwriting.

Here are variables by which major assumptions are tabulated/analyzed in the SOA study.

1. **Voluntary Lapse**: Duration, Issue Age, Attained Age, Gender, Marital Status, Elimination Period, Benefit Period, Maximum Benefit Basis (days/amount), Inflation Protection, Premium Mode, Distribution Channel, and Geographic Region

2. **Mortality**: Attained Age, Gender, Duration, Status (active/disabled), and Geographic Region

3. **Claim Incidence**: Attained Age, Gender, Marital Status, Duration, Level of Care, Coverage Type, Elimination Period, Benefit Period, and Maximum Daily Benefit

4. **Claim Continuance**: Attained Age (at the time of claim), Gender, Initial Level of Care, Marital Status (at issue), Elimination Period, Geographic Region, and Initial Diagnosis


Marital Status is indicated by the presence (or not) of the marital discount and reflects the status at issue. Coverage Type refers to nursing home, home care, and comprehensive policy. Assuming that the
pricing is done for a policy providing particular (known) type, Coverage Type would not be a rating variable.

For some variables in the Study, the information is incomplete. For example, distribution of policies by state shows that for over 60% of policies the state of issue was not reported. Hence, in some cases “unknown” is the largest category.

The Study does not cover expenses or investment returns.

I would suggest the following minimum granularity level for major assumptions.

1. Voluntary Lapse – Gender, Issue Age, and Duration (2 tables, one for males and one for females)
2. Active Life Mortality – Gender, Issue Age, Duration, and Underwriting Class (several tables, one for each gender/underwriting class combination)
3. Disabled Life Mortality – Gender, Attained Age at the time of claim, and Duration of claim
4. Claim Incidence – Gender, Issue Age, and Duration (2 tables, one for males and one for females)
5. Claim Continuance – Gender, Attained Age at the time of claim, and Duration of claim
6. Distribution of Business – Gender, Issue Age, Marital Status, Underwriting Class, Benefit Period, Elimination Period, and Inflation Protection

Marital discounts are fairly significant (up to 30%) and good portion of business written qualifies for the discount. Therefore, Marital Status should be reflected somewhere in the assumptions (possibly in multiple places). We should consider adding Marital Status as a variable to one or all of the above. Similarly with respect to the Underwriting Class (although great majority of the business falls usually into one class).

How would the information regarding assumed distribution of business be provided? Would we want percentage of expected business that falls into any one cell? For example, 3% of issued policies are expected to be to females, age 50-54, married, standard class, 5 year BP, 90 day EP, compound inflation protection at 5%.

With the above granularity, would we expect to be able, at least approximately, to reproduce a target loss ratio for any given rating cell? Would we be able to project durational loss ratios based on assumed distribution of business and some “standard” distribution of business (for benchmarking purposes)?
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call May 15, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Linda Ziegler (FL); Mark Birdsall (KS); Bob Potter (NC); John Rink (NE); Felix Schirripa (NJ); David Ball (OR); Andrew Dvorine (SC); and Tomasz Serbinowski (UT). Also participating was: Jim Laverty (PA).

1. **Voted to Expose an Optional Long-Term Care Insurance Rate Increase Review Proposal**

The Subgroup continued its discussion from its May 8 conference call of a proposal for an optional rate review process of long-term care insurance rate increase filings. Mr. Birdsall presented documents (Attachment Eight-E1, Attachment Eight-E2 and Attachment Eight-E3) that reflect changes to the proposal that were agreed upon during the Subgroup’s May 8 conference call.

Mr. Birdsall made a motion, seconded by Mr. Ball, to expose the optional rate review process documents for public comment until June 16. The motion passed.

Mr. Rink said he anticipates completing a document related to actuarial certification of long-term care insurance rates and developing and monitoring expected long-term care insurance claims within the next two weeks. He said the Subgroup eventually will present the document for discussion.

Mr. Serbinowski said he has prepared a preliminary document related to creating a long-term care insurance rating assumptions template and justification of pricing margins less than 10% and will forward it to Ms. Graeber for her review.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
This Appendix depicts a spreadsheet intended for use with an optional rate review as referenced in this Guidance Manual. For reference in the formulas, the upper left hand corner of the spreadsheet is cell A1, the first shaded cell under "Original Premiums" is cell B2, etc. The shaded cells are the only cells for which the filing company needs to input data. Accumulated values and present values should be calculated using the maximum statutory valuation interest rate pertaining to each year of issue. For credibility reasons, national premiums and claims should be used, but the two shaded cells under "Premiums Adjusted for State Increases" should represent premiums recalculated to represent the premium levels approved for use in the state of this filing.

If this filing proposes that different rate increases apply to different policyholder groups included in this filing, this cost-sharing exhibit should be filled out in aggregate for the entire filing. Separately, the Department may address the issue of whether it is appropriate to apply different rate increases to different portions of the business under consideration.

Additional policy level caps may be applied at the Commissioner’s discretion.

Companies electing this optional rate review agree that no future rate increase filings will be submitted with respect to the subject block of LTC business for at least 5 years from the submission date of the prior filing and not unless experience deteriorates by more than 15% from the tracking experience. This 15% deviation would be measured against the “Future loss ratio based on the Adjusted Rate Increase” shown above. The company would recalculate the future loss ratio as of the prior filing date using actual premium and claims experience for the period up to the new filing date, with a projection of future premiums and claims using best estimate assumptions as of the new filing date. This recalculated future loss ratio would then be compared to the “Future loss ratio based on the Adjusted Rate Increase” from the prior filing. If the recalculated ratio is 15% or more higher (multiplicatively), then the company would be eligible to submit a rate increase request for the subject block of LTC business. For example, if the “Future loss ratio based on the Adjusted Rate Increase” from the prior rate filing is 120% and the recalculated future loss ratio is greater than 138% (1.2 times 1.15), then the company would be eligible to file for a rate increase.

### Long Term Care Cost-Sharing Exhibit

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>AV of past experience</td>
<td>Original Premiums</td>
<td>Premiums Adjusted for State Increases</td>
</tr>
<tr>
<td>Past loss ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Requested Rate Increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future loss ratio (no increase)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PV of future experience (no increase)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future loss ratio (with the requested rate increase)</td>
<td></td>
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</tr>
<tr>
<td>Accumulated Funding for Future Claims</td>
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<td></td>
</tr>
<tr>
<td>Minimum Adjusted Future Loss Ratio ($)</td>
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</tr>
<tr>
<td>Original Target LR</td>
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</tr>
<tr>
<td>PV of future experience limited by minimum future LR</td>
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<td></td>
</tr>
<tr>
<td>Future loss ratio based on the minimum future LR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime experience based on limited increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future loss ratio based on limited increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three tests (guardrails)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised Policyholder Share of additional premiums needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policyholders’ share of additional premiums needed after first two tests</td>
<td></td>
<td></td>
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<tr>
<td>Adjusted Rate Increase</td>
<td></td>
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<tr>
<td>Target Loss Ratio</td>
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<tr>
<td>% Split Guardrail</td>
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<tr>
<td>Revised Policyholder Share of additional premiums needed</td>
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<td></td>
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<tr>
<td>Revised Company Share of additional premiums needed</td>
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<tr>
<td>PV Future Premiums after applying % Split Guardrail</td>
<td></td>
<td></td>
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<tr>
<td>Adjusted Rate Increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PV of future experience limited by the requested rate increase</td>
<td></td>
<td></td>
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<tr>
<td>Future loss ratio based on the requested rate increase</td>
<td></td>
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</tr>
<tr>
<td>Trigger Future loss ratio for a rate filing after 5 years measured from this filing date</td>
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</tbody>
</table>

### Instructions

The company would recalculate the future loss ratio as of the prior filing date using actual premium and claims experience for the period up to the new filing date, with a projection of future premiums and claims using best estimate assumptions as of the new filing date. This recalculated future loss ratio would then be compared to the “Future loss ratio based on the Adjusted Rate Increase” from the prior filing. If the recalculated ratio is 15% or more higher (multiplicatively), then the company would be eligible to submit a rate increase request for the subject block of LTC business. For example, if the “Future loss ratio based on the Adjusted Rate Increase” from the prior rate filing is 120% and the recalculated future loss ratio is greater than 138% (1.2 times 1.15), then the company would be eligible to file for a rate increase.
<table>
<thead>
<tr>
<th></th>
<th>Original Premiums</th>
<th>Premiums Adjusted for State Increases</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>AV of past experience</td>
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<tr>
<td>Past loss ratio</td>
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</tr>
<tr>
<td>PV of future experience (no increase)</td>
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<tr>
<td>Future loss ratio (no increase)</td>
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<td>Lifetime experience (no increase)</td>
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<td>Lifetime loss ratio (no increase)</td>
<td>$DIV/0!</td>
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<tr>
<td>PV of future experience (with the requested rate increase)</td>
<td>$DIV/0!</td>
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<tr>
<td>Future loss ratio (with the requested rate increase)</td>
<td>$DIV/0!</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Requested Rate Increase</td>
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</table>

Three tests (guardrails): Accumulated Funding for Future Claims
Future loss ratio (with the requested increase) adjusted for accum funding for future claim
Minimum Adjusted Future Loss Ratio (LR)

PV of future experience limited by minimum future LR
Future loss ratio based on the minimum future LR

2. Rate increase cap based on small remaining business (sliding scale)

PV of future experience limited by remaining business
Future loss ratio based on the limited increase
Lifetime experience based on limited increase
Lifetime loss ratio based on limited increase

3. Minimum Company Share of Add'l Prem needed to reach Target LR

Target Loss Ratio
Lifetime premium needed to achieve Target LR
PV of future additional premiums needed to achieve target LR
Policyholders share of the additional premiums needed (after first two tests)
Company’s share of the additional premiums needed (after first two tests)

% Split Guardrail
Revised Policyholder Share of additional premiums needed
Revised Company Share of additional premiums needed
PV Future Premiums after applying % Split Guardrail

PV of future experience based on the Adjusted Rate Increase

Future loss ratio based on the Adjusted Rate Increase
Lifetime experience based on the Adjusted Rate Increase
Lifetime loss ratio based on the Adjusted Rate Increase

Adjusted Rate Increase
Section VI. RATE INCREASE FILING

The prior chapters of this manual have related to the initial filing of premium rates and disclosures to applicants for long-term care insurance policy forms under the new LTCI Model Regulation. It is anticipated that the new rules for developing premium rate schedules will allow insurers to include greater margins and reduce the potential need for rate increases. However, the Model Regulation does provide for the filing, review and approval of premium rate increases, as well as the monitoring of ongoing experience in the event of a rate increase for policy contracts issued subject to the new Model Regulation.

This chapter covers the information to be filed and the basis for the regulator’s review of premium rate increase submissions under the new Model Regulation, including a section on the optional rate review that companies may elect to use. Later chapters provide information relating to monitoring, additional regulatory oversight and potential regulatory actions for significant rate increases.

A. MATERIALS THAT ACCOMPANY A RATE INCREASE FILING

The information to accompany a filing for a rate increase is defined in Section 20 of the Model Regulation. The information includes:

- **New Premium Rate Schedule**
- **New Disclosure of Rate Increase History** document that reflects the filed increase. The insurer should also provide a list of all similar policy forms that are available for sale in which applicants will be informed of this rate increase.
- **New Actuarial Certification**
- **Actuarial Memorandum** justifying the new rate schedule which includes:
  - Lifetime projection of earned premiums and incurred claims that illustrate the rate schedule’s compliance with the loss ratio standards;
  - Disclosure of how reserves have been accounted for if the rate increase triggers contingent benefit upon lapse;
  - Disclosure of why the rate increase is necessary, including which pricing assumptions were not realized and why; and
  - Statement that the policy design, underwriting, and claims adjudication practices have been taken into consideration.
- **Rate Comparison Statement** that “renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner…”

1 There are different rules for “exceptional increases.” These are explained in a separate section at the end of this chapter.
1. **New Premium Rate Schedule**

The complete new rate schedule should be filed, including rates for all variations in elimination periods and benefit periods. The percentage increase for each issue age should be provided from both the existing rate (to review the changes to disclosure documents) and the original rate. These percentages should be compared to the levels that trigger Contingent Benefit upon Lapse (CBL). See below for additional issues if CBL is triggered.

2. **New Disclosure of Rate Increase History**

Section 9 of the Model Regulation outlines the disclosure documents that each insurer must provide to all applicants. One part of this is a history of any rate increase on similar policy forms that has occurred within the 10-year period prior to the application date. This disclosure will need to be updated to reflect the actual rate increase that results from the filing. The Commissioner should establish the time frame within which the insurer must change its disclosure documents after the approval of any rate.

3. **Actuarial Certification**

The Actuarial Certification should be reviewed for the specific language used by the actuary. It is possible that the actuary will not be the same person as the one who signed the original certification. A change in the actuary of record should be explained. A sample Actuarial Certification for a rate increase is in Appendix 2.

4. **Actuarial Memorandum**

The review of the actuarial memorandum relating to a rate increase will be more extensive since it contains additional information, actual experience, a loss ratio demonstration and an explanation of the original assumptions that were not realized in support of the requested rate increase.

The actuarial memorandum should be reviewed for completeness. The method and assumptions used in determining projected values should be reviewed in light of reported experience. The assumptions used for the loss ratio demonstration should be consistent with prior actuarial experience, adjusted for known changes in such items as underwriting or claims adjudication that have been made or are anticipated by the insurer. The assumptions for future claims used in the loss ratio demonstration should include the actuary’s margins for moderately adverse claims and persistency experience.

The morbidity assumption and reported morbidity experience may not be credible for any LTCI policy form by itself. Combining experience of different forms with similar benefits may result in more credible historical claims as the basis for future claim costs.

Any assumptions that deviate from those used for pricing other forms currently available for sale should be disclosed and justified.

The lifetime projection of earned premiums and incurred claims (including margin for future adverse experience) shall illustrate that the lifetime loss ratio requirement will be satisfied with the filed rate schedule increase. This lifetime projection must include annual values for at least the five years preceding and three years following the increase. A simplified loss ratio demonstration (not including any detail or justification of assumptions) is in Appendix 4. Please note that this is not the only method or format for providing the required projection and values. The handling of projected lapses that qualify for CBL is described later.
The memorandum should clearly show that it uses the interest rate(s) required to be used by Section 20C(4) of the Model Regulation to demonstrate that the new premium rate scale meets the loss ratio requirements. Any net excess of the expected earnings over the valuation rate would be considered as a part of the provision for moderately adverse experience in the new rates.

The persistency assumption for the future (for both claim costs and premiums) should take into account:

(a) The amount of the proposed rate increase;
(b) The impact of reserves transferred to fund any CBL benefits (triggered proportions of the total in force business subject to rate increases should be shown as well as the percentage for each triggered age or age group that are expected to accept the CBL offer);
(c) Historical renewal lapse rates; and
(d) The actuary’s margin for adverse persistency experience.

The memorandum should describe the analysis done by the actuary comparing prior assumptions with experience. This analysis should cover all important assumptions showing the positive as well as adverse deviations from the expected. The amount of the original pricing margin that is lost when the new assumptions are used should be estimated. Any actions the insurer has taken or is planning to take to offset even greater rate increases should be noted to the extent the actions were relied on by the actuary in developing the new rates.

The memorandum should contain a statement that the policy design (benefits and benefit triggers, etc.), underwriting (to the extent it is still anticipated to affect claim costs) and claims adjudication practices have been taken into consideration by the actuary in the development of assumptions and projections.

For certain group business or particular policy forms it may be necessary to have the same rate for both new issues and in force business. In these cases the actuary’s projections will need to apply the loss ratios to the business subject to a rate increase to show the rate as if there were no new business. A separate rate for new business would be developed consistent with the anticipated loss ratio at issue of the original policy form and the revised assumptions. These two rates would then be combined into a single rate. Actual new business results should then be reviewed as part of the review of projected results for the three-year period following the rate increase.

5. Rate Comparison Statement

Section 20B(4) of the Model Regulation requires that a rate increase filing provide the following:

A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner…

It should be noted that the new business premium rates are not subject to the minimum loss ratio requirements that are applicable to rate increases.

In most situations the insurer will be able to provide a statement that rates after the rate increase are not greater than the new business rates. In some cases, the differences in benefits will be large enough that this comparison cannot be verified by simply comparing the rates. The insurer should provide information justifying significant variations.
In some circumstances the policy forms subject to the rate increase will end up with rates higher than new business rates of another policy form for the same issue age. This will generally result when the future premiums for older policy forms are a much smaller proportion of total premiums while new or newer policy forms will collect more premiums that include the rate increase. The insurer should be able to justify this result to the regulator by including a comparison of the resulting renewal rate with new business rates at the higher (current) age for sample insureds. Although this circumstance demonstrates one reason why the rate increase rates would be higher than new business rates, it may not be a sufficient reason to allow the deviation from the standard. A closed, reducing block of business that has been in force for many years is likely to have this circumstance, which may be the result of initial under-pricing and insurer inaction.

Where the rate increase is applicable to a policy form that is currently being offered, the renewal rates will be limited by the loss ratio standards. The insurer may wish to use higher rates for new sales (which are not subject to loss ratio minimums). Assuming that new sales of the policy form (at rates higher than the renewal rates) are allowed after the rate increase, the insurer will need to eliminate the experience of these new issues for purposes of comparing actual to projected experience following the rate increase. It should be noted that the experience for these new issues should be included when determining future rate increases.

B. ADDITIONAL ASPECTS IF CONTINGENT BENEFIT UPON LAPSE IS TRIGGERED

As noted earlier, the new rates are to be compared to the original rates and the ratio compared to the table for triggering CBL provisions under Section 28 of the Model Regulation. For any issue age where the percentage equals or exceeds the table value, the insurer also will need to provide those policyholders with an explanation of their options and the date the CBL option expires.

Due to the increased popularity of limited pay long-term care insurance, [in 2005] the NAIC expanded the contingent benefit upon lapse provision to address an identified need to improve the value of contingent benefits for limited pay policies. An additional test of a substantial premium increase and separate reduced paid-up benefit calculations were added for these policies in Section 28 of the Model Regulation. These new provisions become effective six months after their adoption. The insurer will need to provide policyholders with an explanation of their options and the date the CBL option expires should this test be triggered.

There are several aspects to be considered:

1. Approval of the process for informing policyholders of their CBL option;
2. Determination of the proportion of policyholders receiving a rate increase for which the CBL is triggered; and
3. Adjustments made in the actuarial memorandum for CBL and the monitoring of actual versus expected use of CBL following the rate increase.

Sections 28D(5) and D(6) of the Model Regulation provide specifics for the notification of policyholders of their rights at the time of a rate increase. Since it is possible that some but not all policyholders subject to a rate increase will trigger the CBL, the regulator should review the different materials to be provided in each situation.

Sections 20G and H of the model become effective if the CBL is triggered for the majority of the policyholders (anything over 50%) subject to a rate increase. The regulator should determine the percentage of policyholders for which the CBL is triggered. The determination of this percentage shall include limited pay policies that trigger the additional substantial premium increase test following the effective date of this provision.
Section 20B(3)(b) provides an exception to the normal rule that active life reserves are not to be reflected in the demonstration that the lifetime loss ratio projection is satisfied. The expected number of changes from premium paying insured (full benefit) to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected value of all future payments for those under CBL, including comparable margins for adverse, should be recognized as immediate benefits in the rate increase calculation subject to a maximum of the total active life reserve held for these insureds. A separate reserve for CBL insureds in this amount should be established and the insurer should adjust the active life reserve for premium-paying policies to reflect this transfer. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. The reserve established for any additional CBL insureds should be reflected as additional benefits in the updated projections. If the number of CBL insureds is lower, the excess reserve for CBL benefits established at the time of the rate increase should reduce total benefits in the updated projections. The actual claims experience of CBL insureds after the transfer is not to be combined with the experience to be monitored.

C. EXCEPTIONAL RATE INCREASES

Section 4A of the Model Regulation defines exceptional increases. Most rate increases will not be exceptional. If an insurer files a rate increase as an exceptional increase, it should provide justification for one of the two possible bases upon which the insurer may rely.

The regulator should review the justification provided before reviewing the remainder of the rate increase request, since the limitations are different. Approval of the basis for the review should be based on a finding that either:

1. The insurer has reflected a change in federal or the state's laws or regulations applicable to LTCI; or
2. The insurer has documented a rationale for increased and unexpected utilization (higher number of claims or longer periods for insureds in claim status) that affects the majority of insureds with similar products.

There are additional issues the regulator may wish to consider as part of this review.

☐ Would it be beneficial to request a review by an independent actuary or to coordinate with other states? This could be especially important in making a determination under 2 above.

☐ Are there offsets to increases that result from the new laws, regulations or even the basis for higher utilization? If so, the insurer should reflect any potential offset.

Insurers are required to file much of the same information for an exceptional increase (new premium rate schedule, new rate history disclosure) as for a non-exceptional increase, with a few slight modifications. There is a difference in the actuarial filing. The certification would be slightly different in wording. (See Appendix 3 for a sample.) The actuarial memorandum would be shorter. There is no requirement to justify differences from initial assumptions or to provide lifetime projections. Instead, the actuary should demonstrate that future claim costs (resulting from the causes the insurer has used to justify the need for an exceptional increase and from any relevant expected changes in insurer experience) are 70% of the future projected additional premium. Experience to date and the future projections of premiums from the original rate (with the expenses and claims to be covered) are not to be included in the demonstration. However, the regulator may request such experience and other information to evaluate the appropriateness of the insurer’s estimate of potential offsets to higher claim costs.
D. OPTIONAL RATE REVIEW ELECTION

Given the nature and history of the long-term care business, including long periods before claims became significant, changing provider and medical practices, as well as changes in family structure and social mores, it has been difficult for insurance companies to anticipate all of the trends that affect the claims incidence and severity of these products. For the continued financial health of insurance companies and to help policyholders have greater certainty regarding the future costs and benefits associated with their policies, an optional rate review election process has been developed that will provide a more objective basis for reviewing rate increase proposals and help develop greater consistency among the states in reviewing rate filings. It should be emphasized that this optional rate review election process is simply an option that the company may elect. Rather than choosing this option, a company may determine to submit a rate filing in connection with the other requirements provided in the Model Regulation. For any rate filing, the company will designate in the cover letter whether or not it is electing an optional rate review process.

The optional rate review process defined in this Section will be based on the following principles:

1. The cost of experience deviations from expected will be shared between the insurance company and the policyholder. See Appendix 4A, “Long-Term Care Cost-Sharing Exhibit”. This cost-sharing exhibit provides for a minimum future loss ratio adjusted for accumulated pre-funding of future claims, as well as a basis for limiting some rate increases due to the relatively small number of remaining policyholders. The exhibit also provides a measure of the percent of cost-sharing between policyholders and the company of actual experience deviating adversely from expected experience and establishes a minimum company share (and maximum policyholder share) of the cost of these experience deviations.

2. Best estimate assumptions with pricing margins will be used as the basis for the rate increase filing. These best estimate assumptions will be used for tracking future experience. A qualified actuary will certify that the assumptions are his or her best estimates, including consideration of company experience, industry experience, trends, and any other factors that may have a material effect on the best estimate assumptions.

3. Sensitivity testing will be performed demonstrating that the proposed premiums can absorb moderately adverse deviations in experience as determined by the company.

4. The submission of long-term care reserves, including premium deficiency reserves as required, that are based on best estimate assumptions that are consistent with the rate increase filing, adjusted for reserve margins and considering timing differences between the calculation of the reserves and the submission of the rate filing. The Appointed Actuary will certify to the consistency of the best estimate assumptions with the best estimate assumptions underlying the rate filing and explain the justification for any material differences.

5. The statutory maximum valuation interest rate will be used in the calculations of accumulated values and present values.

6. Any benefit reduction options offered by the company to mitigate premium increases will represent similar values to the policyholder measured at a policy form level, including an appropriate relationship between the premium offset and the benefits reduced.

7. The policyholder notification letter will be filed for approval with the state insurance department and will contain key information such as the amount of the rate increase, rate mitigation options, contingent benefit offer, and the guaranteed renewable nature of the contract. If an approved rate increase is being implemented over multiple years, the policyholder notification letter and other communications must be clear so the policyholders will know what to expect in the future.

8. To provide an adequate period for future experience to indicate a significant deviation from the tracking experience, the company agrees that no future rate increase filings will be submitted with respect to the subject block of business for at least five years from the date of submission of the rate filing and not unless experience deteriorates at least 15% from the tracking experience related to the prior rate increase filing. For more calculation details, see the instructions in Appendix 4A.

9. If the company is writing new long-term care business, no approved rate may exceed the premium level for new business providing similar benefits.

The cost-sharing exhibit, together with the principles indicated above, provide for approval of an actuarially justified rate increase subject to the three guardrails contained in the exhibit. However, if there are exceptional circumstances related to a filing, such as solvency considerations, the Commissioner retains the discretion to approve a different increase than indicated in the cost-sharing exhibit. Additional policy level caps may also be applied at the Commissioner’s discretion.

Other filing requirements of the Model Regulation will apply to this optional rate filing process.
1. What would be a common list of information a regulator might expect to see in an actuarial memorandum for a rate increase?

A state may wish to require that an actuarial memorandum include some or all of the items listed in Appendix 5. Selected items from that list are discussed below.

(a) Morbidity
The overall pattern of claim costs for LTCI is well known – claim costs increase with increasing age – but there is no industry standard morbidity table.

(b) Lapse
If the LTCI policy does not contain a nonforfeiture provision, the pricing will reflect a “lapse-supported” pricing methodology. The more insureds that leave the block (either by death or voluntary termination), the lower future costs will be. This means that the assumptions that the insurer makes about future expected lapses (voluntary) and deaths are critical to the pricing of LTCI. The lower the expected lapses and deaths, the more conservative the pricing.

Most current filings have ultimate (after the first 5 years or so) lapse rates of 4% or less. This means that fewer than 4% of the insureds that remain will drop their policy. If this assumption is higher than 3–4%, then the insurer should be questioned about the source of its assumption. Remember that the higher this number, the lower the premium and therefore, the less conservative it is.

(c) Mortality
The mortality assumption (death rates) is critical for the same reason that the voluntary lapse rate is critical. If more insureds are assumed to die than actually do, then the premiums could be inadequate. The NAIC Health Insurance Reserves Model Regulation requires the use of an annuity mortality table. The use of a life mortality table would be less conservative.

(d) Interest
Section 20C(4) requires that the interest rates used for discount purposes in determining rate increases be the maximum valuation interest rate for contract reserves as specified in the states’ equivalent to the NAIC Health Reserves Model Regulation. Since this rate may vary from year to year, Section 20 allows the use of an average interest rate if the manner in which it has been determined is disclosed. The regulator should review the filing to determine compliance with the moderately adverse standard based on all assumptions, including the interest assumptions, which may be different from those used for testing loss ratio compliance.

(e) Reserves – Policy and Claim
The reserves, both policy and claim, should be reviewed by the regulatory actuary for reasonableness and adequacy.

2. How are active life reserves utilized under the revised model?

Normally, active life reserves are not included in the rate increase analysis. Section 20B(3)(b) provides an exception to this rule by allowing a transfer of the active life reserves to be reflected as a claim for those insureds transferred from the active life pool to the CBL paid-up pool. The expected number of changes from premium paying (full benefit) insured to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected benefits for those under CBL should be recognized at the time of the rate increase, and the insurer should adjust the active life reserve for these potential benefits. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. Any difference
between the reserve needed for continuing full coverage and the reserve for CBL coverage for the additional (or lower) number of CBL insureds should be reflected in the updated projections.

3. **What differences in the rate increase filing should be expected when an insurer sells both continuous-pay and limited-pay products?**

   The regulator should review the experience to determine whether limited-pay premium experience has been combined with the experience for continuous-pay policies. In general, limited-pay policies may not have credible experience on their own. Rate increases can only be charged to those insureds paying current and future premiums. This means that projected future costs that incorporate higher claim cost assumptions will need to be separated into those for paid-up policies and those for premium paying policies. If these increased costs are combined, the continuous-pay plans would be subsidizing paid-up insureds, and may be considered “unfair discrimination.”

4. **What other differences should the regulator review between continuous-pay and limited-pay products?**

   Limited-pay products have two CBL options. The first (or normal) option is the same as for continuous-pay products and is required if the policy is issued without nonforfeiture benefits. The second (or added) option is a reduced paid-up benefit that applies only to limited-pay products and is required even if the policy includes a SBP nonforfeiture benefit.

   The added CBL option recognizes the gradual change from premium paying to paid-up status of these products. It is triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

   Actual benefits from this CBL option are a reduced paid-up policy where the periodic payment is reduced (versus the normal CBL, which reduces the maximum paid when a claim occurs). The reduced amount is determined by 90% of the ratio of (a) to (b) where:

   
   
   
   $$(a) \text{ is the number of months of premiums paid to the date of lapse, and}$$
   $$b) \text{ is the number of months in the original premium-paying period.}$$

   The added CBL option can only be exercised if the ratio of (a) to (b) is 40% or more and the lapse date is within 120 days of the first due premium following the date of the rate increase.

5. **Is it possible for both CBL options to be triggered by the same rate increase for a limited-pay policy?**

   Yes. The policyholder will then have the choice of the “normal CBL” or the “added CBL” and the Model Regulation provides that, if the policyholder does not make a choice, the added CBL is the automatic option.
6. What should be considered if an insurer offers unisex rates?

Rate increases should continue to be based on unisex rates. Claim and active life reserves may have been established using unisex morbidity and mortality but adjustments may be needed to reflect the actual mix of claims and in force policies.

7. In Section 4A(4) of the Model Regulation, the definition for exceptional increase references “potential offsets.” What are some examples of “potential offsets”?

Consider the example of a state passing a new requirement that all LTCI policies cover home health services, even if policies previously provided only institutional care.

(a) If a policy has a maximum benefit period expressed in years, not dollars, to which all benefits (non-institutional and institutional) are subject, a potential offset would occur because benefits paid under lower cost non-institutional benefits (e.g., home health care) would reduce the amount of time remaining for higher cost institutional benefits.

(b) If an insurer retains the same benefit triggers (e.g., Activities of Daily Living) for home health as for institutional care, costs attributable to increased utilization for home health care (which could be anticipated to be higher than utilization for institutional care) could be offset somewhat by the fact that per visit home health care charges are lower than institutional charges.

8. What happens if the regulator believes that the requested rate increase is too high?

The regulator should review the assumptions in the actuarial memorandum for reasonableness. For example, the insurer could be projecting lapse rates or mortality rates that are significantly lower than what was used in the original pricing assumptions. The regulator should examine which assumptions are reasonable, the original assumptions or the assumptions in the rate increase filing. The filing may be subject to the state’s filing review and approval process. The regulation does not guarantee that the requested increase will be approved. Other state statutory requirements may apply.

The regulator should discuss his or her concerns with the actuary. That discussion may resolve your concerns. If not, you may want to talk to another state actuary who has experience with LTCI.

If you are unable to satisfy your concerns through these approaches, you may contact the Actuarial Board for Counseling and Discipline for its counsel on your concerns.

9. If an insurer wishes to offer the CBL to policyholders when the actual rate increase would not trigger the requirements to offer CBL, is this okay?

So long as the method for determining those policyholders to be offered CBL is not discriminatory and includes all those policyholders who must be offered CBL (based on the resulting rate exceeding the initial rate by the percentage specified in the Model Regulation), the company is allowed to make the offer.

Therefore, the phrase “the majority of policies are eligible for contingent benefits upon lapse” in Section 20G and Section 20H(1)(c) should be interpreted to mean only those who must be offered CBL based on the Model Regulation. Otherwise, companies would not be encouraged to expand the number of policies to be offered CBL in the event of a rate increase.

The phrase “adjust rates to reflect how reserves have been incorporated in the event CBL is triggered” in Section 20B(3)(b) should be interpreted to mean that CBL has been offered to a policyholder or certificate holder and the offer is accepted (or deemed accepted by the failure to pay further premiums during the 120-day offer period).
10. **Can a regulator request more annual values of the lifetime projection than just the five preceding and three projected years?**

The basis of the model relies on professional judgment and certifications. However, in those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. To reduce the time frame, such requests may be part of the filing requirements for that state.

It is recommended that a state performing a detailed review request that the historical experience and projections of future experience provided by the company both include detail for each (calendar) year. This level of detail could illustrate the pattern of emerging experience being assumed. It is also helpful to request the originally anticipated pricing experience by calendar year. It may be insightful to see the difference of actual versus pricing experience.

11. **Can a regulator request projected experience under the assumption that premium rates are not increased?**

In those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. It may be of interest to see the projections with and without the requested rate increase. It is not always intuitively obvious of the result. The rate increase will affect persistency as well as claim experience assumptions.

12. **Is pooling of experience required or permitted?**

As noted previously, morbidity experience will likely be pooled to increase the credibility of the company’s experience. Unless state law requires it, pooling is not required, however, it is encouraged that forms with similar benefits be pooled. When reviewing pooled experience, the reviewer needs to be careful to not jump to conclusions that the rate increase supported by an analysis of the aggregate data is an increase to be applied uniformly over all policy forms. This is generally not the case and in most cases the company will not be asking for a uniform increase. In such situations the reviewer should ask the company to evaluate the benefit differences between forms on a constant morbidity basis. This should show the relativity between the benefits of the different forms. The rates between forms may be increased on a non-uniform basis so as to establish a closer relationship of the premiums to these theoretical relationships and to measure compliance with the required standard that new business rates are not less than premium rates for existing forms, except for benefit differences. Note that some in-force policy forms (not currently for sale) may be excluded from a rate increase and still comply with the model.

13. **How does the regulator compare rates of different forms to determine that the company complies with the required standard that new business rates are not less than the premium rate for existing forms except for benefit differences?**

The comparison must be performed on a consistent basis. This means that it may be inappropriate to simply compare the two rate schedules directly. When the premium rate schedule for a new policy form is less than the premium rate schedule for an existing similar policy form also currently available from the insurer, and it is not clear whether this is a reasonable difference attributable to benefits, the regulator may wish to ask the company actuary to use one set of pricing assumptions to evaluate all forms. This is done for each form as if it were a new issue (the duration of the business is not directly considered at this point). This is not for the intent of determining the rate, but simply to determine the benefit differences between the forms. This analysis will give a benefit comparison between forms—say coverage A is 1.15 of coverage B. This relationship is then used to compare the rate schedule relationships. The model provides that the relationship should account for benefit differences.
Following is an example showing a comparison of product benefits used to determine the rate comparison.

Summary of material benefit differences:

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC benefits</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Waiver of premium</td>
<td>1.10</td>
<td>0.92</td>
<td>Plan B does not have PW</td>
</tr>
<tr>
<td>Restoration</td>
<td>1.10</td>
<td>1.0</td>
<td>Plan A has restoration</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1.10</td>
<td>0.92</td>
<td></td>
</tr>
</tbody>
</table>

Plan A is 19.6% richer (1.10/0.92) than Plan B. When comparing premiums at various ages, Plan A premiums should be 19.6% higher than Plan B premiums.

The actuary needs to use judgment in deciding which benefit factors would be additive and which would be multiplicative. A benefit that affects the entire policy, i.e., restoration, should be multiplicative, but two mutually exclusive coverages, i.e., nursing home or home health care services, may be considered to be additive.
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call May 8, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Mark Birdsall (KS); Bob Potter (NC); John Rink (NE); Frank Horn (NY); David Ball (OR); and Andrew Dvorine (SC). Also participating was: Jim Laverty (PA).

1. Discussed a Long-Term Care Insurance Optional Rate Increase Review Proposal

The Subgroup continued its discussion of a proposal for an expedited rate review process for long-term care insurance rate increase filings from its May 1 conference call. Mr. Birdsall said he has received objections to calling the proposal an “expedited rate review process” and that there may be legal implications concerning required cost-sharing percentages. He said it will now be referred to as an “optional rate review process.” Bill Weller (America’s Health Insurance Plans—AHIP) said AHIP is opposed to any requirement for restating premiums for the purpose of calculating minimum loss ratios. Mr. Birdsall agreed to remove the minimum future loss ratio test from the optional rate review proposal, and to change any references to “expedited rate review” to “optional rate review.”

Ms. Graeber said the Subgroup will continue discussion of the optional rate review proposal during its meeting May 15 via conference call, and will attempt to amend the proposal in preparation to expose it for comment.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.

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Long-Term Care Pricing (B) Subgroup
Conference Call
May 1, 2014

The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call May 1, 2014. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Eric Johnson (FL); Mark Birdsall (KS); Julia Philips (MN); Bob Potter (NC); John Rink (NE); Felix Schirripa (NJ); Leslie Jones and Andrew Dvorine (SC); and Tomasz Serbinowski (UT). Also participating were: Steve Ostlund (AL); and Jim Laverty (PA).

1. Discussed a Long-Term Care Insurance Expedited Rate Increase Review Proposal

Mr. Birdsall gave an overview of an updated version (Attachment Eight-G1) of a proposal for expedited review of long-term care insurance rate increase filings that was initially presented on the Subgroup’s Jan. 9 conference call. He said he is proposing that the expedited rate review become an option that is available to regulators within the NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation (LTC Manual). He introduced a cost-sharing exhibit (Attachment Eight-G2) to illustrate the concept of the proposal’s requirement that the rate increase be shared between the insurer and the policyholder. He presented proposed modifications to the LTC Manual (Attachment Eight-G3, Attachment Eight-G4) to implement the expedited review proposal.

Mr. Ostlund asked what aspects of the proposal differ from current regulations. Mr. Birdsall said his proposal addresses issues with rate increases for existing policies, and that recent changes to the Long-Term Care Insurance Model Regulation (#641) apply only to policies issued after the effective date of the changes. He said his proposal addresses the issue of cost-sharing of the rate increase between the insurer and the policyholder, and that this issue is not resolved in the long-term care insurance Model Bulletin concerning announcement of alternative filing requirements for long-term care premium rate increases (Model Bulletin). He said his proposal provides a uniform, simple and objective way using information readily-available to insurers for regulators to determine what level of cost-sharing is required. He said the cost-sharing exhibit also demonstrates to policyholders and regulators that the insurer is assuming responsibility for its role in mispricing of the initial rates and is not shifting the entirety of the results of the mispricing to policyholders.

Mr. Ostlund said that he is concerned that the cost-sharing exhibit allows the use of the initially-priced loss ratio as a minimum loss ratio, which may be less than the 75% or 80% that is required by the Model Bulletin for rate increases on pre-rate-stability policies. Mr. Rink said he thinks having loss ratio requirements for the cost-sharing exhibit that differ from those in the Model Bulletin will be confusing, and he advises against it. Mr. Birdsall said these are valid concerns and should be discussed further at a later time. Mr. Rink said he thinks there should be consistency between the Model Bulletin and Mr. Birdsall’s proposal, and that the proposal should not be finalized until the details of the Model Bulletin’s actuarial certification process have been determined and implemented. Mr. Birdsall said he does not agree with waiting for completion of work on the actuarial certification process.

Mr. Birdsall said he would like to refine his proposal based on input from the Subgroup, and then expose it for comment by regulators and interested parties.

Mr. Schirripa said he does not think that cost-sharing is an actuarial issue, and should not be addressed by the Subgroup. Mr. Johnson agreed and said he does not think it is appropriate to discuss changes to the LTC Manual until the Subgroup is closer to agreement on the concepts that should be added to it.

Ms. Graeber said Mr. Birdsall should proceed with refinements to his proposal and present the completed proposal to the Subgroup for evaluation. She said the Subgroup will continue to discuss the proposal on its May 8 conference call.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.

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Long-Term Care Rate Reviews- Option for Expedited Review

Kansas Insurance Department

Basic Principles

- The cost of mispricing LTC premiums will be shared between the company and the policyholder-see cost-sharing exhibit
- Use true best estimate assumptions with (pricing) margins
- Certification from filing actuary
- Best estimates used for future experience tracking
- Sensitivity testing demonstrates that proposed premiums can absorb moderately adverse deviations in experience

Basic Principles (cont’d)

- Appropriate LTC reserves have been established
- Premium deficiency reserves, claim reserves, asset adequacy analysis
- Conservative premium increase assumption
- Certification from Appointed Actuary
- Consistency of best estimate assumptions with (reserve) margins between setting reserves and rate filing

Basic Principles (cont’d)

- Use statutory maximum valuation interest rate in calculations of accumulated values and present values
- Company provides equivalent rate mitigation options, including contingent benefit upon lapse
- Special consideration may be given to policyholders of advanced attained ages
- Policyholder notification letter addresses key issues-rate increase, rate mitigation options, contingent benefit offer, guaranteed renewable nature of contract
Basic Principles (cont’d)
- Kansas Department policy approves a single rate increase, not a series (unless very clear disclosure and re-justify every year)
- No future rate filings for five years minimum
- No future rate filings unless experience deteriorates at least 15% of tracking experience from prior filing
- No approved rate may exceed the premium for new business charged for similar benefits (only applies if writing new business)

Basic Principles (cont’d)
- Cost exhibit slide updates
  - Use nationwide claims and recalculated nationwide premiums based on premium increases in state of rate filing
  - Use 85% minimum prospective loss ratio
  - To address a closed block that is a small percentage of the total block, cap the rate increase based on a sliding scale
  - Target loss ratio equals greater of original pricing target and 60%
  - Policy level caps may be applied at the Commissioner’s discretion.

Basic Principles (cont’d)
- Commissioners would agree in principle that the indicated premium increase would be approved if the company share is greater than 75% in the cost-sharing exhibit.
- Commissioners would retain the discretion to approve a different increase if there are exceptional or unforeseen circumstances related to the rate filing, such as solvency issues or “exceptional rate increases”.

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<table>
<thead>
<tr>
<th>Test Type</th>
<th>Calculation</th>
<th>Result</th>
</tr>
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<tbody>
<tr>
<td>Minimum future loss ratio (LR)</td>
<td>85.0%</td>
<td>Future loss ratio based on the minimum future LR</td>
</tr>
<tr>
<td>Future loss ratio based on limited increase</td>
<td></td>
<td>Future loss ratio based on limited increase</td>
</tr>
<tr>
<td>lifetime loss ratio based on limited increase</td>
<td></td>
<td>lifetime loss ratio based on the Adjusted Rate Increase</td>
</tr>
<tr>
<td>Minimum company share of additional premiums needed to reach target LR</td>
<td></td>
<td>ised Premiums after applying % Split Guardrail</td>
</tr>
<tr>
<td>PV of future experience based on the Adjusted Rate Increase</td>
<td></td>
<td>Trigger future loss ratio for a rate filing after 5 years</td>
</tr>
<tr>
<td>Future loss ratio based on the Adjusted Rate Increase (base for rate filing eligibility after 5 years)</td>
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<td>#DIV/0!</td>
</tr>
<tr>
<td>Lifetime experience based on the Adjusted Rate Increase</td>
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</tr>
<tr>
<td>Lifetime loss ratio based on the Adjusted Rate Increase</td>
<td></td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>

Three tests (guardrails):
1. Minimum future LR (FLR)
   
   PV of future experience limited by minimum future LR
   
   Future loss ratio based on the minimum future LR
   
   Lifetime experience based on limited increase
   
   Lifetime loss ratio based on the minimum increase

2. Rate increase cap based on small remaining business (sliding scale)
   
   PV of future experience limited by remaining business
   
   Future loss ratio based on the limited increase
   
   Lifetime experience based on limited increase
   
   Lifetime loss ratio based on the limited increase

3. Minimum company share of additional premiums needed to reach target LR
   
   Original Target LR
   
   Target Loss Ratio
   
   PV of future additional premiums needed to achieve target LR
   
   Policyholders share of the additional premiums needed (after first two tests)
   
   Company's share of the additional premiums needed (after first two tests)

   Adjusted Rate Increase
Appendix 4A-Cost-Sharing Exhibit

This Appendix depicts a spreadsheet intended for use with an expedited rate review as referenced in this Guidance Manual. For reference in the formulas, the upper left hand corner of the spreadsheet is cell A1, the first shaded cell under “Original Premiums” is cell B2, etc. The shaded cells are the only cells for which the filing company needs to input data. Accumulated values and present values should be calculated using the maximum statutory valuation interest rate pertaining to each year of issue. For credibility reasons, national premiums and claims should be used, but the two shaded cells under “Premiums Adjusted for State Increases” should represent premiums recalculated to represent the premium levels approved for use in the state of this filing.

If this filing proposes that different rate increases apply to different policyholder groups included in this filing, this cost-sharing exhibit should be filled out in aggregate for the entire filing. Separately, the Department may address the issue of whether it is appropriate to apply different rate increases to different portions of the business under consideration.

Additional policy level caps may be applied at the Commissioner’s discretion.

Companies electing this expedited rate review agree that no future rate increase filings will be submitted with respect to the subject block of LTC business for at least 5 years from the submission date of the prior filing and not unless experience deteriorates by more than 15% from the tracking experience. This 15% deviation would be measured against the “Future loss ratio based on the Adjusted Rate Increase” shown above. The company would recalculate the future loss ratio as of the prior filing date using actual premium and claims experience for the period up to the new filing date, with a projection of future premiums and claims using best estimate assumptions as of the new filing date. This recalculated future loss ratio would then be compared to the “Future loss ratio based on the Adjusted Rate Increase” from the prior filing. If the recalculated ratio is 15% or more higher (multiplicatively), then the company would be eligible to file for a rate increase.

### Rows 15-19: Three Tests (Guardrails)

1. **Minimum Future Loss Ratio**
   - Formula: \( \min (\text{PV of future experience limited by minimum future LR}) \)
   - Description: Future loss ratio based on the minimum future LR

2. **Rate Increase Cap Based on Small Remaining Business (Sliding Scale)**
   - Formula: \( \min (\text{PV of future experience limited by remaining business}) \)
   - Description: Future loss ratio based on the limited increase

3. **Minimum Company Share of Additional Premiums Needed to Reach Target LR**
   - Formula: \( \text{PV of future additional premiums needed} \)
   - Description: Future loss ratio based on the limited increase

### Rows 20-26: Premiums

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<thead>
<tr>
<th>Long-Term Care Cost-Sharing Exhibit</th>
<th>Original Premiums</th>
<th>Premiums Adjusted for State Increases</th>
<th>Claims</th>
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<tr>
<td>All of past experience</td>
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<tr>
<td>Past loss ratio</td>
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<td></td>
<td></td>
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<td>Future loss ratio (no increase)</td>
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</tr>
<tr>
<td>Lifetime experience (no increase)</td>
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<tr>
<td>AV of past experience</td>
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</tr>
<tr>
<td>Past loss ratio</td>
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<td></td>
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<tr>
<td>Future loss ratio (no increase)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime experience (no increase)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Requested Rate Increase</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Instructions

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Section VI. RATE INCREASE FILING

The prior chapters of this manual have related to the initial filing of premium rates and disclosures to applicants for long-term care insurance policy forms under the new LTCI Model Regulation. It is anticipated that the new rules for developing premium rate schedules will allow insurers to include greater margins and reduce the potential need for rate increases. However, the Model Regulation does provide for the filing, review and approval of premium rate increases, as well as the monitoring of ongoing experience in the event of a rate increase for policy contracts issued subject to the new Model Regulation.

This chapter covers the information to be filed and the basis for the regulator’s review of premium rate increase submissions under the new Model Regulation, including a section on the expedited rate review option that companies may elect to use. Later chapters provide information relating to monitoring, additional regulatory oversight and potential regulatory actions for significant rate increases.

A. MATERIALS THAT ACCOMPANY A RATE INCREASE FILING

The information to accompany a filing for a rate increase is defined in Section 20 of the Model Regulation. The information includes:

- **New Premium Rate Schedule**

- **New Disclosure of Rate Increase History** document that reflects the filed increase. The insurer should also provide a list of all similar policy forms that are available for sale in which applicants will be informed of this rate increase.

- **New Actuarial Certification**

- **Actuarial Memorandum** justifying the new rate schedule which includes:
  - Lifetime projection of earned premiums and incurred claims that illustrate the rate schedule’s compliance with the loss ratio standards;
  - Disclosure of how reserves have been accounted for if the rate increase triggers contingent benefit upon lapse;
  - Disclosure of why the rate increase is necessary, including which pricing assumptions were not realized and why; and
  - Statement that the policy design, underwriting, and claims adjudication practices have been taken into consideration.

- **Rate Comparison Statement** that “renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner…”

---

1 There are different rules for “exceptional increases.” These are explained in a separate section at the end of this chapter.
1. **New Premium Rate Schedule**

   The complete new rate schedule should be filed, including rates for all variations in elimination periods and benefit periods. The percentage increase for each issue age should be provided from both the existing rate (to review the changes to disclosure documents) and the original rate. These percentages should be compared to the levels that trigger Contingent Benefit upon Lapse (CBL). See below for additional issues if CBL is triggered.

2. **New Disclosure of Rate Increase History**

   Section 9 of the Model Regulation outlines the disclosure documents that each insurer must provide to all applicants. One part of this is a history of any rate increase on similar policy forms that has occurred within the 10-year period prior to the application date. This disclosure will need to be updated to reflect the actual rate increase that results from the filing. The Commissioner should establish the time frame within which the insurer must change its disclosure documents after the approval of any rate.

3. **Actuarial Certification**

   The Actuarial Certification should be reviewed for the specific language used by the actuary. It is possible that the actuary will not be the same person as the one who signed the original certification. A change in the actuary of record should be explained. A sample Actuarial Certification for a rate increase is in Appendix 2.

4. **Actuarial Memorandum**

   The review of the actuarial memorandum relating to a rate increase will be more extensive since it contains additional information, actual experience, a loss ratio demonstration and an explanation of the original assumptions that were not realized in support of the requested rate increase.

   The actuarial memorandum should be reviewed for completeness. The method and assumptions used in determining projected values should be reviewed in light of reported experience. The assumptions used for the loss ratio demonstration should be consistent with prior actuarial experience, adjusted for known changes in such items as underwriting or claims adjudication that have been made or are anticipated by the insurer. The assumptions for future claims used in the loss ratio demonstration should include the actuary’s margins for moderately adverse claims and persistency experience.

   The morbidity assumption and reported morbidity experience may not be credible for any LTCI policy form by itself. Combining experience of different forms with similar benefits may result in more credible historical claims as the basis for future claim costs.

   Any assumptions that deviate from those used for pricing other forms currently available for sale should be disclosed and justified.

   The lifetime projection of earned premiums and incurred claims (including margin for future adverse experience) shall illustrate that the lifetime loss ratio requirement will be satisfied with the filed rate schedule increase. This lifetime projection must include annual values for at least the five years preceding and three years following the increase. A simplified loss ratio demonstration (not including any detail or justification of assumptions) is in Appendix 4. Please note that this is not the only method or format for providing the required projection and values. The handling of projected lapses that qualify for CBL is described later.
The memorandum should clearly show that it uses the interest rate(s) required to be used by Section 20C(4) of the Model Regulation to demonstrate that the new premium rate scale meets the loss ratio requirements. Any net excess of the expected earnings over the valuation rate would be considered as a part of the provision for moderately adverse experience in the new rates.

The persistency assumption for the future (for both claim costs and premiums) should take into account:

(a) The amount of the proposed rate increase;

(b) The impact of reserves transferred to fund any CBL benefits (triggered proportions of the total in force business subject to rate increases should be shown as well as the percentage for each triggered age or age group that are expected to accept the CBL offer);

(c) Historical renewal lapse rates; and

(d) The actuary’s margin for adverse persistency experience.

The memorandum should describe the analysis done by the actuary comparing prior assumptions with experience. This analysis should cover all important assumptions showing the positive as well as adverse deviations from the expected. The amount of the original pricing margin that is lost when the new assumptions are used should be estimated. Any actions the insurer has taken or is planning to take to offset even greater rate increases should be noted to the extent the actions were relied on by the actuary in developing the new rates.

The memorandum should contain a statement that the policy design (benefits and benefit triggers, etc.), underwriting (to the extent it is still anticipated to affect claim costs) and claims adjudication practices have been taken into consideration by the actuary in the development of assumptions and projections.

For certain group business or particular policy forms it may be necessary to have the same rate for both new issues and in force business. In these cases the actuary’s projections will need to apply the loss ratios to the business subject to a rate increase to show the rate as if there were no new business. A separate rate for new business would be developed consistent with the anticipated loss ratio at issue of the original policy form and the revised assumptions. These two rates would then be combined into a single rate. Actual new business results should then be reviewed as part of the review of projected results for the three-year period following the rate increase.

5. Rate Comparison Statement

Section 20B(4) of the Model Regulation requires that a rate increase filing provide the following:

A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner…

It should be noted that the new business premium rates are not subject to the minimum loss ratio requirements that are applicable to rate increases.

In most situations the insurer will be able to provide a statement that rates after the rate increase are not greater than the new business rates. In some cases, the differences in benefits will be large enough that this comparison cannot be verified by simply comparing the rates. The insurer should provide information justifying significant variations.
In some circumstances the policy forms subject to the rate increase will end up with rates higher than new business rates of another policy form for the same issue age. This will generally result when the future premiums for older policy forms are a much smaller proportion of total premiums while new or newer policy forms will collect more premiums that include the rate increase. The insurer should be able to justify this result to the regulator by including a comparison of the resulting renewal rate with new business rates at the higher (current) age for sample insureds. Although this circumstance demonstrates one reason why the rate increase rates would be higher than new business rates, it may not be a sufficient reason to allow the deviation from the standard. A closed, reducing block of business that has been in force for many years is likely to have this circumstance, which may be the result of initial under-pricing and insurer inaction.

Where the rate increase is applicable to a policy form that is currently being offered, the renewal rates will be limited by the loss ratio standards. The insurer may wish to use higher rates for new sales (which are not subject to loss ratio minimums). Assuming that new sales of the policy form (at rates higher than the renewal rates) are allowed after the rate increase, the insurer will need to eliminate the experience of these new issues for purposes of comparing actual to projected experience following the rate increase. It should be noted that the experience for these new issues should be included when determining future rate increases.

B. ADDITIONAL ASPECTS IF CONTINGENT BENEFIT UPON LAPSE IS TRIGGERED

As noted earlier, the new rates are to be compared to the original rates and the ratio compared to the table for triggering CBL provisions under Section 28 of the Model Regulation. For any issue age where the percentage equals or exceeds the table value, the insurer also will need to provide those policyholders with an explanation of their options and the date the CBL option expires.

Due to the increased popularity of limited pay long-term care insurance, in 2005 the NAIC expanded the contingent benefit upon lapse provision to address an identified need to improve the value of contingent benefits for limited pay policies. An additional test of a substantial premium increase and separate reduced paid-up benefit calculations were added for these policies in Section 28 of the Model Regulation. These new provisions become effective six months after their adoption. The insurer will need to provide policyholders with an explanation of their options and the date the CBL option expires should this test be triggered.

There are several aspects to be considered:

1. Approval of the process for informing policyholders of their CBL option;
2. Determination of the proportion of policyholders receiving a rate increase for which the CBL is triggered; and
3. Adjustments made in the actuarial memorandum for CBL and the monitoring of actual versus expected use of CBL following the rate increase.

Sections 28D(5) and D(6) of the Model Regulation provide specifics for the notification of policyholders of their rights at the time of a rate increase. Since it is possible that some but not all policyholders subject to a rate increase will trigger the CBL, the regulator should review the different materials to be provided in each situation.

Sections 20G and H of the model become effective if the CBL is triggered for the majority of the policyholders (anything over 50%) subject to the rate increase. The regulator should determine the percentage of policyholders for which the CBL is triggered. The determination of this percentage shall include limited pay policies that trigger the additional substantial premium increase test following the effective date of this provision.
Section 20B(3)(b) provides an exception to the normal rule that active life reserves are not to be reflected in the demonstration that the lifetime loss ratio projection is satisfied. The expected number of changes from premium paying insured (full benefit) to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected value of all future payments for those under CBL, including comparable margins for adverse, should be recognized as immediate benefits in the rate increase calculation subject to a maximum of the total active life reserve held for these insureds. A separate reserve for CBL insureds in this amount should be established and the insurer should adjust the active life reserve for premium-paying policies to reflect this transfer. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. The reserve established for any additional CBL insureds should be reflected as additional benefits in the updated projections. If the number of CBL insureds is lower, the excess reserve for CBL benefits established at the time of the rate increase should reduce total benefits in the updated projections. The actual claims experience of CBL insureds after the transfer is not to be combined with the experience to be monitored.

C. EXCEPTIONAL RATE INCREASES

Section 4A of the Model Regulation defines exceptional increases. Most rate increases will not be exceptional. If an insurer files a rate increase as an exceptional increase, it should provide justification for one of the two possible bases upon which the insurer may rely.

The regulator should review the justification provided before reviewing the remainder of the rate increase request, since the limitations are different. Approval of the basis for the review should be based on a finding that either:

1. The insurer has reflected a change in federal or the state's laws or regulations applicable to LTCI; or
2. The insurer has documented a rationale for increased and unexpected utilization (higher number of claims or longer periods for insureds in claim status) that affects the majority of insureds with similar products.

There are additional issues the regulator may wish to consider as part of this review.

D Would it be beneficial to request a review by an independent actuary or to coordinate with other states? This could be especially important in making a determination under 2 above.

D Are there offsets to increases that result from the new laws, regulations or even the basis for higher utilization? If so, the insurer should reflect any potential offset.

Insurers are required to file much of the same information for an exceptional increase (new premium rate schedule, new rate history disclosure) as for a non-exceptional increase, with a few slight modifications. There is a difference in the actuarial filing. The certification would be slightly different in wording. (See Appendix 3 for a sample.) The actuarial memorandum would be shorter. There is no requirement to justify differences from initial assumptions or to provide lifetime projections. Instead, the actuary should demonstrate that future claim costs (resulting from the causes the insurer has used to justify the need for an exceptional increase and from any relevant expected changes in insurer experience) are 70% of the future projected additional premium. Experience to date and the future projections of premiums from the original rate (with the expenses and claims to be covered) are not to be included in the demonstration. However, the regulator may request such experience and other information to evaluate the appropriateness of the insurer’s estimate of potential offsets to higher claim costs.
D. EXPEDITED RATE REVIEW OPTION

Given the nature and history of the long-term care business, including long periods before claims became significant, changing provider and medical practices, as well as changes in family structure and social mores, it has been difficult for insurance companies to anticipate all of the trends that affect the claims incidence and severity of these products. For the continued financial health of insurance companies and to help policyholders have greater certainty regarding the future costs and benefits associated with their policies, an expedited review process has been developed that will provide a more objective basis for reviewing rate increase proposals and help develop greater consistency among the states in reviewing rate filings. It should be emphasized that this expedited rate review process is an option that the company may elect. Rather than choosing this option, a company may determine to submit a rate filing in connection with the other requirements provided in the Model Regulation. For any rate filing, the company will designate in the cover letter whether or not it is electing an expedited rate review.

An expedited rate review will be based on the following principles:

1. The cost of experience deviations from expected will be shared between the insurance company and the policyholder. See Appendix 4A, “Sample Cost-Sharing Exhibit for an Expedited Rate Increase Filing.” This cost-sharing exhibit provides for a minimum future loss ratio, as well as a basis for limiting some rate increases to remaining policyholders due to the leveraging effect of a level premium product design and increasing claims. The exhibit also provides a measure of the cost-sharing between policyholders and the company of actual experience deviating adversely from expected experience and establishes a minimum company share of this cost.

2. These best estimate assumptions will be used for tracking future experience. A qualified actuary will certify that the assumptions are his or her best estimates, including consideration of company experience, industry experience, trends, and any other factors that may have a material effect on the best estimate assumptions.

3. Sensitivity testing will be performed demonstrating that the proposed premiums can absorb moderately adverse deviations in experience as determined by the company.

4. The company will set up long-term care reserves, including premium deficiency reserves as required, that are based on best estimate assumptions that are consistent with the rate increase filing, adjusted for reserve margins and considering timing differences between the calculation of the reserves and the submission of the rate filing. The Appointed Actuary will certify to the consistency of the best estimate assumptions.

5. The statutory maximum valuation interest rate will be used in the calculations of accumulated values and present values.

6. Any benefit reduction options offered by the company to mitigate premium increases will represent similar values to the policyholder measured at a policy form level, including an appropriate relationship between the premium offset and the benefits reduced.

7. A policyholder notification letter will be filed for approval with the state insurance department and will contain key information such as the amount of the rate increase, rate mitigation options, contingent benefit offer, and the guaranteed renewable nature of the contract. If an approved rate increase is being implemented over multiple years, the policyholder notification letter and other communications must be clear so the policyholders will know what to expect in the future.

8. To provide an adequate period for future experience to indicate a significant deviation from the tracking experience, the company agrees that no future rate increase filings will be submitted with respect to the subject block of business for at least five years from the date of submission of the rate filing and not unless experience deteriorates at least 15% from the tracking experience related to the prior rate increase filing. For more calculation details, see the instructions in Appendix 4A.

9. If the company is writing new long-term care business, no approved rate may exceed the premium level for new business providing similar benefits.

Due to the expectation of far fewer future rate filings with respect to the subject block of business, an expedited rate review filing should be handled on a priority basis by the Insurance Department.

Based on the cost-sharing exhibit, if the company share equals or exceeds 75%, the rate increase in the cost-sharing exhibit would be approved, though the Commissioner retains the discretion to approve a different increase if there are unusual circumstances connected with the filing, such as solvency issues related to the insurance company or provision for exceptional rate increases as defined in the Model Regulation. Additional policy level caps may be applied at the Commissioner’s discretion.

Other filing requirements of the Model Regulation will apply to an optional expedited rate filing.
D.E. QUESTIONS AND ANSWERS

1. What would be a common list of information a regulator might expect to see in an actuarial memorandum for a rate increase?

A state may wish to require that an actuarial memorandum include some or all of the items listed in Appendix 5. Selected items from that list are discussed below.

(a) Morbidity
The overall pattern of claim costs for LTCI is well known – claim costs increase with increasing age – but there is no industry standard morbidity table.

(b) Lapse
If the LTCI policy does not contain a nonforfeiture provision, the pricing will reflect a “lapse-supported” pricing methodology. The more insureds that leave the block (either by death or voluntary termination), the lower future costs will be. This means that the assumptions that the insurer makes about future expected lapses (voluntary) and deaths are critical to the pricing of LTCI. The lower the expected lapses and deaths, the more conservative the pricing.

Most current filings have ultimate (after the first 5 years or so) lapse rates of 4% or less. This means that fewer than 4% of the insureds that remain will drop their policy. If this assumption is higher than 3–4%, then the insurer should be questioned about the source of its assumption. Remember that the higher this number, the lower the premium and therefore, the less conservative it is.

(c) Mortality
The mortality assumption (death rates) is critical for the same reason that the voluntary lapse rate is critical. If more insureds are assumed to die than actually do, then the premiums could be inadequate. The NAIC Health Insurance Reserves Model Regulation requires the use of an annuity mortality table. The use of a life mortality table would be less conservative.

(d) Interest
Section 20C(4) requires that the interest rates used for discount purposes in determining rate increases be the maximum valuation interest rate for contract reserves as specified in the states’ equivalent to the NAIC Health Reserves Model Regulation. Since this rate may vary from year to year, Section 20 allows the use of an average interest rate if the manner in which it has been determined is disclosed. The regulator should review the filing to determine compliance with the moderately adverse standard based on all assumptions, including the interest assumptions, which may be different from those used for testing loss ratio compliance.

(e) Reserves – Policy and Claim
The reserves, both policy and claim, should be reviewed by the regulatory actuary for reasonableness and adequacy.

2. How are active life reserves utilized under the revised model?

Normally, active life reserves are not included in the rate increase analysis. Section 20B(3)(b) provides an exception to this rule by allowing a transfer of the active life reserves to be reflected as a claim for those insureds transferred from the active life pool to the CBL paid-up pool. The expected number of changes from premium paying (full benefit) insured to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected benefits for those under CBL should be recognized at the time of the rate increase, and the insurer should adjust the active life reserve for these potential benefits. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. Any difference
between the reserve needed for continuing full coverage and the reserve for CBL coverage for the additional (or lower) number of CBL insureds should be reflected in the updated projections.

3. **What differences in the rate increase filing should be expected when an insurer sells both continuous-pay and limited-pay products?**

   The regulator should review the experience to determine whether limited-pay premium experience has been combined with the experience for continuous-pay policies. In general, limited-pay policies may not have credible experience on their own. Rate increases can only be charged to those insureds paying current and future premiums. This means that projected future costs that incorporate higher claim cost assumptions will need to be separated into those for paid-up policies and those for premium paying policies. If these increased costs are combined, the continuous-pay plans would be subsidizing paid-up insureds, and may be considered “unfair discrimination.”

4. **What other differences should the regulator review between continuous-pay and limited-pay products?**

   Limited-pay products have two CBL options. The first (or normal) option is the same as for continuous-pay products and is required if the policy is issued without nonforfeiture benefits. The second (or added) option is a reduced paid-up benefit that applies only to limited-pay products and is required even if the policy includes a SBP nonforfeiture benefit.

   The added CBL option recognizes the gradual change from premium paying to paid-up status of these products. It is triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

   Actual benefits from this CBL option are a reduced paid-up policy where the periodic payment is reduced (versus the normal CBL, which reduces the maximum paid when a claim occurs). The reduced amount is determined by 90% of the ratio of (a) to (b) where:

   \[
   \begin{align*}
   (a) & = \text{the number of months of premiums paid to the date of lapse}, \\
   (b) & = \text{the number of months in the original premium-paying period}.
   \end{align*}
   \]

   The added CBL option can only be exercised if the ratio of (a) to (b) is 40% or more and the lapse date is within 120 days of the first due premium following the date of the rate increase.

5. **Is it possible for both CBL options to be triggered by the same rate increase for a limited-pay policy?**

   Yes. The policyholder will then have the choice of the “normal CBL” or the “added CBL” and the Model Regulation provides that, if the policyholder does not make a choice, the added CBL is the automatic option.
6. **What should be considered if an insurer offers unisex rates?**

Rate increases should continue to be based on unisex rates. Claim and active life reserves may have been established using unisex morbidity and mortality but adjustments may be needed to reflect the actual mix of claims and in force policies.

7. **In Section 4A(4) of the Model Regulation, the definition for exceptional increase references “potential offsets.” What are some examples of “potential offsets”?**

Consider the example of a state passing a new requirement that all LTCI policies cover home health services, even if policies previously provided only institutional care.

   (a) If a policy has a maximum benefit period expressed in years, not dollars, to which all benefits (non-institutional and institutional) are subject, a potential offset would occur because benefits paid under lower cost non-institutional benefits (e.g., home health care) would reduce the amount of time remaining for higher cost institutional benefits.

   (b) If an insurer retains the same benefit triggers (e.g., Activities of Daily Living) for home health as for institutional care, costs attributable to increased utilization for home health care (which could be anticipated to be higher than utilization for institutional care) could be offset somewhat by the fact that per visit home health care charges are lower than institutional charges.

8. **What happens if the regulator believes that the requested rate increase is too high?**

The regulator should review the assumptions in the actuarial memorandum for reasonableness. For example, the insurer could be projecting lapse rates or mortality rates that are significantly lower than what was used in the original pricing assumptions. The regulator should examine which assumptions are reasonable, the original assumptions or the assumptions in the rate increase filing. The filing may be subject to the state’s filing review and approval process. The regulation does not guarantee that the requested increase will be approved. Other state statutory requirements may apply.

The regulator should discuss his or her concerns with the actuary. That discussion may resolve your concerns. If not, you may want to talk to another state actuary who has experience with LTCI.

If you are unable to satisfy your concerns through these approaches, you may contact the Actuarial Board for Counseling and Discipline for its counsel on your concerns.

9. **If an insurer wishes to offer the CBL to policyholders when the actual rate increase would not trigger the requirements to offer CBL, is this okay?**

So long as the method for determining those policyholders to be offered CBL is not discriminatory and includes all those policyholders who must be offered CBL (based on the resulting rate exceeding the initial rate by the percentage specified in the Model Regulation), the company is allowed to make the offer.

Therefore, the phrase “the majority of policies are eligible for contingent benefits upon lapse” in Section 20G and Section 20H(1)(c) should be interpreted to mean only those who must be offered CBL based on the Model Regulation. Otherwise, companies would not be encouraged to expand the number of policies to be offered CBL in the event of a rate increase.

The phrase “adjust rates to reflect how reserves have been incorporated in the event CBL is triggered” in Section 20H(3)(b) should be interpreted to mean that CBL has been offered to a policyholder or certificate holder and the offer is accepted (or deemed accepted by the failure to pay further premiums during the 120-day offer period).
10. **Can a regulator request more annual values of the lifetime projection than just the five preceding and three projected years?**

    The basis of the model relies on professional judgment and certifications. However, in those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. To reduce the time frame, such requests may be part of the filing requirements for that state.

    It is recommended that a state performing a detailed review request that the historical experience and projections of future experience provided by the company both include detail for each (calendar) year. This level of detail could illustrate the pattern of emerging experience being assumed. It is also helpful to request the originally anticipated pricing experience by calendar year. It may be insightful to see the difference of actual versus pricing experience.

11. **Can a regulator request projected experience under the assumption that premium rates are not increased?**

    In those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. It may be of interest to see the projections with and without the requested rate increase. It is not always intuitively obvious of the result. The rate increase will affect persistency as well as claim experience assumptions.

12. **Is pooling of experience required or permitted?**

    As noted previously, morbidity experience will likely be pooled to increase the credibility of the company’s experience. Unless state law requires it, pooling is not required; however, it is encouraged that forms with similar benefits be pooled. When reviewing pooled experience, the reviewer needs to be careful to not jump to conclusions that the rate increase supported by an analysis of the aggregate data is an increase to be applied uniformly over all policy forms. This is generally not the case and in most cases the company will not be asking for a uniform increase. In such situations the reviewer should ask the company to evaluate the benefit differences between forms on a constant morbidity basis. This should show the relativity between the benefits of the different forms. The rates between forms may be increased on a non-uniform basis so as to establish a closer relationship of the premiums to these theoretical relationships and to measure compliance with the required standard that new business rates are not less than premium rates for existing forms, except for benefit differences. Note that some in-force policy forms (not currently for sale) may be excluded from a rate increase and still comply with the model.

13. **How does the regulator compare rates of different forms to determine that the company complies with the required standard that new business rates are not less than the premium rate for existing forms except for benefit differences?**

    The comparison must be performed on a consistent basis. This means that it may be inappropriate to simply compare the two rate schedules directly. When the premium rate schedule for a new policy form is less than the premium rate schedule for an existing similar policy form also currently available from the insurer, and it is not clear whether this is a reasonable difference attributable to benefits, the regulator may wish to ask the company actuary to use one set of pricing assumptions to evaluate all forms. This is done for each form as if it were a new issue (the duration of the business is not directly considered at this point). This is not for the intent of determining the rate, but simply to determine the benefit differences between the forms. This analysis will give a benefit comparison between forms—say coverage A is 1.15 of coverage B. This relationship is then used to compare the rate schedule relationships. The model provides that the relationship should account for benefit differences.
Following is an example showing a comparison of product benefits used to determine the rate comparison.

Summary of material benefit differences:

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC benefits</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Waiver of premium</td>
<td>1.0</td>
<td>.92</td>
<td>Plan B does not have PW</td>
</tr>
<tr>
<td>Restoration</td>
<td>1.10</td>
<td>1.0</td>
<td>Plan A has restoration</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1.10</td>
<td>.92</td>
<td></td>
</tr>
</tbody>
</table>

Plan A is 19.6% richer (1.10/.92) than Plan B. When comparing premiums at various ages, Plan A premiums should be 19.6% higher than Plan B premiums.

The actuary needs to use judgment in deciding which benefit factors would be additive and which would be multiplicative. A benefit that affects the entire policy, i.e., restoration, should be multiplicative, but two mutually exclusive coverages, i.e., nursing home or home health care services, may be considered to be additive.
The Long-Term Care Valuation (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call May 22, 2014. The following Subgroup members participated: Perry Kupferman, Chair (CA); Mark Birdsall (KS); Matt Elston (OH); and Aaron Hodges (TX).

1. Discussed Developing PBR Requirements for Long-Term Care Insurance

The Subgroup discussed how to proceed with developing principle-based reserving (PBR) requirements for long-term care insurance with Al Schmitz (American Academy of Actuaries—AAA) and Paul Morrison (AAA). Mr. Schmitz said the AAA Long-Term Care Principle-Based Work Group developed a prototype demonstration model that analyzes long-term care insurance reserves on a stochastic basis using morbidity and persistency as variables. He said stochastic interest rate inputs to the model will be added in the future. He said the AAA work group is currently testing the model and analyzing results of the tests. Mr. Kupferman asked what the current status of the work group’s efforts is and what next steps are planned.

Mr. Morrison said that over the past two months, the AAA work group has been using the model to produce reserve calculations for a block of 6,000 policies and a block of 23,000 policies. He said results from the two blocks are being compared to each other to determine the effect that block size has on the reserve results. He said 1,000 sample reserve runs using the 6,000 policy block have been conducted for each of a 10% increase in morbidity, a 10% decrease in morbidity, a 10% increase in mortality, and a 10% decrease in mortality. He said the Work Group is currently conducting 1,000 sample reserve runs using the 6,000 policy block for each of a 10% increase and a 10% decrease in claim continuation. He said 220 sample reserve runs using the 23,000 policy block have been conducted for the base scenario only, and that these take considerably longer than the runs using the 6,000 policy block. He said the Work Group will likely test the 23,000 policy block with some of the 10% increase and 10% decrease scenarios to determine if the results are similar to those for the 6,000 policy block. He said that, in the near term, the work group wants to finish reserve runs for the 23,000 policy block, and to conduct reserve runs on the 6,000 policy block using each of a 10% increase and 10% decrease in policy lapses. He said that after all the reserve runs have been completed, the work group will need to analyze the results and determine how they can be used to develop a PBR methodology for long-term care insurance. Mr. Kupferman asked when the work group anticipates being able to complete the analysis. Mr. Schmitz said it is difficult to estimate how long it will take to complete the sample reserve runs and then analyze the results. Mr. Kupferman asked if it would help to have the Society of Actuaries’ (SOA) Long-Term Care Section pay for a consultant to assist with completing the sample reserve runs. Mr. Morrison and Mr. Schmitz said this would be helpful. Cindy MacDonald (SOA) said she will discuss this possibility with SOA personnel.

Mr. Kupferman asked why conditional tail expectation (CTE) was chosen as a measure for life insurance PBR and if it makes sense to use CTE as a measure for long-term care insurance PBR. Mr. Birdsall said CTE was chosen because it is a better measure for life insurance liabilities, which tend to have higher probabilities of outcomes that are much larger than the expected values of the liabilities than other insurance coverages. Mr. Kupferman asked who will perform the work to determine if CTE is the appropriate measure for long-term care insurance PBR, or if another measure, such as standard deviation or percentiles, would be better. Mr. Schmitz said the demonstration model produces all of these measures, but it does not assess the validity of the assumptions that are used in the model, and this might preclude the model from being used to determine the most appropriate measure. He said the model’s limitations will be addressed in the work group’s report. He said the work group has targeted the end of the year for completion of the report.

Mr. Kupferman asked what the work group expects to provide to the Subgroup at the conclusion of its modeling and analysis. Mr. Schmitz said the work group expects to provide a report that describes a way to examine a stochastic approach to long-term care insurance projections for different sized blocks of policies given a certain set of assumptions and parameters, and how various scenarios affect measures such as CTE, percentiles and standard deviations. He said the report will also describe the advantages and disadvantages of using such a model for long-term care insurance projections. He said the report could possibly be used as a starting point for developing a PBR standard for long-term care insurance.

Mr. Birdsall said he is not sure what the work group’s charge from the Subgroup is, and that he thinks it is to develop sections for the NAIC Valuation Manual to create PBR requirements for long-term care insurance. Bob Yee (PricewaterhouseCoopers) said the work group was formed to prepare for the transition to long-term care insurance PBR, but
not to actually develop *Valuation Manual* sections. Mr. Birdsall said he thinks an AAA group needs to be formed with the charge of developing *Valuation Manual* sections for experience reporting (VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats) and for reserve calculation (VM-25, Health Insurance Reserves Minimum Reserve Requirements). Mr. Kupferman said he hopes to accomplish this during the conference call. He said his recollection is that a motion was passed by the Long-Term Care Actuarial (B) Working Group to charge the AAA with developing the *Valuation Manual* sections, and directed NAIC staff to research the specifics of the charge. He asked if the work group can use its report to develop the experience reporting section of the *Valuation Manual*. Mr. Schmitz said a new AAA group likely will need to be formed to accomplish this. Mr. Kupferman asked what should be done to develop the experience reporting data format requirements. Tom Rhodes (MIB) said the starting point should be examining available data from the SOA’s Long-Term Care Intercompany Study and discussion of the data requirements with the AAA and the Health Actuarial (B) Task Force. Mr. Kupferman said there should be separate AAA groups for work on each of experience reporting and reserve calculations.

Having no further business, the Long-Term Care Valuation (B) Subgroup adjourned.
Tables Used

- Actual-to–expected mortality calculated for:
  - 1994 Group Annuity Mortality
  - 2012 Individual Annuity Mortality (IAM) Basic Table (without margin)
  - Both tables are age-near-birthday basis. LTC is sold on age-last-birthday basis.

2012 Individual Annuity Reserving

- Generational mortality table includes:
  - Margin (2012 Individual Annuity Mortality period table)
  - Projection factors scale G2 (mortality improvement factors)
  - Projection factors developed from the Social Security Administration data
  - LTC data too limited to validate projection factors

Data

- LTC intercompany experience data 1984-2007
- Work group specified data that was compiled by the Medical Information Bureau (MIB)
- Data summarized and company de-identified by SOA
- Limited to top 9 companies by exposures and experience years 1993 - 2006 to address data quality
- Work group feels comfortable that the resulting experience is an accurate representation of LTC insured mortality
By Policy Duration

- Underwriting selection is observed in actual deaths
- Both 1994 GAM and 2012 IAM are aggregate tables
- 2012 IAM is a better fit than 1994 GAM

Female by Policy Duration

- Limited benefit period versus lifetime benefit period
- Benefit exhaustion eliminates some deaths in limited benefit period experience
- 2012 IAM is a better fit than 1994 GAM
By Attained Age

- Limited benefit period versus lifetime benefit period
- Policy durations 1 – 5 years excluded to reduce the impact of underwriting selection
- 2012 IAM is a better fit than 1994 GAM

1994 GAM Female by Attained Age

Data compiled by MIB

1994 GAM Male by Attained Age

2012 IAM Female by Attained Age

Data compiled by MIB
2012 IAM Male by Attained Age

- A/E Ratio 2012 IAM Male by Attained Age Excludes Durations 1 - 5

By Issue Age

- Lifetime benefit period only
- Policy durations 1 – 5 years excluded to reduce the impact of underwriting selection
- Compares experience of exposed lives summarized to issue ages relevant to LTC
- 2012 IAM is a better fit than 1994 GAM

Female by Issue Age

Male by Issue Age
### Female Policy Duration/Benefit Period

<table>
<thead>
<tr>
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Data compiled by MIB

### Male Policy Duration/Benefit Period

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<td>82.8%</td>
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Data compiled by MIB
### Female Attained Age/Benefit Period/Excludes Durations 1 - 5

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<tr>
<th>Age</th>
<th>Limited BP 2004 GAM</th>
<th>Limited BP 2012 IAM</th>
<th>Lifetime BP 2004 GAM</th>
<th>Lifetime BP 2012 IAM</th>
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<tr>
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### Male Attained Age/Benefit Period/Excludes Durations 1 - 5

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<th>Age</th>
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<th>Limited BP 2012 IAM</th>
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<th>Lifetime BP 2012 IAM</th>
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### Issue Age/Lifetime Benefit Period/Excludes Durations 1 - 5

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<th>Age</th>
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<th>Female 2012 IAM</th>
<th>Male 2004 IAM</th>
<th>Male 2012 IAM</th>
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</thead>
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<tr>
<td>50-54</td>
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<tr>
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<td>68.5%</td>
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<td>70.6%</td>
<td>102.0%</td>
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### Staff Contact Information

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### Objectives of Work Group

- Based on the initial request from the NAIC, the objective of the work group is to develop a prototype stochastic model to be used to help set the direction of PBR for LTC.
- The work group agreed to produce a report that would include considerations of stochastic modeling and suggested next steps.
- The model is intended to be illustrative and not inclusive of all policy features that may be offered by an insurer or inclusive of detailed modeling considerations.

### History and Work to Date

1. **Stochastic modeling**–key variables: morbidity, lapse, mortality, interest
2. **Modeling approach**–morbidity, mortality, and lapse in Excel prototype using “hazard rate approach”
3. **Modeling considerations**–premium rate changes, interest rate impact, morbidity / mortality changes, margins
4. **Assumptions and data collection**–sample assumptions developed by the work group, two in force files provided by two companies
5. **Stochastic and deterministic results**
Update on Recent Activity

Sensitivity tests to base case
- Run the following sensitivities on the block of 6,000 policies and calculate CTEs for each:
  - ±10% load to morbidity incidence and assessment - Complete
  - ±10% load to morbidity termination rates
  - ±10% load to lapse rates
  - ±10% load to active mortality rates
  - ±10% load to disabled mortality rates

Sensitivity tests to size of block and number of scenarios
- Run the 23,000 block of policies and test impact for running 1,000, 500, 250, 100, or 50 scenarios.

Initial Results

Comparison to Deterministic – Inforce Block of LTC Insurance

Initial Results (cont.)

Distribution characteristics of present value of cash flow at 4 percent
- Mean 87 m
- Maximum 106 m
- Minimum 72 m
- Standard Deviation 5.261 m
- Skewness 0.138209
- Kurtosis 0.168010

Initial Results (cont.)

Sample block of 6,000 LTC insurance policies, CTE calculations
- CTE 0 (GPV) 87m 100.0%
- CTE 10 88m 101.2%
- CTE 20 89m 102.1%
- CTE 30 90m 102.9%
- CTE 40 90m 103.5%
- CTE 50 91m 104.0%
- CTE 60 92m 104.8%
- CTE 70 93m 105.8%
- CTE 80 95m 108.0%
- CTE 90 96m 112.0%
- CTE 95 98m 117.8%
- CTE 99 103m 117.8%

Note: CTE 90, for example, is equal to the average of the worst 10 percent of scenarios, each scenario cash flows discounted at 4 percent.
Initial Results (cont.)

Distribution characteristics of present value of cash flow at 4 percent

<table>
<thead>
<tr>
<th>Distribution</th>
<th>Base Incidence Plus 10% Incidence Minus 10% Minus 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>87,130,339, 99,228,164, 74,036,463, 94,746,011</td>
</tr>
<tr>
<td>Max</td>
<td>106,262,080, 117,344,432, 92,581,823, 110,851,459</td>
</tr>
<tr>
<td>Min</td>
<td>72,487,960, 80,432,369, 59,192,117, 80,400,667</td>
</tr>
<tr>
<td>Skewness</td>
<td>0.138, 0.058, 0.210, 0.089</td>
</tr>
<tr>
<td>Kurtosis</td>
<td>0.168, -0.146, 0.278, -0.050</td>
</tr>
<tr>
<td>Std Dev</td>
<td>5,261,055, 5,638,591, 4,949,694, 5,292,701</td>
</tr>
<tr>
<td>Std Dev / Mean</td>
<td>6.0%, 5.7%, 6.7%, 5.6%</td>
</tr>
</tbody>
</table>

CTE
- CTE 0: 100.0%
- CTE 10: 101.2%
- CTE 20: 102.1%
- CTE 30: 102.9%
- CTE 40: 103.8%
- CTE 50: 104.8%
- CTE 60: 105.8%
- CTE 70: 107.1%
- CTE 80: 108.6%
- CTE 90: 110.8%
- CTE 95: 112.8%
- CTE 99: 117.8%

Developed by members of the work group. For illustrative purposes only.

Report Outline

- Introduction
- Objective of Academy workgroup
- Brief history of workgroup
- Description of model
  - Strengths/weaknesses
  - Documentation including flow chart
- Description of analysis performed
  - Summarize project plan
- Results
- Discussion
  - Result considerations
  - Modeling considerations
  - PBR implications
- Potential next steps

Target Timeline

- Complete sensitivity tests and summarize results
  - End of September
- Run larger block of policies (20,000) through model and analyze results.
  - End of October
- Summarize results in written report
  - Draft end of November
Review of Work Group Objectives

- Establish the applicability of ASOP 25: Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages to LTC insurance
- Establish the importance of incorporating credibility procedures into LTC-related actuarial work
- Develop a framework for advancing actuarial practice in this regard
- Define next steps

Progress Since Last Update

- Worked with various subgroups to further discuss and revise the monograph outline, especially relating to Section III (i.e., current status of industry practice and documentation), Section V (i.e., credibility theory – background/introduction) and former Section VII (i.e., evaluating and selecting the optimal credibility procedure)
- Worked with various subgroups individually and collectively to draft resulting outline of Sections II, IV and V
- Developed and distributed to the work group an updated project timeline on July 2
Updated Outline of the Monograph

I. Executive summary
II. Introduction – need(s) for practice advancement
III. Current status of industry actuarial practice and documentation
IV. Understanding LTC insurance – mis-estimation and volatility risks
V. Credibility theory – background/introduction

VI. Considerations in the selection of credibility procedures for LTC
VII. Impact of credibility procedures used and resulting attributed credibility on the presentation of results
VIII. Next Steps

Revised Target Timeline

- Developed a revised target timeline on July 2
- August 22: Finalize draft of outline for Sections VI, VII and VIII and develop draft of outline for Section I
- Week of August 25-29: conference call
- September 5: Finalize draft of outline Section I and distribute complete draft for review
- Week of September 8-12: conference call
- September 19: Finalize complete draft and submit for Academy peer and policy review

Questions?
Staff Contact Information

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REGULATORY FRAMEWORK (B) TASK FORCE

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Stop Loss Insurance, Self-Funding and the ACA White Paper, Aug. 12, 2014, Draft (Attachment Five-A) ............ 7-215
The Regulatory Framework (B) Task Force met in Louisville, KY, Aug. 16, 2014. The following Task Force members participated: Ted Nickel, Chair, represented by J.P. Wieske (WI); Todd E. Kiser, Vice Chair, represented by Tanji Northrup (UT); Germaine L. Marks (AZ); Dave Jones represented by Tyler McKinney (CA); Marguerite Salazar represented by Peg Brown (CO); Thomas B. Leonard represented by Mary Ellen Breault (CT); Kevin M. McCarty represented by Rich Robleto (FL); William W. Deal represented by Kathy McGill (ID); Andrew Boron represented by Yvonne Clearwater (IL); Sandy Praeger represented by Linda Sheppard (KS); Sharon P. Clark represented by Maggie Woods (KY); Eric A. Cioppa represented by Robert Wake (ME); Mike Rothman represented by Alyssa Von Ruden (MN); Monica J. Lindeen represented by Christina Goe (MT); Bruce R. Ramge represented by Martin Swanson (NE); Scott J. Kipper represented by Glenn Shippey (NV); Mary Taylor represented by Matt Elston (OH); John D. Doak represented by Eli Snowbarger (OK); Laura N. Cali represented by Gayle Woods (OR); Michael F. Consedine represented by Peter Camacci (PA); Julie Mix McPeak represented by Chlora Lindley-Myers (TN); Jacqueline K. Cunningham represented by Althelia Battle (VA); and Michael D. Riley represented by Andrew Pauley (WV).

1. **Adopted its July 10 Minutes**

Ms. Clearwater made a motion, seconded by Ms. Goe, to adopt the Task Force’s July 10 minutes (Attachment One). The motion passed unanimously.

2. **Discussed and Exposed Individual Market Regulation and Small Group Market Regulation Drafts**

Jolie Matthews (NAIC) said revised drafts of the proposed Individual Market Health Insurance Coverage Model Regulation (Individual Market Regulation) (Attachment Two) and the Small Group Market Health Insurance Coverage Model Regulation (Small Group Market Regulation) (Attachment Three) were distributed Aug. 7. She said the revised drafts reflect the comments and discussion from the Task Force’s meeting at the Spring National Meeting. The drafts also include revisions that were necessary due to the promulgation of federal final rules by the federal agencies implementing the federal Affordable Care Act (ACA).

   a. **Individual Market Regulation Draft**

Ms. Matthews reviewed the provisions in the revised Individual Market Regulation draft section-by-section starting first with the revisions in Section 2—Definitions. She said revisions to this section add two new definitions of “plan” in Section 2K and “product” in Section 2M. These definitions were added based on federal final rules. The definition of “wellness programs” was deleted because the term was not used.

Ms. Matthews said the revisions to Section 4—Restrictions Relating to Premium Rates were based on the comments received and federal final regulations. Specifically, the revisions to Section 4A(1)(a) related to determining total family premium were based on Mr. Wake’s suggested revision.

Ms. Matthews said no changes were made to Section 5—Single Risk Pool. Turning to Section 6—Guaranteed Availability of Individual Market Health Insurance Coverage; Enrollment Periods, she said Section 6C was revised to clarify the provisions related to open enrollment when the commissioner may establish a different open enrollment period from the open enrollment established by the U.S. Department of Health and Human Services (HHS). Ms. Matthews also said revisions were made to broaden the language concerning when a health carrier must ensure coverage is effective to avoid having to revise the model’s language in the future.

Ms. Matthews said one revision was made to Section 7—Guaranteed Renewability of Individual Market Health Insurance Coverage. She said the revision adds language concerning uniform modification of coverage based on federal final rules.

Ms. Matthews said one revision was made to Section 8—Prohibition of Preexisting Condition Exclusions to clarify the prohibition on preexisting condition exclusions. She said the only revision to Section 9—Prohibition on Discrimination Based on Health Factors is in the drafting note and is based on comments received from the Blue Cross and Blue Shield.
Association (BCBSA). Ms. Matthews said the BCBSA suggested adding language to the drafting note to alert states to language found in the preamble of the final rule “Incentives for Nondiscriminatory Wellness Programs in Group Health Plans; Final Rule” (78 Fed. Reg. 33158) published in the Federal Register June 3, 2013, which states that HHS believes that participatory wellness programs in the individual market do not violate the nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because they do not base rewards on achieving a standard related to a health factor.

Ms. Matthews said no substantive revisions were made to Section 10—Essential Health Benefits Package and Section 11—Parity in Mental Health and Substance Use Disorder Benefits. She said one revision was made to Section 12—Prescription Drug Benefits. The revision adds language to the section concerning an expedited appeal process based on a federal final rule.

Ms. Matthews said a new drafting note was added to Section 13—Prohibition on Discrimination in Providing Essential Health Benefits based on comments received from the BCBSA. The new drafting note suggests that states review their discrimination laws and regulations for consistency with the language in Section 13B.

Ms. Matthews said revisions were made in Section 14—Cost-Sharing Requirements in Section 14B to clarify the application of the annual limitation on cost-sharing for benefits provided out-of-network. She said the revisions were based on comments received from Mr. Wake and the NAIC consumer representatives. A new drafting note also was added to this provision to alert states that nothing in Section 14B would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Section 14A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. Ms. Matthews noted that other revisions in Section 14C were based on federal final rules.

Ms. Matthews said no revisions were made to Section 15—Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage or Section 16—Enrollment in Catastrophic Plans.

Turning to Section 17—Provision of Summary of Benefits and Coverage; Uniform Glossary, Ms. Matthews said the drafting note was revised to clarify that the federal agencies charged with implementing the ACA have extended the federal sub-regulatory guidance and compliance safe harbors for health carriers until they issue further guidance in the future. She said the other revision adds a drafting note, as suggested by the BCBSA, alerting states that consumers may review and obtain the uniform glossary from other sources, including websites maintained by the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Labor (DOL), Employee Benefits Security Administration (EBSA).

Ms. Matthews said the language and drafting note in Section 18—Certification of Creditable Coverage was stricken and replaced with language and a drafting note reflecting the language in final rules published May 27 in the Federal Register eliminating the requirement in the individual market to provide certificates of creditable coverage and to demonstrate creditable coverage.

Ms. Matthews said the only revision to Section 19—Rules Related to Fair Marketing was to add a drafting note identical to the drafting note already discussed for Section 9. She said no revisions were made to the remaining sections in the Individual Market Regulation draft.

b. Small Group Market Regulation Draft

Ms. Matthews next discussed the revisions to the Small Group Market Regulation draft that differed from the revisions to the Individual Market Regulation draft. For Section 2—Definitions, she said that based on a comment from the Minnesota Department of Commerce, she deleted the definition of “benefit year” because many small group health insurance plans do not use calendar year. Ms. Matthews explained that the term “benefit year” was used once in the proposed model regulation in Section 16—Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage. She changed that reference to “plan year.”

Ms. Matthews said Section 4—Restrictions Relating to Premium Rates was revised in the same manner as the same section in the Individual Market Regulation. However, she made one additional revision to Section 4A(3) to delete Subparagraph (d). She explained that she deleted the language in that subparagraph because it discussed the ability of states to require health carriers to offer, or health carrier voluntarily offer, to group premiums that are based on the average covered person amounts under certain circumstances. Ms. Matthews said that because this language is something that states may in their discretion
decide to do or to permit, then she thought it would be better included in a drafting note that states may decide to include in any regulations if they decide it is appropriate. She asked for comments from regulators and interested parties on this approach.

Ms. Matthews noted that she received several comments from interested parties suggesting that a drafting note be added to the provision in Section 4A(4) related to the use of tobacco use in determining premium rate to alert states to the requirement that a health carrier offer a wellness program if it is going to rate small groups based on tobacco use. She said she believed such a drafting note would be appropriate to add, but none of the comments provided proposed language. Ms. Matthews requested specific language to include in this possible drafting note.

Ms. Matthews said the revisions were made to Section 5—Single Risk Pool to correct certain language. For Section 6—Guaranteed Availability of Small Group Market Health Insurance Coverage; Enrollment Periods, she said Section 6D(2) was revised to clarify language related to a special enrollment period involving network plans. She said the revisions to Section 7—Guaranteed Renewability of Small Group Market Health Insurance Coverage related to the uniform modification requirements consistent with the federal final rule.

Ms. Matthews said the revisions to Section 8—Prohibition on Waiting Periods Exceeding Ninety (90) Days were made for consistency with federal final rules. She said another revision was made to Section 8C based on a suggestion from the NAIC consumer representatives. She said clarifying revisions were made to Section 9—Prohibition on Preexisting Condition Exclusions. Ms. Matthews explained that the revisions to Section 10—Prohibition on Discrimination Based on Health Factors were generally nonsubstantive based on suggested comments from the BCBSA. She said no revisions were made to Section 11—Essential Health Benefits Package. Ms. Matthews said clarifying revisions were made to the drafting note for Section 12—Parity in Mental Health and Substance Use Disorder Benefits. She said the purpose of the revisions was to clarify the application of mental health and substance abuse parity requirements to small employers following the change in small group employer size to 100 in 2016.

Ms. Matthews said the revisions to both Section 13—Prescription Drug Benefits and Section 14—Prohibition on Discrimination in Providing Essential Health Benefits were identical to the revisions she previously discussed for the Individual Market Regulation. She said the revisions to Section 15—Cost-Sharing Requirements delete the language concerning limitations on annual deductibles because of a federal law eliminating such restrictions from the ACA. Ms. Matthews said the other revisions to this section are identical to the revisions she previously discussed for the Individual Market Regulation. She said no revisions were made to Section 16—Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage. Ms. Matthews said the revisions made to Section 17—Provision of Summary of Benefits and Coverage; Uniform Glossary were the same as those made in the draft Individual Market Regulation.

Ms. Matthews said she made clarifying revisions to the drafting note in Section 18—Certification and Disclosure of Prior Creditable Coverage. For Section 19—Rules Related to Fair Marketing, she said she made one revision in Section 19B(5) related to the use of small group size as criteria for establishing eligibility for a health benefit plan. The revision would permit consideration of group size to the extent necessary to establish eligibility as a small employer. Ms. Matthews requested comments on this proposed revision.

Mr. Wieske asked for comments from Task Force members. Mr. Wake said he believed the language in Section 4A(4) related to imposing the tobacco use surcharge, as discussed by Ms. Matthews, should be included in the body of the Small Group Market Regulation rather than in a drafting note. He also expressed concern that despite the proposed additional language to Section 8—Prohibition on Waiting Periods Exceeding Ninety (90) Days, having both a waiting period and an orientation period could be used as a means to avoid compliance with the 90-day waiting period limitation. Ms. Goe expressed agreement with Mr. Wake’s comments regarding Section 4A(4), Candy Gallaher (America’s Health Insurance Plans—AHIP) clarified that with respect to the tobacco use rating surcharge, a health carrier must have a wellness program that includes a smoking cessation program.

Timothy S. Jost (Washington and Lee University School of Law) said the NAIC consumer representatives have several suggested revisions that they would be submitting in a comment letter for the Task Force’s consideration. Kathleen Gmeiner (UICAN Ohio) outlined some of the NAIC consumer representative comments that will be reiterated in the comment letter to the Task Force, including: 1) revising Section 5—Single Risk Pool to add a drafting note to explain that states may define “health carrier” such that it includes subsidiaries more broadly than is provided in the federal definition of “health insurance issuer;” 2) revising Section 10—Essential Health Benefits Package to include language to clarify that states have the ability under federal rules to determine which services are included in the habilitative services category; and 3) revising Section 19-
Rules Related to Fair Marketing to include language requiring health carriers’ toll-free telephone services to provide appropriate assistance to individuals with disabilities and those with limited proficiency in English. Lynn Quincy (Consumers Union) reiterated the NAIC consumer representatives’ suggested comment that Section 17—Provision of Summary of Benefits and Coverage; Uniform Glossary be revised to include a drafting note alerting states that they may require health carriers to submit their summary of benefits and coverage (SBC) for review and approval.

Mr. Wieske suggested the Task Force expose the Individual Market Regulation draft and the Small Group Market Regulation draft for a 30-day public comment period ending Sept. 16. The Task Force agreed with his suggestion.

3. Discussed Comments Received on Accident and Sickness Insurance Minimum Standards Model Act (#170)

Mr. Wieske said the Task Force decided during its July 10 conference call to request comments on the Accident and Sickness Insurance Minimum Standards Model Act (#170). In response, comments were received from AHIP, the Idaho Department of Insurance, the Florida Office of Insurance Regulation and the NAIC consumer representatives. Ms. Matthews said that, generally, the comments were similar in that they suggested that provisions in Model #170 related to major medical coverage be removed from the model because the Individual Market Health Insurance Coverage Model Act (#36) and the proposed model regulation implementing Model #36 include provisions related to such coverage. As such, these provisions are no longer necessary. She said other comments suggest that Model #170’s remaining provisions related to excepted benefits should be revised. Ms. Matthews noted that in their comments, the NAIC consumer representatives suggest removing the provisions in Model #170 on disability income protection coverage and including them in a new NAIC model.

Mr. Wieske said these initial comments on Model #170 were informative. He suggested that the Task Force continue its discussion of next steps for revising Model #170 during a conference call in the next few months. The Task Force agreed to his suggestion.


Mr. Wieske said the Task Force began discussion of the provisions of the Group Health Insurance Standards Model Act (#100) during its July 10 conference call and decided to continue the discussion at the Summer National Meeting. He said he discussed Model #100 with NAIC staff and suggested that the Task Force request NAIC staff to review and revise Model #100, as appropriate, for consistency with the ACA. He said NAIC staff would distribute the proposed revisions for comment sometime prior to the Fall National Meeting. The Task Force would discuss the proposed revisions and any comments received at the Fall National Meeting. The Task Force agreed to Mr. Wieske’s suggestion.

5. Adopted the Report of the Network Adequacy Model Review (B) Subgroup

Mr. Wieske gave a summary report of the Network Adequacy Model Review (B) Subgroup (Attachment Four), which met via conference call Aug. 7 (Attachment Four-A), July 31 (Attachment Four-B), June 19 (Attachment Four-C), June 12 (Attachment Four-D), June 5 (Attachment Four-E), May 29 (Attachment Four-F), May 22 (Attachment Four-G) and May 8 (Attachment Four-H). During these calls, the Subgroup reviewed its charge to consider revisions to the Managed Care Plan Network Adequacy Model Act (#74). Mr. Wieske said that before discussing specific revisions to Model #74, the Subgroup heard testimony from various stakeholders on their issues and concerns with network adequacy and possible ways to address them. He said the Subgroup also heard a summary of Washington State’s newly revised network adequacy regulations.

Mr. Wieske said the Subgroup discussed and finalized a work plan to complete its work to revise Model #74 by the Fall National Meeting. The Subgroup requested initial comments on Model #74, including specific proposed revisions, by July 3. More than 30 comment letters were received. Mr. Wieske said the Subgroup began reviewing these comments and discussing specific revisions to Model #74 July 31 via conference call. He said the Subgroup is continuing these discussions during weekly conference calls. After the Subgroup completes its review of the initial comments, it would distribute a revised draft of Model #74 for additional comments before submitting a revised draft of Model #74 to the Task Force for its consideration.

Mr. Robleto suggested that the Subgroup might want to review the Centers for Medicare and Medicaid Services’ (CMS) network adequacy standards developed for Medicare Advantage plans. Mr. Wieske said he would be willing to review those standards, but he believes the Subgroup should continue its work. He also said he believes that there is a difference between Medicare Advantage plans and health benefit plans in the commercial market. As such, network adequacy standards developed for Medicare Advantage plans might not be appropriate for health benefit plans in the commercial market.
Mr. Wieske noted that the network adequacy issues in the commercial market, such as narrow networks, also might be different.

Ms. Goe agreed with Mr. Wieske’s comments. She also said that the one-size-fits-all approach in the CMS’ network adequacy standards for Medicare Advantage plans would not work because they do not have the needed flexibility to deal with the differences among the states in their populations and health insurance markets. Mr. Robleto expressed agreement with Ms. Goe’s comments. He said he suggested reviewing the Medicare Advantage plan network adequacy standards as another resource the Working Group could use to assist it in completing its work.

Elizabeth Abbott (Health Access California) urged the Subgroup to continue its work. She agreed with Mr. Wieske’s comments about the differences between Medicare Advantage plans and health benefit plans in the commercial market. This is particularly true with respect to the populations covered. Medicare Advantage plans provide coverage for individuals 65 years of age and older whereas health benefit plans in the commercial market provide coverage for individual under the age of 65.

Ms. Quincy said she believes the NAIC, through the work of the Subgroup, has the opportunity to ensure consumers understand their health benefit plan network. She said she believed any provisions related to improving network transparency and enhancing consumer education related to networks could be uniform across the states. Ms. Quincy said that given this, perhaps, the Subgroup and the CMS could work together to address these issues.

Ms. Abbott updated the Task Force on the status of the NAIC consumer representatives’ survey sent to each of the state insurance departments on network adequacy. She said only a few states have yet to respond to the survey. Ms. Abbott urged those states that have not responded to do so as soon as possible. She said she anticipates releasing the survey results in an aggregated manner in order to not identify a particular state by the end of the year. Ms. Abbott said she anticipates the report will highlight state best practices.

Mr. Swanson made a motion, seconded by Ms. Sheppard, to adopt the report of the Network Adequacy Model Review (B) Subgroup. The motion passed unanimously.

6. Adopted the Report of the ERISA (B) Working Group

Ms. Goe said the ERISA (B) Working Group met Aug. 16. During this meeting, the Working Group discussed the Aug. 12 draft of the Stop Loss Insurance, Self-Funding and the ACA white paper. She said the Working Group is requesting comments on the draft by Sept. 16. Ms. Goe said she anticipates the Working Group meeting via conference call by the end of September. She said the Working Group would develop additional drafts and schedule additional open conference calls as needed.

Ms. Goe said the Working Group voted to adjourn into regulator-to-regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters) of the NAIC Policy Statement on Open Meetings. Ms. Goe made a motion, seconded by Ms. Brown, to adopt the report of the ERISA (B) Working Group (Attachment Five). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Regulatory Framework (B) Task Force met via conference call July 10, 2014. The following Task Force members participated: Ted Nickel, Chair, represented by J.P. Wieske (WI); Todd E. Kiser, Vice Chair, represented by Tanji Northrup (UT); Germaine L. Marks represented by Erin Klug (AZ); Dave Jones represented by Sheirin Ghoddoucy (CA); Marguerite Salazar represented by Peg Brown (CO); Thomas B. Leonardi represented by Marjorie Breen (CT); Kevin M. McCarty represented by Rich Robleto (FL); William W. Deal represented by Kathy McGill (ID); Andrew Boron represented by Yvonne Clearwater (IL); Stephen W. Robertson represented by Tyler Ann McGuffee (IN); Sandy Praeger represented by Cindy Hermes and Julie Holmes (KS); Sharon P. Clark represented by Maggie Woods (KY); Eric A. Cioppa represented by Robert Wake and Norm Stevens (ME); Mike Rothman represented by Alyssa Von Ruden (MN); John M. Huff represented by Molly White, Amy Hoyt and Angela Nelson (MO); Monica J. Lindeen represented by Christina Goe (MT); Bruce R. Ramge represented by John Rink and Stephen E. King (NE); Kenneth E. Kobylowski represented by Chanell McDevitt (NJ); Scott J. Kipper represented by Kim Everett (NV); Mary Taylor represented by Matt Elston (OH); John D. Doak represented by Mike Rhoads (OK); Laura N. Cali represented by Gayle Woods (OR); Jacqueline K. Cunningham represented by Julie Blauvelt (VA); and Michael D. Riley represented by Ellen Potter (WV). Also participating was: Herb Olson (RI).

1. Discussed Work Plan for NAIC Model Acts

Mr. Wieske reminded the Task Force that at the Spring National Meeting, the Task Force agreed that the next NAIC models to be reviewed for possible revision would be the Accident and Sickness Insurance Minimum Standards Model Act (#170), the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) and the Group Health Insurance Standards Model Act (#100). He suggested that the Task Force request comments on these models for discussion at the Summer National Meeting. Mr. Wieske noted that the Network Adequacy Model Review (B) Subgroup is currently working to revise the Managed Care PlanNetwork Adequacy Model Act (#74). In addition, the Task Force is working to finish the proposed new Individual Market Health Insurance Coverage Model Regulation and the Small Group Market Health Coverage Model Regulation. As such, at the Summer National Meeting, the Task Force’s goal will be to review any comments received on the models in order to further ascertain which of these models should be prioritized for review and revision after the Network Adequacy Model Review (B) Subgroup finishes its work on Model #74.

Mr. Olson asked if Mr. Wieske is suggesting that comments be submitted with specific proposed revisions to each of the models related to necessary updates due to the federal Affordable care Act (ACA) and any other necessary revisions. He said Rhode Island is currently in the process of revising its regulations based on Model #171 and has found that the regulations need to be completely rewritten. As such, revising Model #171 could be time-consuming. Mr. Wieske asked if the Task Force should focus first on Model #170 and Model #171. Ms. Brown asked about Model #100.

Chris Petersen (Morris, Manning & Martin) said Model #100 has a different focus than Model #170. He said Model #100 focuses on permitted groups, while Model #170 focuses on the terms and coverages under individual accident and sickness policies and group supplemental health insurance. Mr. Petersen suggested that the Task Force focus on ACA-related revisions only. He also said the fundamental issue to be discussed for Model #100 is whether the ACA permits other groups besides ERISA employer-sponsored groups. Timothy S. Jost (Washington and Lee University School of Law) noted that the provisions of Model #170 and Model #171 include both disability insurance and health insurance. He said it might be useful for the Task Force to consider separating the two types of insurance. Mr. Jost also noted that some of the types of insurance referenced in Model #171 no longer exist. He also suggested that the Task Force consider focusing on excepted benefits, such as dental and vision insurance, and develop a new model law for these types of insurance.

Ms. Goe urged caution with using terms like “disability” insurance when referring to the types of insurance because in some states, including Montana, disability insurance is considered a type of health insurance. She also said that, although it might be good to focus on ACA-related revisions, the Task Force should be able to consider any necessary non-ACA-related revisions. The Task Force agreed.

Mr. Wieske asked if the Task Force should focus on Model #170 or Model #100. After discussion, the Task Force decided to request comments on Model #170 by Aug. 11. Any comments received will be discussed at the Summer National Meeting.
Mr. Wieske said the Task Force would discuss Model #100 and whether the ACA permits any other groups besides ERISA employer-sponsored groups.

2. Received Status Update on the Individual and Small Group Market Health Insurance Coverage Model Regulation Drafts

Jolie Matthews (NAIC) said that, at the Spring National Meeting, she reviewed revised drafts of the proposed Individual Market Health Insurance Coverage Model Regulation (refer to Attachment Two of the Regulatory Framework (B) Task Force Minutes, NAIC Proceedings – Spring 2014) and the Small Group Market Health Insurance Coverage Model Regulation (refer to Attachment Three of the Regulatory Framework (B) Task Force Minutes, NAIC Proceedings – Spring 2014). She said the Task Force requested comments on those drafts. Ms. Matthews said she anticipates distributing revised drafts prior to the Summer National Meeting or during the Task Force’s meeting at the Summer National Meeting. She said the revised drafts will reflect the nonsubstantive comments included in the comment letters received on the previous drafts. Ms. Matthews said the revised drafts also will reflect the provisions of several final regulations promulgated by the federal agencies charged with implementing the provisions of the ACA.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

Section 1. Statement of Purpose
This regulation is intended to implement the provisions of the Individual Market Health Insurance Coverage Model Act ("Act"). The purposes of the Act and this regulation are to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market.

Section 2. Definitions
As used in this Regulation:

A. “Actuarial Value” or “AV” means the percentage paid by a health benefit plan of the allowed costs of benefits.

B. “Annual open enrollment period” means the period each year during which an individual may enroll or change coverage in a health benefit plan.

C. “Benefit year” means a calendar year for which a health benefit plan provides coverage for health benefits.

D. “CMS” means the federal Centers for Medicare and Medicaid Services.

E. (1) “Cost-sharing” means any expenditure required by or on behalf of an enrollee with respect to essential health benefits.

(2) “Cost-sharing” includes deductibles, coinsurance, copayments or similar charges, but excludes

Comments are being requested on this draft by Sept. 16, 2014. The revisions to this draft reflect changes made from the previous March 12, 2014, draft. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.
premiums, balance billing amounts for non-network providers and spending for non-covered services.

F. “EHB-benchmark plan” means the standardized set of essential health benefits (EHB) that a health carrier must provide as required by the commissioner or Secretary.

G. “HHS” means the U.S. Department of Health and Human Services.

H. (1) “Health factor” means, in relation to any individual, any of the following health status-related factors:
   
   (a) Health status;
   
   (b) Medical condition, including both physical and mental illnesses;
   
   (c) Claims experience;
   
   (d) Receipt of health care services;
   
   (e) Medical history;
   
   (f) Genetic information;
   
   (g) Evidence of insurability, including:
      
      (i) Conditions arising out of acts of domestic violence; or
      
      (ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or
   
   (h) Disability.

   (2) For purposes of this subsection, “health factor” does not include the decision whether to elect individual market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.

I. “Minimum essential coverage” has the meaning stated in section 5000A(f) of the Internal Revenue Code (Code).

J. “Percentage of the total allowed costs of benefits” means the anticipated covered medical spending for EHB coverage, as defined in Section 3K of the Act, paid by a health benefit plan for a standard population, computed in accordance with the plan’s cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and express as a percentage.

K. “Plan” means, with respect to a health carrier and a product, the pairing of health insurance coverage benefits under the product with a metal tier level, as described in section 1302(d) and (e) of the Federal Act. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.

KL. “Policy year” means, with respect to:

   (1) Grandfathered health plan coverage providing individual market health insurance coverage and student health insurance coverage, the 12-month period that is designated as the policy year in the policy documents of the individual market health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not
imposed on a yearly basis, the policy year is the calendar year; or

(2) Non-grandfathered health plan coverage providing individual market health insurance coverage, or a market in which the State has merged has merged the individual and small group market risk pools for coverage issued or renewed beginning Jan. 1, 2014, a calendar year for which health insurance coverage provides coverage for health benefits.

M. “Product” means a discrete package of health insurance coverage benefits that a health carrier offers using a particular product network type within a geographic service area.

LN. “Special enrollment period” means a period during which an individual or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the initial and annual open enrollment periods.

M. “Wellness program” means a program of health promotion or disease prevention.

Section 3. Applicability and Scope

Subject to the provisions in Section 4 of the Act and specific provisions in this regulation, this regulation is applicable to health carriers offering health benefit plans providing individual market health insurance coverage in this State.

Section 4. Restrictions Relating to Premium Rates

A. The premium rate charged by a health carrier offering a health benefit plan providing individual market health insurance coverage may vary only, with respect to the particular coverage involved, on the basis of the following:

(1) Whether the coverage covers an individual or family:

(a) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member, except that if there are more than three (3) covered children under the age of twenty-one (21), only the premiums for the three (3) oldest covered children under the age twenty-one (21) must be taken into account in determining the total family premium. The total family premium shall include only the premiums for the three (3) oldest children under the age of twenty-one (21); and

(b) For family coverage, any rating variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

Drafting Note: As specified in 45 CFR §147.102(c)(3), a state has the option to establish uniform family tiers and uniform rating multipliers for those tiers in lieu of the family rating methodology specified in Paragraph (1), but only if the state does not permit any rating variation for age and tobacco use described the factors described in Paragraphs (3) and (4). If a state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology in this section under Paragraph (1) will apply in that state.

(2) (a) (i) Geographic rating area, as established by HHS in accordance with 45 CFR §147.102(b), unless the commissioner establishes alternative geographic rating areas pursuant to Subparagraph (b) of this paragraph; and

(ii) The commissioner may adopt regulations establishing uniform geographic rating areas subject to the provisions of 45 CFR §147.102(b); and

Drafting Note: States choosing to limit the permissible variation based on geographic rating areas, or to establish uniform geographic area multipliers, should consider incorporating those provisions in an additional provision under this subparagraph, such as Item (iii).
Drafting Note: States should be aware that 45 CFR §147.102(b) of the final rule published in the Federal Register Feb. 27, 2013, permits a state to establish one or more geographic rating areas within that state. If a state does not establish geographic rating areas, or the federal Centers for Medicare and Medicaid Services (CMS) determines that the state’s geographic rating areas are not adequate, the default will be one geographic rating area for each metropolitan statistical area in the state and one geographic rating comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget (OMB).

(b) For purposes of this paragraph, geographic rating area is to be determined in the individual market using the primary policyholder’s address;

(3) Age:

(a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);

(b) The rate for each enrollee must be based on the enrollee’s age as of the date of policy issuance or renewal or addition to the policy;

(c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147.102(e), unless the commissioner establishes an alternative age rating curve pursuant to Subparagraph (d) of this paragraph; and

(d) The commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147.102(e). Any uniform age rating curve must be based on the following uniform age bands:

(i) A single age band for individuals age 0 through 20;

(ii) One-year age bands for individuals age 21 through 63; and

(iii) A single age band for individuals age 64 and older; and

Drafting Note: States should be aware that 45 CFR §147.102(e) of the final rule published in the Federal Register Feb. 27, 2013, permits a state to establish a uniform age rating curve in the individual or small group market, or both markets. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with 45 CFR §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(4) Tobacco use:

(a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;

(b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;

(c) A rating surcharge for “tobacco use” may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and

(d) The health carrier may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health carrier must consider “tobacco use” in terms of when a tobacco product was last used.
Drafting Note: States should be aware that federal law does not preempt state laws that impose stronger consumer protections than federal law. Therefore, states may prohibit tobacco use as a rating factor or may impose stronger restrictions on tobacco use rating than the restrictions in this Regulation as provided in Paragraph (4) above.

B. A premium rate may not vary with respect to a particular coverage involved by any other factor not described in Subsection A.

C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 5. Single Risk Pool

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must consider the claims experience of all enrollees in all other health benefit plans (other than grandfathered health plan coverage) subject to Section 5 of the Act and offered by the carrier in the individual market in a state, including enrollees who do not enroll in such plans through the exchange, to be members of a single risk pool.

Drafting Note: As specified in 45 CFR §156.80, a state may require the individual and small group health insurance markets within the state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in 45 CFR §147.103.

B. (1) (a) A health carrier must establish an index rate that is effective January 1 of each calendar year for the individual market, described in Subsection A or, if applicable, a merged market, if the state has required such merger, based on the total combined claims cost for providing essential health benefits within the single risk pool of that state market.

(b) The index rate must be adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and exchange user fees (expected to be remitted under 45 CFR §156.50(b) or §156.50(c) and (d), as applicable, plus the dollar amount under 45 §156.50(d)(3)(i) and (ii) expected to be credited against user fees payable in that state market).

(c) The premium rate for all of the health carrier’s plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to plan-level adjustments permitted in Paragraph (2).

(2) For policy years beginning on or after January 1, 2014, a health carrier may vary premium rates for a particular health benefit plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(a) The actuarial value and cost-sharing design of the plan;

(b) The plan’s provider network, delivery system characteristics and utilization management practices;

(c) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits;

(d) Administrative costs, excluding exchange user fees; and

(e) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.
(3) A health carrier may not establish an index rate and make the market-wide adjustments pursuant to Paragraph (1), or make the plan-level adjustments pursuant to Paragraph (2), more or less frequently than annually.

C. This section does not apply to grandfathered health plan coverage in accordance with the provisions of Section 1312(c)(4) of the Federal Act.

Section 6. Guaranteed Availability of Individual Market Health Insurance Coverage; Enrollment Periods

A. Subject to Section 6 of the Act and Subsections B through D, a health carrier offering a health benefit plan providing individual market health insurance coverage must offer to any individual in the state all products that are approved for sale in the individual market and must accept any individual that applies for coverage under any of those products.

B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

C. (1) A health carrier must allow an individual to purchase health insurance coverage during an annual open enrollment period established by HHS unless the commissioner establishes a different broader open enrollment period that is no more restrictive than the open enrollment period established by HHS. Coverage must become effective consistent with the dates described in Paragraph (2).

Drafting Note: States should be aware that 45 CFR §147.104(b)(1)(ii) of the final rule, as published in the Federal Register, Feb. 27, 2013, requires health carriers to allow for an initial enrollment period for individuals to enroll to purchase health insurance coverage based on the requirements in 45 CFR §155.410(b). 45 CFR §155.410(b) states that the initial enrollment period begins Oct. 1, 2013 and extends through March 31, 2014. With respect to the initial enrollment period, 45 CFR §147.104(b)(1)(ii) of the final rule also requires that the coverage must be effective consistent with 45 CFR §155.410(c). 45 CFR §155.410(c) provides that for a request to purchase health insurance coverage received by a health carrier from an individual: 1) on or before Dec. 15, 2013, the health carrier must ensure a coverage effective date of Jan. 1, 2014; 2) between the first and fifteenth day of any subsequent month during the initial enrollment period, the health carrier must ensure a coverage effective date of the first day of the following month; and 3) between the sixteenth and the last day of the month for any month between December 2013 and March 31, 2014, the health carrier must ensure a coverage effective date of the first day of the second following month.

(2) The health carrier must ensure coverage is effective as of the first day of the following benefit year for an individual who has applied for coverage under the health benefit plan in accordance with requirements established by the commissioner if the commissioner establishes a broader open enrollment period or as established by HHS.

D. For individuals enrolled in non-calendar year health benefit plans, a health carrier must provide a limited open enrollment period that begins on the date that is thirty (30) calendar days prior to the date the policy year ends in 2014. The effective date of coverage under this subsection must be consistent with the dates described in Subsection E(2)(b).

Drafting Note: States that permitted health carriers to renew non-ACA compliant policies pursuant to the November 2013 “Transitional Policy,” and any extensions of that transitional policy, may need to alert carriers that they must provide a special enrollment period for those covered persons at least 30 calendar days prior to the date the policy ends.

E. (1) (a) In addition to the special enrollment periods provided in Section 9B of the Act and qualifying events, as defined under section 603 of ERISA, a health carrier must provide special enrollment periods for the following triggering events:

(i) An individual or dependent loses minimum essential coverage;

(ii) An individual gains a dependent through marriage, birth, adoption or placement for adoption or placement in foster care;
(iii) An individual’s enrollment or non-enrollment in a health benefit plan is unintentional, inadvertent or erroneous and as a result of the error, misrepresentation or inaction of an officer, employee or agent of the health carrier or HHS or its instrumentalities as evaluated and determined by the health carrier. In such cases, the health carrier may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction;

(iv) A covered person adequately demonstrates to the health carrier that the health benefit plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the covered person;

(v) A covered person is determined newly eligible for exchange-based subsidies or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions. A health carrier must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer’s upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; and

(vi) An individual or covered person gains access to new health benefit plans as a result of a permanent move.

(b) These special enrollment periods are in addition to any other special enrollment periods required under state or federal law.

Drafting Note: States should be aware that federal preemption standards allow states to impose stronger consumer protections in state law such as, for example, additional special enrollment periods or open enrollment periods that allow individuals to purchase coverage more frequently than the federal minimum requirements.

(2) (a) With respect to an election made under Subsection D or Paragraph (1) of this subsection, coverage must become effective consistent with the dates described in Subparagraph (b) of this paragraph.

(b) Except as provided in Subparagraph (c) of this paragraph, for a health benefit plan selection received by the health carrier from an individual:

(i) Between the first and fifteenth day of any month, the health carrier must ensure a coverage effective date of the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the health carrier must ensure a coverage effective date of the first day of the second following month.

(c) (i) In the case of birth, adoption or placement for adoption, the health carrier must ensure that coverage is effective regardless of enrollment date in accordance with the provisions of Section 9B of the Act on the date of birth, adoption or placement for adoption.

(ii) In the case of marriage, or in the case where an individual loses minimum essential coverage, as described in Paragraph (1)(a)(i), the health carrier must ensure coverage is effective on the first day of the following month.

F. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.
Section 7. Guaranteed Renewability of Individual Market Health Insurance Coverage

A. As provided in Section 7 of the Act and this section, subject to Subsection B, a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must renew or continue in force the coverage at the option of the individual.

B. A health carrier may nonrenew or discontinue health insurance coverage based only on one or more of the following:

1. The individual has failed to pay premiums in accordance with the terms of the health insurance coverage, including any timeliness requirements;

2. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;

3. The carrier is ceasing to offer coverage in the market in accordance with section 7C (discontinuing a particular product) or section 7D (discontinuing all coverage) of the Act and applicable state law;

4. For network plans, there is no longer any covered person who lives, resides or works in the service area of the carrier (or the area for which the carrier is authorized to do business); or

5. For coverage made available in the individual market only through one or more bona fide associations, the individual’s membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered persons.

C. (1) At the time of coverage renewal only, a health carrier may modify the health insurance coverage for a product offered in the individual market if the modification is consistent with state law and is effective uniformly among all policyholders with that product.

(2) For purposes of Paragraph (1), a modification made uniformly and solely pursuant to applicable federal or state law is considered a uniform modification of coverage if:

(a) The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and

(b) The modification is directly related to the imposition or modification of the federal or state requirement.

(3) Other types of modifications made uniformly are considered a uniform modification of coverage if the individual market health insurance coverage for the product meets all of the following criteria:

(a) The product is offered by the same health carrier, as that term is defined in section 3B of the Act;

(b) The product is offered as the same product network type;

(c) The product continues to cover at least a majority of the same service area;

(d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services, or to maintain the same metal tier level described in section 1302(d) and (e) of the Federal Act; and

(e) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, as described in section 5B of this Act.
regulation, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable federal or state requirements.

Drafting Note: States should be aware that 45 CFR §147.106(c)(4) permits a state to broaden the standards described in Paragraph (3)(b) and (c) above.

D. If a health carrier is renewing non-grandfathered individual market health insurance coverage as described in Subsection A, or uniformly modifying non-grandfathered individual market health insurance coverage as described in Subsection C, the health carrier must provide to each individual written notice of the renewal at least sixty (60) calendar days before the date of the coverage will be renewed in a form and manner specified by the Secretary.

E. (1) Nothing in this section should be construed to require a health carrier to renew or continue in force small group market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.

(2) Medicare eligibility or entitlement to such benefits is not a basis for non-renewal or termination of an individual’s health insurance coverage in the individual market.

CF. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under section 2742 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 8. Prohibition of Preexisting Condition Exclusions

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not impose any preexisting condition exclusions as provided in Section 9A of the Act.

B. As described in Section 4 of the Act, a grandfathered health plan coverage that is individual health insurance coverage is not required to comply with this section.

Section 9. Prohibition on Discrimination Based on Health Factors

Drafting Note: The Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively, the Departments) published joint final regulations implementing the HIPAA nondiscrimination and wellness provisions Dec. 13, 2006, at 71 FR 75014 (the 2006 regulations). These regulations implemented the provisions of Section 2702 of the Public Health Service Act (PHSA), as enacted by HIPAA, which generally prohibited group health plans and group health insurance issuers from discriminating against individual employees and their dependents in eligibility, benefits or premiums based on a health factor. These regulations, however, permitted group health plans and group health insurance issuers to establish certain rules which, under the ACA, are no longer permitted. One example of such rules is a provision in the 2006 regulations permitting group health plans and group health insurance issuers to impose rating differentials and preexisting condition exclusions for the group market. Because such provisions from the 2006 regulations are no longer permitted due to the ACA, they have not been included in this section. However, states should be aware that they may want to somehow retain these provisions for purposes of continued enforcement related to grandfathered health plan coverage and some group health benefit plan coverage with plan years that extend into 2014 (and possibly additional years, as permitted). States also should be aware that the ACA retained provisions from Section 2702 of the PHSA, now Section 2705 of the PHSA, as enacted by Section 1201 the ACA. For the group market only, this section provides for a general exception to the general rule to allow premium discounts or rebates and modification to otherwise applicable cost sharing, including copayments, deductibles or coinsurance, in return for adherence to certain programs of health promotion and disease prevention. For purposes of this Individual Market Health Insurance Coverage Model Regulation (??), states also should be aware that Section 2705 of the PHSA also extends the HIPAA nondiscrimination protections to the individual market. However, Section 2705 of the PHSA does not extend the wellness program exception to the prohibition on discrimination to coverage in the individual market. In addition, states should be aware that in the Incentives for Nondiscriminatory Wellness Programs in Group Health
Plans: Final Rule (78 Fed. Reg. 33158) published in the Federal Register June 3, 2013, the preamble of that final rule (78 Fed. Reg. 33167) states that “[c]ommenters requested that the wellness provisions be extended to the individual market or that states be allowed to authorize participatory programs in the individual market. Although the proposed rule addressing the individual market is being finalized without change, it is HHS’s belief that participatory wellness programs in the individual market do not violate the nondiscrimination provisions provided that such programs are consistent with State law and available to similarly situated individuals enrolled in the individual health insurance coverage. This is because participatory wellness programs do not base rewards on achieving a standard related to a health factor, and thus do not discriminate based upon health status.”

A. (1) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not establish a rule for eligibility, including continued eligibility, of an individual to enroll for benefits under the plan that discriminates based on any health factor that relates to the individual or dependent of the individual.

(2) For purposes of this section, a rule of eligibility includes a rule relating to:

(a) Enrollment;
(b) The effective date of coverage;
(c) Waiting or affiliation periods;
(d) Late and special enrollment;
(e) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
(f) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Subsection C(1) and (2);
(g) Continued eligibility; and
(h) Terminating coverage, including disenrollment, of an individual under the plan.

(3) Nothing in this section prohibits a health carrier from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.

B. (1) Subject federal or state law or regulations and Paragraph (2), Subsection A does not require a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act to provide coverage for any particular benefit to similarly situated individuals.

(2) (a) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act shall make the benefits provided under a plan available uniformly to all individuals.

(b) For any restriction on a benefit or benefits provided under a plan, the health carrier:

(i) Shall apply the restriction uniformly; and
(ii) May not direct the restriction, as determined based on all of the relevant facts and circumstances, at any individual or dependents of an individual based on any health factor of the individual or a dependent of the individual.
(c) The health carrier may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the cost-sharing requirement:

(i) Applies uniformly; and

(ii) Is not directed at any individual or dependents of an individual based on any health factor of the individual or dependent of an individual.

(d) For purposes of this paragraph, a plan amendment applicable to all individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual or dependent of an individual.

(3) If the health carrier generally provides benefits for a type of injury, the health carrier may not deny any individual or dependent of an individual benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition. This provision applies to an injury resulting from a medical condition even if the medical condition is not diagnosed before the injury.

C. (1) Except to the extent permitted under Paragraph (2), in accordance with Subsection A, a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual policyholder’s premium or contribution rate based on:

(a) Whether the policyholder is confined in a hospital or other health care institution; or

(b) The policyholder’s ability to engage in normal life activities.

(2) Notwithstanding Paragraph (1), a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may establish a rule of eligibility or set a policyholder’s premium or contribution rate with respect to similarly situated individuals.

Section 10. Essential Health Benefits Package

A. To meet the requirements of Section 13 of the Act, provision of essential health benefits means that a health benefit plan provides health benefits that:

(1) Are substantially equal to the EHB-benchmark plan including:

(a) Covered benefits;

(b) Limitations on coverage including coverage of benefit amount, duration and scope; and

(c) Prescription drug benefits that meet the requirements of Section 1012 of this Regulation;

(2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;

(4) Include preventive health services, as provided in Section 14 of the Act;

(5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:
(a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services; or

(b) Is determined by the health carrier and reported to HHS.

B. A health carrier offering a health benefit plan in the individual market providing essential health benefits may substitute benefits if the carrier meets the following conditions:

Drafting Note: States should be aware that they may adopt more restrictive requirements related to health carriers substituting benefits, including not permitting the practice.

(1) Substitutes a benefit that:

(a) Is actuarially equivalent to the benefit that is being replaced as determined in Paragraph (2);

(b) Is made only within the same essential health benefit category; and

(c) Is not a prescription drug benefit; and

(2) Submits evidence of actuarial equivalence that is:

(a) Certified by a member of the American Academy of Actuaries;

(b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(c) Based on a standardized plan population; and

(d) Determined regardless of cost-sharing.

C. A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).

D. A health carrier offering a health benefit plan in the individual market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.

Drafting Note: States should be aware that in the preamble of the final regulations published in the Federal Register Feb. 25, 2013 (78 FR 12866), there is commentary related to a provision in the ACA and implementing regulations that provides that if an exchange offers a standalone dental plan offering a pediatric dental EHB benefit, medical insurance plans are not required to offer a pediatric dental plan on that exchange. HHS was encouraged by commenters on the proposed regulation to extend into the non-exchange market (outside market) the ability of a medical insurance plan to not offer the pediatric dental EHB in cases where a standalone dental plan that meets the standards to cover the pediatric dental EHB is offered. In its response, HHS notes that the ACA does not provide for the same exclusion of a pediatric dental EHB outside of the exchange as it does in Section 1304(b)(4) of the ACA for exchanges. Therefore, individuals enrolling in health insurance coverage in the outside market must be offered the full ten EHB categories, including the pediatric dental benefit. HHS notes, however, that in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an exchange-certified stand-alone dental plan off the exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. As such, when an issuer is reasonably assured that an individual has obtained such coverage through an exchange-certified stand-alone dental plan offered outside an exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers a policy that, when combined with the exchange-certified stand-alone dental plan, ensures full coverage of EHB. HHS also notes that this alternative method of compliance is at the option of the medical insurance plan issuer, and would only apply with respect to individuals for whom the medical insurance plan issuer
is reasonably assured have obtained pediatric dental coverage through an exchange-certified stand-alone dental plan. In addition, this option is only available for pediatric dental EHB, and not for any other EHB. States should be aware that because this alternative option is included in the final regulation’s preamble, but not in the text of the final regulation, states may be taking a different approach to address this issue.

Section 11. Parity in Mental Health and Substance Use Disorder Benefits

A. (1) The provisions of 45 CFR §146.136 apply to a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act in the same manner and to the same extent as such provisions apply to health insurance coverage offered in connection with a group health insurance plan in the large group market.

(2) For purposes of this subsection, “large group market” has the meaning stated in 45 CFR §144.103.

B. This section applies to non-grandfathered health plan coverage and grandfathered health plan coverage.

Section 12. Prescription Drug Benefits

A. A health benefit plan does not provide essential health benefits unless it:

(1) Except as provided in Subsection B, covers at least the greater of:

   (a) One drug in every United States Pharmacopeia (USP) category and class; or

   (b) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the state.

B. A health benefit plan does not fail to provide essential health benefits prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).

C. (1) A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan.

(2) (a) The procedures must include a process for an enrollee, the enrollee’s designee or the enrollee’s prescribing physician or other prescriber to request an expedited review based on exigent circumstances.

   (b) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

   (c) A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee’s designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than twenty-four (24) hours after it receives the request.

   (d) A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Drafting Note: The provisions of Subsection C above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically
appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the NAIC Health Carrier Prescription Drug Benefit Management Model Act (§22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

**Section 13. Prohibition on Discrimination in Providing Essential Health Benefits**

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.

B. A health carrier must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

**Drafting Note:** States should review their laws and regulations for consistency with the provisions of Subsection B above and, if necessary, revise the language in Subsection B.

C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

**Section 14. Cost-Sharing Requirements**

A. (1) For a policy year beginning in calendar year 2014, cost-sharing may not exceed the following:

   (a) For self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended; or

   (b) For non-self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended.

   (2) For a policy year beginning in a calendar year after 2014, cost-sharing may not exceed the following:

   (a) For self-only coverage, the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in Subsection E; or

   (b) For non-self-only coverage, twice the dollar limit for self-only coverage described in Subparagraph (a) of this paragraph.

B. In the case of a network plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of the network may not count towards the annual limitation on cost-sharing, as defined in Subsection A; the annual limitation on cost-sharing, as defined in Subsection A, does not apply to benefits provided out-of-network.

**Drafting Note:** Subject to state or federal law or regulations, nothing in this section would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Subsection A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network.

C. For a policy year beginning in a calendar year after 2014, any increase in the annual dollar limits described in Subsections A and B that does not result in a multiple of 50 dollars must be rounded down to the next lowest multiple of 50 dollars.
D. The premium adjustment percentage is the percentage, if any, by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

E. Nothing in this section is in derogation of the requirements of Section 14 of the Act.

F. Emergency department services must be provided as follows:

   (1) Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and
   
   (2) If such services are provided out of network, cost-sharing must be limited as provided in [insert reference to state law or regulation equivalent to Section 11C of the Utilization Review and Benefit Determination Model Act].

Section 15. Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage

A. Subject to Subsection B, a health carrier must use the AV Calculator developed and made available by HHS to calculate the AV of a health benefit plan.

B. If a health benefit plan’s design is not compatible with the AV Calculator, the health carrier must meet the following:

   (1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in Subparagraphs (a) and (b) of this paragraph:

      (a) Calculate the plan’s AV by:

         (i) Estimating the fit of its plan design into the parameters of the AV calculator; and
         (ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

      (b) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator; and

   (2) The calculation methods described in Paragraph (1)(a) and (b) may include in-network cost-sharing, including multi-tier networks.

C. (1) Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set, in a format specified by HHS that can support the use of the AV Calculator as described in Subsection A, will be used as the standard population to calculate AV in accordance with Subsection A.

   (2) The AV will be calculated using the default standard population described in Paragraph (3), unless a data set in a format specified by HHS that can support the use of the AV Calculator, as described in Subsection A, is submitted by a state and approved by HHS consistent with the requirements of 45 CFR §156.135(d) by a state specified by HHS.
(3) The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in Subsection A.

D. (1) The AV, calculated as described in Subsections A through C, and within a de minimis variation as defined in Paragraph (3), determines whether a health benefit plan offers a bronze, silver, gold or platinum level of coverage.

(2) The levels of coverage are:

(a) A bronze plan is a health benefit plan that has an AV of 60%.

(b) A silver plan is a health benefit plan that has an AV of 70%.

(c) A gold plan is a health benefit plan that has an AV of 80%.

(d) A platinum plan is a health benefit plan that has an AV of 90%.

(3) The allowable variation in the AV of a health benefit plan that does not result in a material difference in the true dollar value of the health benefit plan is +/-2 percentage points.

Section 16. Enrollment in Catastrophic Plans

A. A health benefit plan is a catastrophic plan if it meets the following conditions:

(1) Meets all of the applicable requirements for individual market health insurance coverage and is offered only in the individual market;

(2) Does not provide a bronze, silver, gold or platinum level of coverage described in Section 1302(d) of the Federal Act;

(3) Provides coverage of essential health benefits under Section 1302(b) of the Federal Act once the annual limitation on cost-sharing in Section 1302(c)(1) of the Federal Act is reached and, except as provided in Paragraph (4) and Subsection B, provides no benefits for any policy year until such limitation on cost-sharing is reached;

(4) Provides coverage for at least three (3) primary care visits per year before reaching the deductible; and

(5) Covers only individuals who meet either of the following conditions:

(a) Have not attained the age of thirty (30) years prior to the first day of the policy year; or

(b) Have received a certificate of exemption for reasons identified in Section 1302(e)(2)(B)(i) or (ii) of the Federal Act.

B. A catastrophic plan may not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, for preventive services, in accordance with Section 2713 of the Public Health Service Act (PHSA).

C. For other than self-only coverage, each individual enrolled must meet the requirements of Subsection A(5).

Section 17. Provision of Summary of Benefits and Coverage; Uniform Glossary

Drafting Note: States should be aware that in addition to the provisions of 45 CFR §147.200, the federal agencies charged with implementing the ACA have issued extensive sub-regulatory guidance in the form of frequently asked questions (FAQs)
and enforcement safe harbors for issuers subject to Section 2715 of the PHSA and the implementing federal regulations. The drafting note below details this sub-regulatory guidance and issuer enforcement safe harbors.

**Drafting Note:** The federal agencies charged with implementing the provisions of the ACA, including the provisions of Section 2715 of the PHSA and the implementing federal regulations, have maintained their intent to continue the safe harbors and other enforcement relief provided to issuers for the first year of applicability related to the requirement to provide a Summary of Benefits and Coverage (SBC) and a uniform glossary during subsequent years of applicability. The federal agencies confirmed this intent in the Affordable Care Act Implementation FAQs Part XIV, Q5-Q8 issued April 23, 2013, with respect to the second year of applicability. Specifically, the federal agencies, May 2, 2014, “in recognition of and to ensure a smooth transition to new market changes in 2014,” believe it prudent to extend the following previously-issued enforcement and transition relief guidance to apply through the end the second year of applicability until further guidance is issued:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the federal agencies’ basic approach to implementation of the SBC requirements during the first year of applicability);
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer’s obligation to provide an SBC with respect to benefits it does not insure); and
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage).

In addition, the federal agencies have extended the following enforcement relief through the second year of applicability, consistent with existing guidance:

- The Special Rule contained in the Instruction Guides for Group and Individual Coverage;
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically); and
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage).

Additionally, Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements) applies “until further guidance is issued.” The relief provided in this Affordable Care Act Implementation FAQs Part VIII, Q5 continues to apply, and plans and issuers may rely on this relief at least through the end of 2014.

The Departments also extended the enforcement safe harbor for plans and issuers with respect to insurance products that are no longer being offered for purchase (“closed blocks of business”) as initially provided in ACA Implementation FAQs Part IX, Q12. Specifically in ACA Implementation FAQs Part XIV, Q6, the initial relief provided is extended to Sept. 23, 2014, for plans and issuers with respect to an insured product that meets three conditions:

- The insured product is no longer being actively marketed;
- The health insurance issuer stopped actively marketing the product prior to Sept. 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and
- The health insurance issuer has never provided an SBC with respect to the insured product.

That is, if a health insurance product is not being actively marketed and the health insurance issuer has not actively marketed the product at any time on or after Sept. 23, 2012, the federal agencies will not take any enforcement action against the plan or issuer for failing to provide an SBC before Sept. 23, 2014 with respect to a product, provided the SBC is provided for that product no later than Sept. 23, 2014. However, if an insured product was actively marketed for business on or after Sept. 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the insured product, the plan and issuer must provide the SBC with respect to such coverage, as required by Section 2715 of the PHSA and the final regulations.
A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must provide a summary of benefits and coverage (SBC) for each benefit package without charge to the individuals described in this section and in accordance with this section.

Drafting Note: States should be aware that, as enacted, the Federal Act retained, with amendment, what was Section 2713 of the PHSA, now Section 2709 of the PHSA (Disclosure of Information), which requires health carriers to disclose information to individuals concerning the carrier’s right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health insurance coverage for which the individual is qualified. The provisions of this section do not include these required disclosure requirements.

B. (1) A health carrier must provide an SBC to an individual covered under the health benefit plan, including every dependent, upon receiving an application for any plan, as soon as practicable following receipt of the application, but in no event later than seven (7) business days following receipt of the application.

(2) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the individual no later than the first day of coverage.

(3) (a) A health carrier must provide the SBC to policyholders annually at renewal in accordance with Subparagraph (b) of this paragraph. The SBC must reflect any modified plan terms that would be effective on the first day of the new policy year.

(b) The SBC must be provided as follows:

(i) If written application is required in either paper or electronic form for renewal or reissuance, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or

(ii) If renewal or reissuance is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new policy year; however, if the policy, certificate or contract of insurance has not been issued or renewed before such 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issuance of the new policy, certificate or contract of insurance or the receipt of the written confirmation of intent to renew, whichever is earlier.

(4) (a) A health carrier must provide an SBC to any individual or dependent anytime the individual or dependent requests an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

(b) For purposes of this subsection, a request for an SBC or summary information about a health insurance product includes a request made both before and after an individual submits an application for coverage.

(5) If a health carrier provides a single SBC to an individual and any dependents at the individual’s last known address, then the carrier’s requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent’s last known address is different than the individual’s last known address, the carrier must provide a separate SBC to the dependent at the dependent’s last known address.

C. (1) Subject to Paragraph (3), an SBC provided under this section must include the following:
(a) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of, or exceptions to, their coverage, in accordance with guidance as specified by the Secretary;

(b) A description of the coverage, including cost-sharing, for each category of benefits identified by the Secretary in guidance;

(c) The exceptions, reductions and limitations of coverage;

(d) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

(e) The renewability and continuation of coverage provisions;

(f) Coverage examples in accordance with Paragraph (2);

(g) A statement about whether the coverage provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code of 1986, as amended and whether the coverage’s share of the total allowed costs of benefits provided under the coverage meets applicable requirements;

(h) A statement that the SBC is only a summary and that the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(i) Contact information for questions and obtaining a copy of the insurance policy, certificate or contract of insurance, such as a telephone number for customer service and a publicly accessible Internet address where a copy of the plan document or the insurance policy, certificate or contract of insurance can be reviewed and obtained;

(j) For carriers that maintain one or more provider networks, an Internet address, or similar contact information, for obtaining a list of network providers;

(k) For carriers that use a formulary in providing prescription drug coverage, an Internet address, or similar contact information, for obtaining information on prescription drug coverage; and

(l) An Internet address for obtaining the uniform glossary, as described in Subsection H, as well as a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(2) (a) The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the coverage for common benefit scenarios, including pregnancy and serious or chronic medical conditions in accordance with this paragraph. The Secretary may identify up to six (6) coverage examples that may be required in an SBC.

(b) For purposes of this paragraph, a benefit scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specified period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

Drafting Note: The HHS Secretary of will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.
For purposes of this paragraph, to illustrate benefits provided under the coverage for a particular benefits scenario, a carrier simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the policy or benefit package.

The illustration of benefits provided will take into account any cost-sharing, excluded benefits and other limitations on coverage as specified by the Secretary in guidance.

In lieu of summarizing coverage for items and services provided outside of the United States, a carrier may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States.

Drafting Note: In Frequently Asked Questions (FAQs), the federal agencies charged with implementing the ACA provide that expatriate coverage is not subject to the ACA requirements for plan years ending before Dec. 15, 2015, including the requirements to provide an SBC with respect to expatriate coverage during the first year of applicability. States should refer to the Drafting Note at the beginning of this section for additional information regarding this enforcement safe harbor.

In any case, the carrier must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the coverage within the United States.

A carrier must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in regulations and applicable guidance.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the safe harbor for plans and issuers provided in the Special Rule in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition) for completing the SBC. As stated in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition), the Special Rule provides: “To the extent a plan’s terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program.”

The SBC must be provided in a uniform format, use terminology understandable by the average individual covered under the policy, not exceed four (4) double-sided pages in length and not include print smaller than 12-point font.

The carrier must provide the SBC as a stand-alone document.

A carrier must provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the circumstances in which a SBC may be provided electronically consistent with the safe harbor provided by the federal agencies.

A carrier satisfies the requirements of this subsection if the carrier:

(a) Hand-delivers a printed copy of the SBC to the individual or dependent;

(b) Mails a printed copy of the SBC to the mailing address provided to the carrier by the individual or dependent;
(c) Provides the SBC by email after obtaining the individual’s or dependent’s agreement to receive the SBC or other electronic disclosures by email;

(d) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with Subparagraphs (a) through (c) of this paragraph, that the SBC is available on the Internet and includes the applicable Internet address; or

(e) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

(3) An SBC may not be provided electronically unless:

(a) The format is reasonably accessible;

(b) The SBC is placed in a location that is prominent and readily accessible;

(c) The SBC is provided in an electronic form which can be electronically retained and printed;

(d) The SBC is consistent with the appearance, content and language requirements of this section; and

(e) The carrier notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.

(4) A carrier that provides the content required under Subsection C, as specified in guidance published by the Secretary, to the federal health reform Web portal described in 45 CFR 159.120 will be deemed to satisfy the requirements of Subsection B(4) with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this paragraph should be construed as otherwise limiting the carrier’s obligations under this section.

F. A health carrier must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this section, a carrier is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR §147.136(e) are met as applied to the SBC.

G. (1) If a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act makes any material modification, as defined under section 102 of ERISA, in any terms of the coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with renewal or reissuance of coverage, the health carrier must provide notice of the modification to an individual covered under a health benefit plan not later than sixty (60) days prior to the date on which the modification will become effective.

(2) The health carrier must provide the notice of modification in a form that is consistent with Subsection E.

H. (1) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must make available to applicants, policyholders and covered dependents, the uniform glossary described in Paragraph (2) of this subsection in accordance with the appearance and form and manner requirements of Paragraphs (3) and (4).

(2) The uniform glossary must provide uniform definitions, specified by the Secretary in guidance of the following health-coverage-related terms and medical terms:
(a) Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital outpatient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care;

(b) Such other terms as the Secretary determines are important to define so that individuals may compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits, as specified in guidance.

(3) A carrier must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable to the average individual covered under a health insurance policy.

(4) A carrier must make the uniform glossary described in this subsection available upon request, in either paper or electronic form (as requested), within seven (7) business days after receipt of the request.

Drafting Note: States should be aware that consumers may review and obtain the uniform glossary at several websites, including www.healthcare.gov (Centers for Medicare and Medicaid Services (CMS)), www.cciio.cms.gov (Center for Consumer Information and Insurance Oversight (CCIIO)), and www.dol.gov/ebsa/healthreform (U.S. Department of Labor (DOL), Employee Benefits Security Administration (EBSA)).

Section 18. Certification and Disclosure of Prior Creditable Coverage

Drafting Note: The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 10295) in the Federal Register Feb. 24, 2014, finalizing their proposed rule to amend 45 CFR §146.115 to eliminate the requirement for the group market to provide certificates of credible coverage and to demonstrate credible coverage. There is no corresponding notice of proposed rulemaking (NPRM) or final rule that provides the same amendment for the individual market. However, states should be aware that 45 CFR §146.115 contained in the 2004 HIPAA regulations implemented the provisions of Section 2701(e) of the PHSA, as enacted by HIPAA. The Federal Act amended Section 2701(e) to include the individual market and transferred it to Section 2704(e) of the PHSA. As such, although this section has been included in this regulation, states may want to consider not including this section or revising it for consistency with the amended 45 CFR §146.115, as finalized.

A. This section applies to all health carriers offering a health benefit plan providing individual market health insurance coverage subject to the Act.

B. (1) A certificate must be provided, without charge, for individuals who are or were covered under a health benefit plan providing individual market health insurance coverage as follows:

   (a) An automatic certificate must be provided within a reasonable time period consistent with state law after the individual ceases to be covered under the plan; and

   (b) Requests for certificates may be made by, or on behalf of, an individual within twenty-four (24) months after coverage ends.

   (2) Except as provided in Subparagraph (b) of this paragraph, the carrier must provide the certificate in writing, including any form approved by CMS.
(b) No written certificate must be provided if all of the following occur:

(i) An individual is entitled to receive a certificate;

(ii) The individual requests that the certificate be sent to another plan or carrier instead of the individual;

(iii) The plan or carrier that would otherwise receive the certificate agrees to accept the information in Paragraph (3) through means other than a written certificate; and

(iv) The receiving plan or carrier receives the information from the sending carrier in the prescribed form within the time periods required under Paragraph (1).

(c) The certificate must include the following:

(i) The date the certificate is issued;

(ii) The name of the individual or dependent for whom the certificate applies, and any other information necessary for the carrier providing the coverage specified in the certificate to identify the individual, such as the individual’s identification number under the policy and the name of the policyholder if the certificate is for, or includes, a dependent;

(iii) The name, address and telephone number of the carrier required to provide the certificate;

(iv) The telephone number to call for further information regarding the certificate, if different from item (iii);

(v) Either one of the following:

(I) A statement that the individual has at least eighteen (18) months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, as defined in 45 CFR §146.113(b)(2)(iii); or

(II) Both the date the individual first sought coverage, as evidenced by a substantially complete application, and the date creditable coverage began; and

(vi) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(d) If an automatic certificate is provided under Paragraph (1)(a), the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate under Paragraph (1)(b), a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request, or continuing on the date of the request. A separate certificate may be provided for each period of continuous coverage.

(e) A carrier may provide a single certificate for both an individual and the individual’s dependents if it provides all of the required information for each individual and dependent, and separately states the information that is not identical.

(f) The requirements of Paragraph (2)(c) are satisfied if the carrier provides a certificate in accordance with a model certificate provided by CMS.

(g) No certificate is required to be furnished with respect to excepted benefits described in 45 CFR §148.220. If excepted benefits are provided concurrently with other creditable coverage, such that the coverage does not consist solely of excepted benefits, information concerning the benefits may be required to be disclosed in Subsection C.

(3) (a) The certificate is required to be provided, without charge, to each individual described in Paragraph(1)(a) or an entity requesting the certificate on behalf of the individual. The certificate may be
provided by first-class mail. If the certificate or certificates are provided to the individual and the individual’s spouse at the individual’s last known address, the requirements of this paragraph are satisfied with respect to all individuals and dependents residing at that address. If a dependent’s last known address is different than the individual’s last known address, a separate certificate must be provided to the dependent at the dependent’s last known address. If separate certificates are provided by mail to individuals and dependents who reside at the same address, separate mailings of each certificate are not required.

(b) A carrier must establish a procedure for individuals and dependents to request and receive certificates under Paragraph 1(b).

c
(i) If an automatic certificate is required to be provided under Paragraph 1(a), and the individual or dependent entitled to receive the certificate designates another individual or entity to receive the certificate, the carrier responsible for providing the certificate may provide the certificate to the designated party.

(ii) If a certificate must be provided upon request under Paragraph 1(b), and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the carrier responsible for providing the certificates must provide the certificate to the designated party.

4) A carrier must use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. If an automatic certificate must be furnished with respect to a dependent under Paragraph 1(a), no individual certificate must be furnished unless the carrier knows, or make reasonable efforts should know, of the dependent’s cessation of coverage under the plan.

(b) If a certificate furnished by a carrier does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in Subsection D(3) for demonstrating dependent status.

C. (1) If an individual enrolls in a group health insurance plan and the plan or carrier uses the alternative method of determining creditable coverage described in 45 CFR §146.113(c), the individual provides a certificate of coverage under Subsection B or demonstrates creditable coverage under Subsection D, and the plan or coverage in which the individual enrolls requests from the prior entity, the prior entity must disclose promptly to the requesting plan or carrier (“requesting entity”) the information set forth in Paragraph (2).

(2) The prior entity must identify to the requesting entity the category of benefits under which the individual was covered and with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs to determine the individual’s creditable coverage with respect to any of those categories. The prior entity must promptly disclose to the requesting entity the creditable coverage information that was requested.

(3) The prior entity furnishing the information under Paragraph (2) may charge the requesting entity for the reasonable cost of disclosing the information.

D. (1) An individual may establish creditable coverage through means other than a certificate. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of other means.

(2) (a) A carrier must take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on relevant facts and circumstances, whether or not an individual has eighteen (18) months of creditable coverage.

(i) A carrier must treat the individual as having furnished a certificate if the individual attests to the period of creditable coverage, the individual presents relevant corroborating evidence of some creditable
coverage during the period, and the individual cooperates with the carrier’s efforts to verify the individual’s coverage.

(II) For this purpose, cooperation includes providing, upon the carrier’s request, a written authorization for the carrier to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and dates of creditable coverage.

(III) While a carrier may refuse to credit coverage if the individual fails to cooperate with the carrier’s efforts to verify coverage, the carrier may not consider an individual’s ability to obtain a certificate to be evidence of the absence of creditable coverage.

(b) Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit (EOB) claims or other correspondence from a plan or carrier indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health plan, records from medical care providers indicating health coverage, third party statements verifying periods of coverage and any other relevant documents that evidence periods of health coverage.

(c) Creditable coverage (and waiting period or affiliation period information) may be established through other means other than documentation, such as by a telephone call from the carrier to a third party verifying creditable coverage.

(3) If, in the course of providing evidence, including a certificate, of creditable coverage, an individual is required to demonstrate dependent status, the carrier must treat the individual as having furnished a certificate showing dependent status if the individual attests to the dependency and the period of the status and the individual cooperates with the carrier’s efforts to verify the dependent status.

Section 18. Certification and Disclosure of Prior Creditable Coverage

Drafting Note: The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 30341) in the Federal Register May 27, 2014, amending 45 CFR §148.124 to eliminate the requirement in the individual market to provide certificates of credible coverage and to demonstrate creditable coverage. The language in this section is consistent with the language from the final rule.

A. The federal rules for providing certificates of creditable coverage and demonstrating creditable coverage under 45 CFR §148.124 have been superseded by the prohibition on preexisting condition exclusions in accordance with Section 2704 of the Public Health Service Act.

B. The provisions of this section apply beginning December 31, 2014.

Section 19. Rules Related to Fair Marketing

A. A health carrier offering health benefit plans providing individual market health insurance coverage subject to the Act must actively market each of its health benefit plans to individuals in this state, except that for closed blocks of coverage, a health carrier must offer coverage upon request and is not required to actively market such coverage.

Drafting Note: This regulation requires the active marketing of all individual market health benefit plans offered by a carrier. This requirement is present to prevent targeted marketing by a carrier or producer. Marketing materials should make clear, however, that not all individuals may be eligible for all individual market health benefit plans issued by the carrier. Those materials should also make clear that some individual market health benefit plans may only be available in certain geographic areas.

B. The health carrier shall maintain a toll-free telephone service that answers its telephone calls in a timely manner to provide information to individuals regarding the availability of individual market health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the
The health carrier may not require an individual to join or contribute to an association or group as a condition of being accepted for coverage by the carrier.

D. The health carrier may not require, as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

E. (1) A health carrier must file annually the following information with the commissioner related to individual market health benefit plans issued by the carrier to individuals in this state:

(a) The number of individuals that were issued, or received renewals of, individual market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(b) The number of individual market health benefit plans in force in the state as of December 31 of the previous calendar year;

Drafting Note: Instead of requesting information on the number of individual health benefit plans in force in the state, as provided in Subparagraph (b) above, a state may decide it is more appropriate to request such information by county, three-digit zip code or metropolitan statistical area and non-metropolitan statistical area geographic divisions.

(c) The number of individual market health benefit plans that were voluntarily not renewed by individuals in the previous calendar year; and

(d) The number of individual market health benefit plans that were terminated or not renewed and reasons (other than nonpayment of premium) for the termination or nonrenewal by the carrier in the previous calendar year.

(2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.

F. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its individual market health benefit plans. The commissioner shall have authority to review a carrier’s commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its individual market health benefit plans are created by the structure.

G. A health carrier may not employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual’s race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection G above and, if necessary, revise the language in Subsection G.

Section 20. Rules Related to Quality of Care Reporting

To be completed at a later date.
Section 21. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 22. Effective Date

This regulation shall be effective on [insert date].
Comments are being requested on this draft by Sept. 16, 2014. The revisions to this draft reflect changes made from the previous March 12, 2014, draft. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

Section 1. Statement of Purpose
This regulation is intended to implement the provisions of the Small Group Market Health Insurance Coverage Model Act ("Act"). The purposes of the Act and this regulation are to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the small group market and provide for the establishment of coverage and other benefit requirements in the small group market.

Section 2. Definitions
As used in this regulation:

A. "Actuarial Value" or "AV" means the percentage paid by a health benefit plan of the total allowed costs of benefits.

B. "Annual open enrollment period" means the period each year during which a small employer, eligible employee or covered person may enroll or change coverage in a health benefit plan.

C. "Benefit year" means a calendar year for which a health benefit plan provides coverage for health benefits.

D. "CMS" means the federal Centers for Medicare and Medicaid Services.

E. "Cost-sharing" means any expenditure required by or on behalf of a covered person with respect to essential health benefits.

   (1) "Cost-sharing" includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.
“EHB-benchmark plan” means the standardized set of essential health benefits (EHB) that a health carrier must provide as required by the commissioner or Secretary.

“Enrollment date” means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

“HHS” means the U.S. Department of Health and Human Services.

(1) “Health factor” means, in relation to any individual, any of the following health status-related factors:

(a) Health status;
(b) Medical condition, including both physical and mental illnesses;
(c) Claims experience;
(d) Receipt of health care services;
(e) Medical history;
(f) Genetic information;
(g) Evidence of insurability, including:
   (i) Conditions arising out of acts of domestic violence; or
   (ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or
(h) Disability.

(2) For purposes of this subsection, “health factor” does not include the decision whether to elect small group market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.

“Late enrollee” means an individual whose enrollment in a health benefit plan is a late enrollment.

“Late enrollment” means enrollment of an individual in a health benefit plan providing small group market health insurance coverage other than the earliest date on which coverage can be effective for the individual under the terms of the plan.

“Minimum essential coverage” has the meaning stated in section 5000A(f) of the Internal Revenue Code (Code).

“Percentage of the total allowed costs of benefits” means the anticipated covered medical spending for EHB coverage, as defined in Section 3L of the Act, paid by a health benefit plan for a standard population, computed in accordance with the plan’s cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and express as a percentage.

“Plan” means, with respect to a health carrier and a product, the pairing of health insurance coverage benefits under the product with a metal tier level, as described in section 1302(d) and (e) of the Federal Act. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.
§NN. “Plan year” means the year that is designated as the plan year in the plan document of a health benefit plan providing small group market health insurance coverage, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible or limit year used under the plan;
2. If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;
3. If the plan does not impose deductibles or limits on a yearly basis, and the policy is not renewed on an annual basis, the plan year is the employer’s taxable year; or
4. In any other case, the plan year is the calendar year.

O. “Product” means a discrete package of health insurance coverage benefits that a health carrier offers using a particular product network type within a geographic service area.

Q. “Special enrollment period” means a period during which an eligible employee or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the annual open enrollment periods.

P. “Wellness program” means a program of health promotion or disease prevention.

Section 3. Applicability and Scope

Subject to the provisions in Section 4 of the Act and specific provisions in this regulation, this regulation is applicable to health carriers offering health benefit plans providing small group market health insurance coverage in this State.

Section 4. Restrictions Relating to Premium Rates

A. The premium rate charged by a health carrier offering a health benefit plan providing small group market health insurance coverage, in accordance with Section 5 of this regulation, may vary only, with respect to the particular coverage involved, on the basis of the following:

1. Whether the coverage covers an individual or family:
   (a) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member, except that if there are more than three (3) covered children under the age of twenty-one (21), only the premiums for the three (3) oldest children under the age of twenty-one (21) must be taken into account in determining the total family premium; the total family premium shall include only the premiums for the three (3) oldest covered children under the age of twenty-one (21);
   (b) For family coverage, any rating premium variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

Drafting Note: As specified in 45 CFR §147.102(c)(3), a state has the option to establish uniform family tiers and uniform rating multipliers for those tiers in lieu of the family rating methodology specified in Subparagraphs (a) and (b) of this paragraph, but only if the state does not permit any rating variation for age and tobacco use described the factors described in Paragraphs (3) and (4). If a state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology in this section under Subparagraphs (a) and (b) of this paragraph will apply in that state.

(c) The total premium charged to the small group is determined by summing the premiums of covered persons in accordance with Subparagraphs (a) and (b) of this paragraph, or for a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4), the methodology established by the state for calculating total premium; and
Nothing in this section precludes a state from requiring a health carrier to offer, or a health carrier from voluntarily offering, to group premiums that are based on the average covered person amounts, provided the total small group premium is the same total amount derived in accordance with Subparagraphs (a) and (b) of this paragraph or determined using the methodology to calculate total premium established by a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4).

**Drafting Note:** States should be aware that in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015-Notice of Proposed Rulemaking (NPRM) (78 FR 72922); Final Rule (79 FR 13743) published in the *Federal Register* Dec. 2, 2013March 11, 2014, proposed additional standards for composite rating found provides in 45 CFR §147.102(c)(3) that a state may require a health carrier to offer or a health carrier may voluntarily offer to a small employer group premiums that are based on the average covered amounts provided the total small employer group premium is the same total amount derived in accordance with Subparagraphs (a) and (b) of this paragraph or determined using the methodology to calculate premium established by a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4). If a state requires a health carrier to offer, or a health carrier decides to voluntarily offer, a small employer group premiums that are based on the average covered person amounts or a health carrier voluntarily offers such premiums, then effective for plan years beginning on or after Jan. 1, 2015, the health carrier must comply with the additional requirements found in 45 CFR §147.102(c)(3)(ii).

(2) (a) (i) Geographic rating area, as established by HHS in accordance with 45 CFR §147.102(b), unless the commissioner establishes alternative geographic rating areas pursuant to Item (ii) of this subparagraph; and

(ii) The commissioner may adopt regulations establishing uniform geographic rating area subject to the provisions of 45 CFR §147.102(b); and

**Drafting Note:** States choosing to limit the permissible variation based on geographic rating areas, or to establish uniform geographic area multipliers, should consider incorporating those provisions in an additional provision under this paragraph, such as Item (iii).

**Drafting Note:** States should be aware that 45 CFR §147.102(b) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish one or more geographic rating areas within that state. If a state does not establish geographic rating areas, or the federal Centers for Medicare and Medicaid Services (CMS) determines that the state’s geographic rating areas are not adequate, the default will be one geographic rating area for each metropolitan statistical area in the state and one geographic rating comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget (OMB).

(b) For purposes of this paragraph, geographic rating area is to be determined in the small group market using the small employer’s principal business address;

(3) Age:

(a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);

(b) The rate for each covered person must be based on the covered person’s age as of the date of plan issuance or renewal or addition to the plan;

(c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147.102(e), unless the commissioner establishes an alternative age rating curve pursuant to Subparagraph (d) of this paragraph; and

(d) The commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147.102(e). Any uniform age rating curve must be based on the following uniform age bands:
(i) A single age band for individuals age 0 through 20;

(ii) One-year age bands for individuals age 21 through 63; and

(iii) A single age band for individuals age 64 and older; and

**Drafting Note:** States should be aware that 45 CFR §147.102(e) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish a uniform age rating curve in the individual or small group market, or both markets. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with 45 CFR §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(4) Subject to Section 2705 of the Public Health Service Act (PHSA) and its implementing regulations (related to prohibiting discrimination based on health status and programs of health promotion or disease prevention), tobacco use:

(a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;

(b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;

(c) A rating charge for “tobacco use” may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and

(d) The health carrier may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health carrier must consider “tobacco use” in terms of when a tobacco product was last used.

**Drafting Note:** States should be aware that federal law does not preempt state laws that impose stronger consumer protections than federal law. Therefore, states may prohibit tobacco use as a rating factor or may impose stronger restrictions on tobacco use rating than the restrictions in this Regulation as provided in Paragraph (4) above.

B. A premium rate may not vary with respect to a particular coverage involved by any other factor not described in Subsection A.

C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

**Section 5. Single Risk Pool**

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must consider the claims experience of all covered persons in all other health benefit plans (other than grandfathered health plan coverage) subject to Section 5 of the Act and offered by the carrier in the small group market in a state, including covered persons who do not enroll in such plans through the exchange, to be members of a single risk pool.

**Drafting Note:** As specified in 45 CFR §156.80, a state may require the individual and small group health insurance markets within the state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in 45 CFR §147.103.

B. (1) (a) A health carrier must establish an index rate that is effective January 1 of each calendar year for the small group market, described in Subsection A or, if applicable, a merged market, if the state has required such merger, based on the total combined claims cost for providing essential health benefits within the single risk pool of that state market.

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(b) The index rate must be adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and exchange user fees (expected to be remitted under 45 CFR §156.50(b) or §156.50(c) and (d), as applicable, plus the dollar amount under 45 §156.50(d)(3)(i) and (ii) expected to be credited against user fees payable in that state market).

(c) The premium rate for all of the health carrier’s plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to plan-level adjustments permitted in Paragraph (2).

(2) For policy plan years beginning on or after January 1, 2014, a health carrier may vary premium rates for a particular health benefit plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(a) The actuarial value and cost-sharing design of the plan;

(b) The plan’s provider network, delivery system characteristics and utilization management practices;

(c) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits; and

(d) Administrative costs, excluding exchange user fees; and

(e) With respect to catastrophic plans, if applicable, the expected impact of the specific eligibility categories for those plans.

(3) (a) A health carrier may not establish an index rate and make the market-wide adjustments pursuant to Paragraph (1), or make the plan-level adjustments pursuant to Paragraph (2), more or less frequently than annually, except as provided in Subparagraph (b) of this paragraph.

(b) Beginning the quarter after HHS issues notification that the federally-facilitated Small Business Health Options Program (SHOP), as that term is defined in 45 CFR §155.20, can process quarterly rate updates, a health carrier in the small group market (not including a merged market) may establish index rates and make the market-wide adjustments pursuant to Paragraph (1), and make the plan-level adjustments pursuant to Paragraph (2), no more frequently than quarterly, provided that any changes to rates must have effective dates of January 1, April 1, July 1 or October 1.

C. This section does not apply to grandfathered health plan coverage in accordance with the provisions of 45 CFR §147.140.

Section 6. Guaranteed Availability of Small Group Market Health Insurance Coverage; Enrollment Periods

A. Subject to Subsections B through D and Section 6 of the Act, a health carrier offering a health benefit plan providing small group market health insurance coverage must offer to any small employer in the state all products that are approved for sale in the small group market and must accept any small employer that applies for coverage under any of those products.

B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

C. (1) Subject to Paragraph (2), a health carrier must allow a small employer to purchase health insurance coverage at any point during the year.
A health carrier may limit the availability of coverage to an annual enrollment period that begins
November 15 and extends through December 15 of each year in the case of a plan sponsor that is
unable to comply with a material plan provision relating to employer contribution or group
participation rules as provided in Section 6D of the Act and Section 7B(3) of this regulation, and
pursuant to applicable state law.

D. (1) A health carrier must establish special enrollment periods for qualifying events consistent with the
requirements of Section 9 of the Act and as defined under section 603 of ERISA. These special
enrollment periods are in addition to any other special enrollment periods required under state or
federal law.

(2) In addition to the provisions of Paragraph (1), a health carrier must permit an individual to enroll
in a health benefit plan when:

(a) The individual is enrolled in a health benefit plan that is a network plan that does not
provide benefits to individuals who no longer reside, live or work in the service area and
the individual loses coverage under the plan because the individual no longer resides,
lives or works in the service area; and

(b) The individual is enrolled in a health benefit plan that no longer offers any benefits to the
class of similarly situated individuals, as described in Section 10C of this regulation that
includes the individual.

Drafting Note: States should be aware that federal preemption standards allow states to impose stronger consumer
protections in state law such as, for example, additional special enrollment periods or open enrollment periods that allow
individuals to purchase coverage more frequently that the federal minimum requirements.

E. (1) A health carrier must provide covered persons thirty (30) days after the date of the qualifying
event described in Subsection D to elect coverage.

(2) (a) The health carrier must offer to special enrollees all of the benefit packages available to
similarly situated individuals who enroll when first eligible for coverage and may not
require a special enrollee to pay more for coverage than a similarly situated individual
who enrolls in the same coverage when first eligible for coverage.

(b) Any difference in benefits or cost-sharing requirements for different individuals is a
different benefit package.

(3) The coverage must become effective consistent with the following based on when the health
carrier receives the election:

(a) Between the first and fifteenth day of any month, the health carrier must ensure a
coverage effective date of the first day of the following month; and

(b) Between the sixteenth and the last day of any month, the health carrier must ensure a
coverage effective date of the first day of the second following month.

F. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the
extent the grandfathered health plan coverage was required to comply with the guaranteed availability
provisions under section 2711 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the
effective date of the Federal Act.

Section 7. Guaranteed Renewability of Small Group Market Health Insurance Coverage

A. As provided in Section 7 of the Act and this section, subject to Subsection B, a health carrier offering a
health benefit plan providing small employer market health insurance coverage subject to the Act must
renew or continue in force the coverage at the option of the small employer.
B. A health carrier may nonrenew or discontinue health insurance coverage based only on one or more of the following:

(1) The plan sponsor has failed to pay premiums in accordance with the terms of the health insurance coverage, including any timeliness requirements;

(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;

(3) The plan sponsor has failed to comply with a material provision related to employer contribution or group participation requirements, pursuant to applicable state law. For purposes of this paragraph the following apply:

   (a) The term “employer contribution requirement” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and employee dependents; and

   (b) The term “group participation requirement” means a requirement relating to the minimum number of employees or employee dependents that must be enrolled in relation to a specified percentage or number of eligible employees of a small employer;

(4) The carrier is ceasing to offer coverage in the market in accordance with section 7D (discontinuing a particular product) or section 7E (discontinuing all coverage) of the Act and applicable state law; or

(5) For network plans, there is no longer any employee who lives, resides or works in the service area of the carrier (or the area for which the carrier is authorized to do business) using the same criteria the carrier under which the carrier would deny enrollment in the plan under Section 6E of the Act.

C. (1) At the time of coverage renewal only, a health carrier may modify the small group market health insurance coverage for a health benefit plan if, for product coverage available offered in the small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with state law and is effective uniformly among small group market health insurance plans with that plan product.

(2) For purposes of Paragraph (1), a modification made uniformly and solely pursuant to applicable federal or state law is considered a uniform modification of coverage if:

   (a) The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and

   (b) The modification is directly related to the imposition or modification of the federal or state requirement.

(3) Other types of modifications made uniformly are considered a uniform modification of coverage if the small group market health insurance coverage for the product meets all of the following criteria:

   (a) The product is offered by the same health carrier, as that term is defined in section 3B of the Act;

   (b) The product is offered as the same product network type;

   (c) The product continues to cover at least a majority of the same service area;
(d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services, or to maintain the same metal tier level described in section 1302(d) and (e) of the Federal Act; and

(e) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, as described in section 5B of this regulation, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable federal or state requirements.

Drafting Note: States should be aware that 45 CFR §147.106(e)(4) permits a state to broaden the standards described in Paragraph (3)(b) and (c) above.

D. If a health carrier is renewing small group market health insurance coverage as described in Subsection A, or uniformly modifying coverage as described in Subsection C, the health carrier must provide to each plan sponsor written notice of the renewal at least sixty (60) calendar days before the date of the coverage will be renewed in a form and manner specified by the Secretary.

DE. In the case of group health insurance coverage that is made available by a health carrier in the small group market to small employers only through one or more associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to a small employer member of the association, to include a reference to the small employer.

F. Nothing in this section should be construed to require a health carrier to renew or continue in force small group market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.

EG. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under section 2712 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 8. Prohibition on Waiting Periods Exceeding Ninety (90) Days

A. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage may not apply any waiting period longer than ninety (90) days.

(2) (a) A health carrier may not consider the period before an individual’s late or special enrollment date a waiting period.

(b) (i) If an individual loses eligibility for coverage under the health benefit plan and subsequently becomes eligible for coverage, a health carrier may only consider the individual’s most recent period of eligibility in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage.

(ii) Similarly, a health carrier must apply the provisions of Item (i) to an individual who becomes eligible for coverage under the health benefit plan after a suspension of coverage that applied generally under the plan.

B. (1) (a) Except as provided in Paragraphs (2) and (3), an individual is otherwise eligible to enroll under the terms of a health benefit plan if the individual has met the plan’s substantive eligibility conditions, such as being in an eligible job classification, achieving job-related licensure requirements specified in the plan’s terms or satisfying a reasonable bona fide employment-based orientation period.
(b) A plan sponsor is not required to offer small group market health insurance coverage to any particular individual or class of individuals despite the individual being otherwise eligible to enroll under the plan, but individuals otherwise eligible for coverage under the plan may not be required to wait more than ninety (90) days before coverage is effective.

(2) Conditions of eligibility to enroll for coverage under the terms of a health benefit plan may be based solely on the lapse of a time period, but only for a time period of no more than ninety (90) days.

(3) (a) Other conditions of eligibility to enroll for coverage under the terms of a health benefit plan are permitted unless the condition is designed to avoid compliance with this section as determined in accordance with the following provisions:

(i) Subject to Subparagraph (b) of this paragraph, if eligibility is based on an employee having a specified number of hours of service per pay period, or working full-time, and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period, or work full-time, the terms of the health benefit plan may allow a reasonable time period of time, not to exceed twelve (12) months and beginning on any date between the employee’s employment start date and the first day of the first calendar month following the employee’s start date, to determine whether the employee meets the plan’s eligibility condition; or

(ii) If eligibility is based on an employee’s having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.

(b) Except for cases in which the health benefit plan imposes a waiting period exceeding a 90-day period in addition to a measurement period, as described in Subparagraph (a)(i) of this paragraph, the time period for determining whether the employee meets the plan’s eligibility requirements will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no more than thirteen (13) months after the employee’s employment start date plus the time remaining until the first day of the next calendar month if the employee’s employment start date is not the first day of a calendar month.

(c) (i) To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month.

(ii) For purposes of Item (i), one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee’s start date in a position otherwise eligible for small group market health insurance coverage under the health benefit plan.

C. The health carrier may treat an employee whose employment has terminated and then rehired as newly eligible to enroll for coverage upon rehire and, therefore, required to meet the health benefit plan’s eligibility requirements and waiting period anew, if reasonable under the circumstances and the termination and rehiring is not used or designed as a subterfuge to avoid compliance with the 90-day waiting period limitation.

D. (1) Under this section, all calendar days are counted beginning on the enrollment date, including weekends and holidays.
(2) For administrative convenience, a health carrier that imposes a 90-day waiting period may choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

E. A health carrier satisfies the requirements of this section if, under the terms of the health benefit plan, an individual employee can elect coverage that begins on a date before the end of a 90-day waiting period and may not be considered in violation of this section if an individual employee takes, or is permitted to take, additional time beyond any 90-day waiting period to elect coverage.

F. A health carrier that relies on the eligibility information reported to it by the small employer will not be considered to violate the requirements of this section with respect to the carrier’s administration of any waiting period if the following is satisfied:

(1) The carrier requires the small employer to make a representation and update this representation with any changes regarding the terms of any eligibility conditions or waiting periods imposed before an individual is eligible for coverage under the health benefit plan; and

(2) The carrier has no specific knowledge of a waiting period imposed that exceeds the permitted 90-day period.

Section 9. Prohibition of Preexisting Condition Exclusions

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not impose any preexisting condition exclusions as provided in Section 9A of the Act.

B. As described in Section 4 of the Act, a grandfathered health plan coverage that is individual health insurance coverage is not required to comply with this section.

Section 10. Prohibition on Discrimination Based on Health Factors

Drafting Note: The Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively, the Departments) published joint final regulations implementing the HIPAA nondiscrimination and wellness provisions Dec. 13, 2006, at 71 FR 75014 (the 2006 regulations). These regulations implemented the provisions of Section 2702 of the Public Health Service Act (PHSA), as enacted by HIPAA, which generally prohibited group health plans and group health insurance issuers from discriminating against individual employees and their dependents in eligibility, benefits or premiums based on a health factor. These regulations, however, permitted group health plans and group health insurance issuers to establish certain rules which, under the ACA, are no longer permitted. One example of such rules is a provision in the 2006 regulations permitting group health plans and group health insurance issuers to impose rating differentials and preexisting condition exclusions for the group market. Because such provisions from the 2006 regulations are no longer permitted due to the ACA, they have not been included in this section. However, states should be aware that they may want to somehow retain these provisions for purposes of continued enforcement related to grandfathered health plan coverage and some group health benefit plan coverage with plans years that extend into 2014 (and possibly additional years, as permitted). States also should be beware that the ACA retained provisions from Section 2702 of the PHSA, now Section 2705 of the PHSA, as enacted by Section 1201 the ACA. For the group market only, this section provides for a general exception to the general rule to allow premium discounts or rebates and modification to otherwise applicable cost sharing, including copayments, deductibles or coinsurance, in return for adherence to certain programs of health promotion and disease prevention. States also should be aware that Section 2705 of the PHSA also extends the HIPAA nondiscrimination protections to the individual market. However, Section 2705 of the PHSA does not extend the wellness program exception to the prohibition on discrimination to coverage in the individual market.

A. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule for eligibility, including continued eligibility, of an employee to enroll for benefits under the plan that discriminates based on any health factor that relates to the employee or dependent of the employee.

(2) For purposes of this section, a rule of eligibility includes a rule relating to:
(a) Enrollment;
(b) The effective date of coverage;
(c) Waiting or affiliation periods;
(d) Late and special enrollment;
(e) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
(f) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Subsection C(1) and (2);
(g) Continued eligibility; and
(h) Terminating coverage, including disenrollment, of an individual under the plan.

(3) Nothing in this section prohibits a health carrier from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.

B. (1) (a) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not require an employee, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution rate that is greater than the premium or contribution rate for a similarly situated individual enrolled in the plan based on any health factor that relates to the employee or a dependent of the employee.

(b) In determining an individual employee’s premium or contribution rate, discounts, rebates, payments-in-kind and any other premium differential mechanisms shall be taken into account.

(2) (a) Subject to Subparagraph (b) of this paragraph, nothing in this subsection restricts the aggregate amount that a health carrier may charge a small employer for coverage under a plan.

(b) A health carrier may not quote or charge a small employer or an individual employee or dependent of an employee a different premium than that quoted or charged an individual employee in a group of similarly situated individuals based on a health factor unless permitted under Paragraph (3) or under Section 4 of this regulation.

(3) Notwithstanding Paragraphs (1) and (2), a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may establish a premium or contribution differential based on whether an individual has complied with the requirements of a wellness program that satisfies the requirements of Subsection E.

C. (1) (a) Subject to federal or state law or regulations and Subparagraph (b) of this paragraph, Subsection A does not require a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act to provide coverage for any particular benefit to any group of similarly situated individuals.

(b) (i) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act shall make the benefits provided
under a plan available uniformly to all similarly situated individuals, as those
groups are determined under Paragraph (2).

(ii) For any restriction on a benefit or benefits provided under a plan, the health
carrier:

(I) Shall apply the restriction uniformly to all similarly situated
individuals; and

(II) May not direct the restriction, as determined based on all of the relevant
facts and circumstances, at individual employees or dependents of
employees based on any health factor of the individual employee or a
dependent of the individual employee.

(iii) The health carrier may require a deductible, copayment, coinsurance or other
cost-sharing requirement in order to obtain a benefit under the plan if the cost-
sharing requirement:

(I) Applies uniformly to all similarly situated individuals; and

(II) Is not directed at individual employees or dependents of individual
employees based on any health factor of the individual employee or
dependent of an individual employee.

(iv) For purposes of this paragraph, a plan amendment applicable to all individuals
in one or more groups of similarly situated individuals under the plan and made
effective no earlier than the first day of the first plan year after the amendment is
adopted is not considered to be directed at any individual employee or
dependent of an individual employee.

(b) If the health carrier generally provides benefits for a type of injury, the health carrier may
not deny an individual employee or dependent of an employee benefits otherwise
provided under the plan for treatment of the injury if the injury results from an act of
domestic violence or a medical condition. This provision applies to an injury resulting
from a medical condition even if the medical condition is not diagnosed before the injury

(c) A health carrier offering a health benefit plan providing small group market health
insurance coverage subject to the Act with a cost-sharing mechanism, such as a
deductible, copayment or coinsurance, that requires a higher payment from an individual
employee, based on a health factor of that individual employee or dependent of the
individual employee, than for a similarly situated individual under the plan, does not
violate this subsection if the payment differential is based on whether the individual has
complied with the requirements of a wellness program that satisfies the requirements of
Subsection E.

(2) (a) This paragraph applies only within a group of individuals who are treated as similarly
situated individuals.

(b) (i) Subject to Subparagraph (d) of this paragraph, Subsection A does not prohibit a
health carrier offering a health benefit plan providing small group market health
insurance coverage subject to the Act from treating dependents of employees as
two (2) or more distinct groups of similarly situated individuals if the distinction
made between or among groups of dependents is based on a bona fide
employment-based classification that is consistent with the small employer’s
usual business practice.
whether an employment-based classification is bona fide shall be determined based on all of the relevant facts and circumstances.

(iii) For purposes of Item (ii), relevant facts and circumstances include whether the small employer uses the classification for purposes independent of qualification for health insurance coverage, such classifications may include:

(I) Full-time versus part-time status;

(II) Geographic location;

(III) Membership in a collective bargaining unit;

(IV) Date of hire;

(V) Length of service;

(VI) Current employee versus former employee status; and

(VII) Occupation.

(iv) A classification based on a health factor may not be determined to be a bona fide employment-based classification for purposes of this subsection unless the requirements of Subsection A(3) and Subsection B(3) are satisfied.

(c) Subject to Subparagraph (d) of this paragraph, Subsection A does not prohibit a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act from treating dependents of individual employees as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among the groups is based on any of the following factors:

(I) A bona fide employment-based classification of the individual employee through whom the dependent is receiving coverage;

(II) Relationship to the individual employee (e.g., as a spouse or as a dependent child);

(III) Marital status;

(IV) With respect to a dependent child of the individual employee, age or student status to the extent that such treatment does not conflict with the requirements of section 2714 of the PHSA; or

(V) Any other factor, if the factor is not a health factor.

(ii) Item (i) may not be construed to prevent the health carrier from providing more favorable treatment of individuals under the plan with adverse health factors in accordance with Subsection A(3) and Subsection B(3).

(d) Notwithstanding Subparagraphs (b) and (c) of this paragraph, unless permitted under Subsection A(3) or Subsection B(4), if the creation or modification of an employment or coverage classification is directed at individual employees or dependents of individual employees based on a health factor of an individual employee or a dependent of an individual employee, the classification is not permitted under this subsection.
D. (1) Except to the extent permitted under Paragraph (2)(b) or Paragraph (3), in accordance with Subsections A and B, a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual employee’s premium or contribution rate based on:

(a) Whether the individual employee is confined in a hospital or other health care institution; or

(b) The individual employee’s ability to engage in normal life activities.

(2) (a) In accordance with Subsections A and B, a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule for eligibility or set an individual’s premium or contribution rate based on whether the individual is actively-at-work, including whether the individual is continuously employed, unless absence from work due to any health factor is treated, for purposes of the plan, as being actively-at-work.

(b) Notwithstanding Subparagraph (a) of this paragraph, the health carrier may establish a rule for eligibility that requires an individual to begin work for the small employer sponsoring the plan before coverage under the plan becomes effective if the rule for eligibility applies regardless of the reasons for the absence.

(3) Notwithstanding Paragraphs (1) and (2), a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may establish a rule of eligibility or set an individual’s premium or contribution rate with respect to similarly situated individuals, as those groups are determined under Subsection C(2).

E. (1) For purposes of this subsection, the following terms have the meanings indicated:

(a) (i) “Activity-only wellness program” means a health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward, but does not require the individual to attain or maintain a specific health outcome.

(ii) Examples of an “activity-only wellness program” include walking, diet or exercise programs, which some individuals may be unable to participate or complete (or have difficulty participating or completing) due to a health factor, such as severe asthma, pregnancy or a recent surgery.

(b) (i) “Health-contingent wellness program” means a wellness program that requires an individual to:

(I) Satisfy a standard related to a health factor to obtain a reward; or

(II) Undertake more than a similarly situated individual based on a health factor in order to obtain the same reward.

(ii) “Health-contingent wellness program” includes a wellness program that is an activity-only wellness program or an outcome-based wellness program.

(c) (i) “Outcome-based wellness program” means a health-contingent wellness program that requires an individual to attain or maintain a specific health outcome, such as not smoking or attaining certain results on biometric screenings, in order to obtain a reward.

(ii) To comply with this subsection, an “outcome-based wellness program” typically has two tiers:
(I) For individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program; and

(II) If a measurement, test or program screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified conditions or risk factors, including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index or high glucose level, and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range or at risk to take additional steps, such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program or complying with a health care provider’s plan of care, to obtain the same reward, the program is an outcome-based wellness program.

(d) (i) “Participatory wellness program” means a wellness program that:

(I) Does not base any condition for obtaining an award on an individual satisfying a standard that is related to a health factor; or

(II) Does not provide a reward.

(ii) Examples of “participatory wellness program” include:

(I) A program that reimburses employees for all or part of the cost for membership in a fitness program;

(II) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes;

(III) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a small group market health insurance coverage health benefit plan for the costs of, for example, prenatal care or well-baby visits;

(IV) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking;

(V) A program that provides a reward to employees for attending a monthly, no-cost health education seminar; and

(VI) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action, educational or otherwise, required by the employee with regard to the health issues identified as part of the assessment.
(e) (i) Except where expressly provided otherwise, references in this section to an individual obtaining a “reward” include both obtaining a reward, such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit or any financial or other incentive and avoiding a penalty, such as the absence of a premium surcharge or other financial or nonfinancial disincentive.

(ii) Except where expressly provided otherwise, references in this section to a small group health benefit plan providing a “reward” include both providing a reward, such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit or any financial or other incentive and imposing a penalty, such as a premium surcharge or other financial or nonfinancial disincentive.

(2) Subsection B(3) and Subsection C(2)(c) provide exceptions to the general prohibition against discrimination based on a health factor for plan provisions that vary benefits, including cost-sharing mechanisms, or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this subsection.

(3) A participatory wellness program, as defined in Paragraph (1)(d), does not violate the provisions of this section only if participation in the program is made available to all similarly situated individuals, regardless of health status.

(4) A health-contingent wellness program that is an activity-only wellness program, as defined in Paragraph (1)(a), does not violate the provisions of this section only if all of the following requirements are satisfied:

(a) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year;

(b) (i) The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage provided in Paragraph (6) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents, such as spouses or spouses and dependent children, may participate in the wellness program, the reward may not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled.

(ii) For purposes if this subparagraph, the cost of coverage is determined based on the total amount of employer and employee contributions toward the cost of coverage for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage;

(c) (i) The program must be reasonably designed to promote health or prevent disease.

(ii) A program satisfies Item (i) if, based on all of the relevant facts and circumstances:

(I) It has a reasonable chance of improving the health of, or preventing disease in, participating individuals; and
(II) It is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease;

(d) (i) The full reward under the activity-only wellness program must be available to all similarly situated individuals.

(ii) Under this subparagraph, a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:

(I) The program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) The program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, is it medically inadvisable to attempt to satisfy the otherwise applicable standard.

(iii) While a carrier is not required to determine a particular reasonable alternative standard in advance of an individual’s request for one, if an individual is described in either item (ii)(I) or (II), a reasonable alternative standard must be furnished by the carrier upon the individual’s request or the condition for obtaining the reward must be waived;

(iv) All of the facts and circumstances are taken into account in determining whether a carrier has furnished a reasonable alternative standard, including but not limited to the following:

(I) If the reasonable alternative standard is completion of an educational program, the carrier must make the educational program available or, instead of requiring the employee to find such a program unassisted, assist the employee in finding such a program, and may not require an individual to pay for the cost of the program;

(II) The time commitment required must be reasonable;

(III) If the reasonable alternative standard is a diet program, the carrier is not required to pay for the cost of food, but must pay any membership or participation fee; and

(IV) If an individual’s personal physician states that a plan standard, including, if applicable, the recommendations of the plan’s medical professional, is not medically appropriate for that individual, the carrier must provide a reasonable alternative standard that accommodates the recommendations of the individual’s personal physician with regard to medical appropriateness. Carriers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician’s recommendations;
(v) (I) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this paragraph in the same manner as if it were an initial program standard.

(II) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of Paragraph (5), including Paragraph (5)(d)(iv);

(vi) If reasonable under the circumstances, a carrier may seek verification, such as a statement from an individual’s personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program. Carriers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request; and

(e) The carrier must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual’s personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in paragraph (7) of this subsection.

(5) A health-contingent wellness program that is an outcome-based wellness program, as defined in Paragraph (1)(c), does not violate the provisions of this subsection only if all of the following are satisfied:

(a) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year;

(b) (i) The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage, as defined in Paragraph (6) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents, such as spouses or spouses and dependent children, may participate in the wellness program, the reward may not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents of the employee are enrolled;

(ii) For purposes if this subparagraph, the cost of coverage is determined based on the total amount of small employer and employee contributions toward the cost of coverage for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage;

(c) (i) The program must be reasonably designed to promote health or prevent disease;
(ii) A program satisfies Item (i) if, based on all of the relevant facts and circumstances:

(I) It has a reasonable chance of improving the health of, or preventing disease in, participating individuals; and

(II) It is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease;

(iii) To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test or screening that is related to a health factor, as explained in Subparagraph (d) of this paragraph;

(d) (i) The full reward under the outcome-based wellness program must be available to all similarly situated individuals;

(ii) Under this subparagraph, a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test or screening, as described in this subparagraph;

(iii) While health carriers are not required to determine a particular reasonable alternative standard in advance of an individual’s request for one, if an individual is described in item (ii), a reasonable alternative standard must be furnished by the carrier upon the individual’s request or the condition for obtaining the reward must be waived;

(iv) All of the facts and circumstances are taken into account in determining whether a health carrier has furnished a reasonable alternative standard, including but not limited to the following:

(I) If the reasonable alternative standard is the completion of an educational program, the health carrier must make the educational program available or, instead of requiring an employee to find an educational program unassisted, assist the employee in finding such a program and may not require the employee to pay for the cost of the program;

(II) The time commitment required must be reasonable;

(III) If the reasonable alternative standard is a diet program, the health carrier is not required to pay for the cost of food, but must pay any membership or participation fee; and

(IV) If an individual’s personal physician states that a plan standard, including, if applicable, the recommendations of the plan’s medical professional, is not medically appropriate for that individual, the health carrier must provide a reasonable alternative standard that accommodates the recommendations.
of the individual’s personal physician with regard to medical appropriateness. Health carriers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician’s recommendations;

(v) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of Paragraph (4) in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this paragraph, such to the following special rules:

(I) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual’s circumstances; and

(II) An individual must be given the opportunity to comply with the recommendations of the individual’s personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the carrier, but only if the physician joins in the request. The individual can make a request to involve a personal physician’s recommendations at any time and the personal physician can adjust the physician’s recommendations at any time, consistent with medical appropriateness;

(vi) (I) It is not reasonable to seek verification, such as a statement from an individual’s personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard;

(II) However, if a health carrier provides an alternative standard to otherwise applicable measurement, test or screening that involves an activity that is related to a health factor, then the rules of Paragraph (4) for activity-only wellness programs apply to that component of the wellness program and the health carrier may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity or it is medically inadvisable to attempt to perform or complete the activity; and

(e) The health carrier must disclose in all plan materials describing the terms of an outcome-based wellness program the availability of a reasonable alternative standard to qualify for the reward and, in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual’s personal physician will be accommodated. If plan materials merely mention that such a program is available,
without describing its terms, this disclosure is not required. Sample language is provided in Paragraph (7).

(6) (a) For purposes of this subsection, the applicable percentage is thirty (30) percent, except that the applicable percentage is increased by an additional twenty (20) percentage points to fifty (50) percent to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.

(b) The rules of this paragraph are illustrated in examples found in 45 CFR 146.121(f)(5).

(7) The following language, or substantially similar language, can be used to satisfy the notice requirement of Paragraphs (4) and (5):

“Your health benefit plan small group market health insurance coverage health benefit plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.”

Section 11. Essential Health Benefits Package

A. To meet the requirements of Section 13 of the Act, provision of essential health benefits means that a health benefit plan provides health benefits that:

(1) Are substantially equal to the EHB-benchmark plan including:

(a) Covered benefits;

(b) Limitations on coverage including coverage of benefit amount, duration and scope; and

(c) Prescription drug benefits that meet the requirements of Section 10 of this regulation;

(2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;

(4) Include preventive health services, as provided in Section 14 of the Act;

(5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:

(a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services; or

(b) Is determined by the health carrier and reported to HHS.

B. A health carrier offering a health benefit plan in the small group market providing essential health benefits may substitute benefits if the carrier meets the following conditions:

Drafting Note: States should be aware that they may adopt more restrictive requirements related to health carriers substituting benefits, including not permitting the practice.
(1) Substitutes a benefit that:
   (a) Is actuarially equivalent to the benefit that is being replaced as determined in Paragraph (2);
   (b) Is made only within the same essential health benefit category; and
   (c) Is not a prescription drug benefit; and

(2) Submits evidence of actuarial equivalence that is:
   (a) Certified by a member of the American Academy of Actuaries;
   (b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
   (c) Based on a standardized plan population; and
   (d) Determined regardless of cost-sharing.

C. A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).

D. A health carrier offering a health benefit plan in the small group market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.

Section 12. Parity in Mental Health and Substance Use Disorder Benefits

A. The provisions of 45 CFR §146.136 do not apply to a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act, as the term “small employer” is defined in section 2791 of the PHSA as provided in Section 11 of this Regulation.

Drafting Note: Section 1304 of the Federal Act gives states the option, prior to Jan. 1, 2016, to define a “small employer” as an employer that employed an average of at least one (1), but not more than fifty (50) employees on business days during the preceding calendar year and that employs at least one (1) employee on the first day of the plan year. On or after Jan. 1, 2016, a “small employer” must be defined as an employer that employed an average of at least one (1) but not more than one hundred (100) employees on business days during the preceding calendar year and who employs at least one (1) employee on the first day of the plan year. As such, the small employer exemption provided in Section 2726 of the PHSA and implementing regulations will not continue to apply to employers with fifty-one (51) to one hundred (100) employees in 2016 when the upper limit of the small employer size increases in accordance with Section 1304 of the Federal Act.

B. This section applies to non-grandfathered health plan coverage and grandfathered health plan coverage.

Section 13. Prescription Drug Benefits

A. A health benefit plan does not provide essential health benefits unless it:
   (1) Except as provided in Subsection B, covers at least the greater of:
      (a) One drug in every United States Pharmacopeia (USP) category and class; or
      (b) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and
   (2) Submits its drug list to the state.
B. A health benefit plan does not fail to provide essential health benefits prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).

C. (1) A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan.

(2) (a) The procedures must include a process for an enrollee, the enrollee’s designee or the enrollee’s prescribing physician or other prescriber to request an expedited review based on exigent circumstances.

(b) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(c) A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee’s designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than twenty-four (24) hours after it receives the request.

(d) A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Drafting Note: The provisions of Subsection C above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the NAIC Health Carrier Prescription Drug Benefit Management Model Act (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Section 14. Prohibition on Discrimination in Providing Essential Health Benefits

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.

B. A health carrier must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection B above and, if necessary, revise the language in Subsection B.

C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

Section 15. Cost-Sharing Requirements

A. (1) For a plan year beginning in calendar year 2014, cost-sharing may not exceed the following:

(a) For self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended; or
(b) For non-self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended.

(2) For a plan year beginning in a calendar year after 2014, cost-sharing may not exceed the following:

(a) For self-only coverage, the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in Subsection E; or

(b) For non-self-only coverage, twice the dollar limit for self-only coverage described in Subparagraph (a) of this paragraph.

B. (1) For a plan year beginning in calendar year 2014, the annual deductible for a health benefit plan offered in the small group market may not exceed the following:

   (a) For self-only coverage, $2,000; or

   (b) For other than self-only coverage, $4,000.

(2) For a plan year beginning in calendar year after 2014, the annual deductible for a health benefit plan offered in the small group market may not exceed the following:

   (a) For self-only coverage, the annual limitation on deductibles for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage as defined in Subsection E; and

   (b) For other than self-only coverage, twice the annual deductible limit for self-only coverage described in Subparagraph (a) of this paragraph.

(3) A health benefit plan’s annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage as defined in Section 13 of this regulation without exceeding the annual deductible limit.

CB. In the case of a network plan using a network of providers, cost-sharing paid by, or on behalf of, a covered person for benefits provided outside of the network shall not count towards the annual limitation on cost-sharing, as defined in Subsection A or the annual limitation on deductibles, as defined in Subsection B the annual limitation on cost-sharing, as defined in Subsection A does not apply to benefits provided out-of-network.

Drafting Note: Subject to state or federal law or regulations, nothing in this section would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Subsection A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network.

DC. For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in Subsections A and B that does not result in a multiple of 50 dollars must be rounded down to the next lowest multiple of 50 dollars.

ED. The premium adjustment percentage is the percentage, if any, by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

FE. Nothing in this section is in derogation of the requirements of Section 14 of the Act.

GF. Emergency department services must be provided as follows:
(1) Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out of network, cost-sharing must be limited as provided in [insert reference to state law or regulation equivalent to Section 11C of the Utilization Review and Benefit Determination Model Act].

Section 16. Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage

A. Subject to Subsection B, a health carrier must use the AV Calculator developed and made available by HHS to calculate the AV of a health benefit plan.

B. If a health benefit plan’s design is not compatible with the AV Calculator, the health carrier must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in Subparagraphs (a) and (b) of this paragraph:

(a) Calculate the plan’s AV by:

(i) Estimating the fit of its plan design into the parameters of the AV calculator; and

(ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(b) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator; and

(2) The calculation methods described in Paragraph (1)(a) and (b) may include in-network cost-sharing, including multi-tier networks.

C. For health benefit plans offered in the small group market that, at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health benefit plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit plan year so that:

(a) Any current year HSA contributions are accounted for; and

(b) The amounts newly made available under such integrated HRAs for the current year are accounted for.

D. (1) Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set, in a format specified by HHS that can support the use of the AV Calculator as described in Subsection A, will be used as the standard population to calculate AV in accordance with Subsection A.
(2) The AV will be calculated using the default standard population described in Paragraph (3), unless a data set in a format specified by HHS that can support the use of the AV Calculator, as described in Subsection A, is submitted by a state and approved by HHS consistent with the requirements of 45 CFR §156.135(d) by a state specified by HHS.

(3) The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in Subsection A.

E. (1) The AV, calculated as described in Subsections A through D, and within a de minimis variation as defined in Paragraph (3), determines whether a health benefit plan offers a bronze, silver, gold or platinum level of coverage.

(2) The levels of coverage are:

(a) A bronze plan is a health benefit plan that has an AV of 60%.

(b) A silver plan is a health benefit plan that has an AV of 70%.

(c) A gold plan is a health benefit plan that has an AV of 80%.

(d) A platinum plan is a health benefit plan that has an AV of 90%.

(3) The allowable variation in the AV of a health benefit plan that does not result in a material difference in the true dollar value of the health benefit plan is +/-2 percentage points.

F. Any health benefit plan offered in the small group market that meets any of the levels of coverage described in Subsection E satisfies minimum value.

Section 17. Provision of Summary of Benefits and Coverage; Uniform Glossary

Drafting Note: States should be aware that in addition to the provisions of 45 CFR §147.200, the Secretary of the U.S. Department of Health and Human Services has issued extensive sub-regulatory guidance in the form of frequently asked questions (FAQs) and enforcement safe harbors for issuers subject to Section 2715 of the PHSA and the implementing federal regulations. This section includes drafting notes reflecting this sub-regulatory guidance and issuer enforcement safe harbors.

Drafting Note: States should be aware that the federal agencies charged with implementing the provisions of the ACA, including the provisions of Section 2715 of the PHSA and the implementing federal regulations, have maintained their intent to continue the safe harbors and other enforcement relief provided to issuers for the first year of applicability related to the requirement to provide a Summary of Benefits and Coverage (SBC) and a uniform glossary during subsequent years of applicability. The federal agencies confirmed their intent in the Affordable Care Act Implementation FAQs Part XIV, Q9, issued April 23, 2013, with respect to the second year of applicability. May 2, 2014. Specifically, the federal agencies, “in recognition of and to ensure a smooth transition to new market changes in 2014,” believe it is prudent to extend the following previously-issued enforcement and transition relief guidance to apply through the end of the second year of applicability until further guidance is issued:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the federal agencies’ basic approach to implementation of the SBC requirements during the first year of applicability);
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
• Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer’s obligation to provide an SBC with respect to benefits it does not insure); and
• Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage).

In addition, the federal agencies have extended the following enforcement relief continues to apply through the second year of applicability, consistent with existing guidance:

• The Special Rule contained in the Instruction Guides for Group and Individual Coverage;
• Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically); and
• Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage).

Additionally, Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements) applies “until further guidance is issued.” The relief provided in this Affordable Care Act Implementation FAQs Part VIII, Q5 continues to apply, and plans and issuers may rely on this relief at least through the end of 2014.

The Departments also extended the enforcement safe harbor for plans and issuers with respect to insurance products that are no longer being offered for purchase (“closed blocks of business”) as initially provided in ACA Implementation FAQs Part IX, Q12. Specifically in ACA Implementation FAQs Part XIV, Q6, the initial relief provided is extended to Sept. 23, 2014, for plans and issuers with respect to an insured product that meets three conditions:

• The insured product is no longer being actively marketed;
• The health insurance issuer stopped actively marketing the product prior to Sept. 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and
• The health insurance issuer has never provided an SBC with respect to the insured product.

That is, if a health insurance product is not being actively marketed and the health insurance issuer has not actively marketed the product at any time on or after Sept. 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the insured product, the plan and issuer must provide the SBC with respect to such coverage, as required by Section 2715 of the PHSA and the final regulations.

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must provide a summary of benefits and coverage (SBC) for each benefit package without charge to persons and individuals described in this section and in accordance with this section.

Drafting Note: States should be aware that, as enacted, the Federal Act retained, with amendment, what was Section 2713 of the PHSA, now Section 2709 of the PHSA (Disclosure of Information), which requires health carriers to disclose information to individuals concerning the carrier’s right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health insurance coverage for which the individual is qualified. The provisions of this section do not include these required disclosure requirements.

B. (1) A health carrier offering a health benefit plan providing small group health insurance coverage must provide the SBC to the plan sponsor upon application for coverage, as soon as practicable following receipt of the application, but in no event later than seven (7) business days following receipt of the application.

(2) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the individual no later than the first day of coverage.

(3) If a health carrier renews or reissues the certificate or contract of coverage, the health carrier must provide a new SBC as follows:
(a) If written application is required in either paper or electronic form for renewal or reissuance, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or

(b) If renewal or reissuance is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new plan year; however, if the certificate or contract of insurance has not been issued or renewed before such 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issuance of the new certificate or contract of insurance or the receipt of the written confirmation of intent to renew whichever is earlier.

(4) If a plan sponsor requests an SBC or summary information about a health insurance product from a health carrier, the health carrier must provide an SBC as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

C. (1) A health carrier must provide an SBC to covered persons and, consistent with Subsection D, with respect to each benefit package offered by the carrier for which the covered person is eligible.

(2) A health carrier must provide an SBC as part of any written application materials that are distributed by the carrier for enrollment. If the carrier does not distribute written application materials for enrollment, the carrier must distribute the SBC no later than the first date on which the employee is eligible to enroll in coverage for the employee and any dependents of the employee.

(3) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the covered person no later than the first day of coverage.

(4) A health carrier must provide the SBC to special enrollees, as described in Section 6 of this regulation, no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is ninety (90) days from enrollment.

(5) If a health carrier requires covered persons to renew in order to maintain coverage, the carrier must provide a new SBC when the coverage is renewed as follows:

(a) If written application is required for renewal in either paper or electronic form, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or

(b) If the renewal is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new plan year; however, if the certificate or contract of insurance has not been issued or renewed before the 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issue of the new certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(6) A health carrier must provide the SBC to covered persons upon request for an SBC or summary information about health coverage, as soon as practicable, but in no event no later than seven (7) business days following receipt of the request.

D. (1) A person required to provide an SBC under this section with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the requirements of this section. Therefore, for example, in the case of a health benefit plan providing small group market health insurance coverage, the person satisfies the requirement to provide an SBC with respect to an individual if the health carrier provides a timely and complete SBC to the individual.
(2) If a health carrier provides a single SBC to an employee and any dependents of the employee at the employee’s last known address, then the requirement to provide the SBC to the employee and any dependents of the employee is generally satisfied. However, if an employee’s dependent’s last known address is different than the employee’s last known address, the health carrier must provide a separate SBC to the employee’s dependent at the dependent’s last known address.

(3) With respect to a health benefit plan providing small group health insurance coverage that offers multiple benefit packages, the health carrier must provide a new SBC automatically upon renewal only with respect to the benefit package in which the covered person is enrolled. A health carrier is not required to provide SBCs automatically upon renewal with respect to benefit packages in which the covered person is not enrolled. However, if the covered person requests an SBC with respect to another benefit package or more than one other benefit package for which the covered person is eligible, the health carrier must provide the SBC, or in the case of a request for SBCs relating to more than one benefit package, upon request as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

E. (1) Subject to Paragraph (3), an SBC provided under this section must include the following:

(a) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of, or exceptions to, their coverage, in accordance with guidance as specified by the Secretary;

(b) A description of the coverage, including cost-sharing, for each category of benefits identified by the Secretary in guidance;

(c) The exceptions, reductions and limitations of coverage;

(d) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

(e) The renewability and continuation of coverage provisions;

(f) Coverage examples in accordance with Paragraph (2);

(g) A statement about whether the coverage provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code of 1986, as amended and whether the coverage’s share of the total allowed costs of benefits provided under the coverage meets applicable requirements;

(h) A statement that the SBC is only a summary and that the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(i) Contact information for questions and obtaining a copy of the insurance policy, certificate or contract of insurance, such as a telephone number for customer service and a publicly accessible Internet address where a copy of the plan document or the insurance policy, certificate or contract of insurance can be reviewed and obtained;

(j) For carriers that maintain one or more provider networks, an Internet address, or similar contact information, for obtaining a list of network providers;

(k) For carriers that use a formulary in providing prescription drug coverage, an Internet address, or similar contact information, for obtaining information on prescription drug coverage; and
An Internet address for obtaining the uniform glossary, as described in Subsection G, as well as a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the coverage for common benefit scenarios, including pregnancy and serious or chronic medical conditions in accordance with this paragraph. The Secretary may identify up to six (6) coverage examples that may be required in an SBC.

For purposes of this paragraph, a benefit scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specified period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

Drafting Note: The HHS Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

For purposes of this paragraph, to illustrate benefits provided under the coverage for a particular benefits scenario, a carrier simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the policy or benefit package.

The illustration of benefits provided will take into account any cost-sharing, excluded benefits and other limitations on coverage as specified by the Secretary in guidance.

In lieu of summarizing coverage for items and services provided outside of the United States, a carrier may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States.

Drafting Note: In Frequently Asked Questions (FAQs), the federal agencies charged with implementing the ACA provide that expatriate coverage is not subject to the ACA requirements for plan years ending before Dec. 15, 2015, including the requirements to provide an SBC with respect to expatriate coverage during the first year of applicability. States should refer to the Drafting Note at the beginning of this section for additional information regarding this enforcement safe harbor.

In any case, the carrier must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the coverage within the United States.

A carrier must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in regulations and applicable guidance.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the safe harbor for plans and issuers provided in the Special Rule in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition) for completing the SBC. As stated in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition), the Special Rule provides: “To the extent a plan’s terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program.”
(2) The SBC must be provided in a uniform format, use terminology understandable by the average individual covered under the policy, not exceed four (4) double-sided pages in length and not include print smaller than 12-point font.

(3) The carrier must provide the SBC as a stand-alone document.

G. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage may provide an SBC in paper form.

(2) In lieu of providing an SBC in paper form under Paragraph (1), a health carrier may provide an SBC electronically, such as by email or an Internet posting, if the following is satisfied:

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the circumstances in which a SBC may be provided electronically consistent with the safe harbor provided by the federal agencies.

(a) The form is readily accessible by the plan sponsor;

(b) The SBC is provide in paper form free of charge upon request; and

(c) If the electronic form is an Internet posting, the carrier timely advises the plan sponsor in paper form or email that the documents are available on the Internet and provides the Internet address.

(3) A health carrier offering a health benefit plan providing small group market health insurance coverage may provide an SBC to a covered person in paper form.

H. A health carrier must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this section, a carrier is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR §147.136(e) are met as applied to the SBC.

I. If a health carrier offering a health benefit plan providing small group market health insurance coverage makes any material modification, as defined under section 102 of ERISA, in any terms of coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the health carrier must provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with Subsection G.

J. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must make available to covered persons, the uniform glossary described in Paragraph (2) of this subsection in accordance with the appearance and form and manner requirements of Paragraphs (3) and (4).

(2) The uniform glossary must provide uniform definitions, specified by the Secretary in guidance of the following health-coverage-related terms and medical terms:

(a) Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital out-patient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care;
(b) Such other terms as the Secretary determines are important to define so that individuals may compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits, as specified in guidance.

(3) A health carrier must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable to the average individual covered under a health insurance policy.

(4) A health carrier must make the uniform glossary described in this subsection available upon request, in either paper or electronic form (as requested), within seven (7) business days after receipt of the request.

**Drafting Note:** States should be aware that consumers may review and obtain the uniform glossary at several websites, including www.healthcare.gov (Centers for Medicare and Medicaid Services (CMS)), www.cciio.cms.gov (Center for Consumer Information and Insurance Oversight (CCIIO)), and www.dol.gov/ebsa/healthreform (U.S. Department of Labor (DOL), Employee Benefits Security Administration (EBSA)).

### Section 18. Certification and Disclosure of Prior Creditable Coverage

**Drafting Note:** The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 10295) in the Federal Register Feb. 24, 2014, finalizing their proposed rule to amend 45 CFR §146.115 to eliminate the requirement in the group market to provide certificates of creditable coverage and to demonstrate creditable coverage. The language in this section is consistent with the language from the final rule.

A. The federal rules for providing certificates of creditable coverage and demonstrating creditable coverage under 45 CFR §146.115 have been superseded by the prohibition on preexisting condition exclusions in accordance with Section 2704 of the Public Health Service Act.

B. The provisions of this section apply beginning December 31, 2014.

### Section 19. Rules Related to Fair Marketing

A. A health carrier offering health benefit plans providing small group market health insurance coverage subject to the Act must actively market each of its health benefit plans to individuals in this state, except that for closed blocks of coverage, a health carrier must offer coverage upon request and is not required to actively market such coverage.

B. (1) (a) A health carrier offering health benefit plans providing small group market health insurance coverage must actively offer all health benefit plans it actively markets in this state to any small employer that applies for or makes an inquiry regarding small group market health insurance coverage from the carrier.

(b) The offer may be provided directly to the small employer or delivered through a producer.

(2) The offer must be in writing and must include at least the following information:

(a) A general description of the benefits contained in the health benefit plan being offered to the small employer, and

(b) Information describing how the small employer may enroll in the plans.

(3) The carrier must provide a price quote to a small employer directly or through an authorized producer within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. The carrier must notify a small employer directly or through an
authorized producer within five (5) working days of receiving a request for a price quote of any additional information needed by the carrier to provide the quote.

(4) Subject to Section 6A of the Act, the carrier must issue any health benefit plan to any eligible small employer that applies for the plan.

(5) The carrier may not directly or indirectly use group size, except to the extent it is used to establish eligibility as a small employer, or any health status-related factor as criteria for establishing eligibility for a health benefit plan.

C. A health carrier must establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health benefit plans providing small group health insurance coverage in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

Drafting Note: Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of health benefit plans providing small group health insurance coverage in their state.

D. (1) The health carrier may not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the carrier or for the issuance of any health benefit plan offered by the carrier.

(2) A health carrier may modify the terms of a policy issued to a small employer that is not a member of the association provided the modifications do not affect the policy’s benefit design or other substantive terms of coverage.

Drafting Note: The provisions of Paragraph (2) are intended to allow a carrier to make necessary technical or administrative modifications to a health benefit plan issued to a small employer that is not a member of an association.

E. A health carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

F. (1) Health carriers offering health benefit plans providing individual and small group health insurance coverage in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this regulation.

(2) Health carriers must elicit the following information from applicants for such plans at the time of application:

(a) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(b) Whether or not the prospective policyholder, certificateholder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.

(3) If a health carrier offering a health benefit plan providing small group health insurance coverage fails to comply with Paragraph (2), the carrier will be deemed to be on notice of any information that could reasonably have been attained if the carrier had complied with Paragraph (2).

G. (1) A health carrier must file annually the following information with the commissioner related to small group market health benefit plans issued by the carrier to individuals in this state:
(a) The number of small employer that were issued, or received renewals of, small group market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(b) The number of small group market health benefit plans in force in the state as of December 31 of the previous calendar year;

Drafting Note: Instead of requesting information on the number of individual small group market health benefit plans in force in the state, as provided in Subparagraph (b) above, a state may decide it is more appropriate to request such information by county, three-digit zip code or metropolitan statistical area and non-metropolitan statistical area geographic regions.

(c) The number of small group market health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; and

(d) The number of small group market health benefit plans that were terminated or not renewed and reasons (other than nonpayment of premium) for the termination or nonrenewal by the carrier in the previous calendar year.

(2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.

H. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its small group market health benefit plans. The commissioner shall have authority to review a carrier’s commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its small group market health benefit plans are created by the structure.

I. A health carrier may not employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual’s race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection I above and, if necessary, revise the language in Subsection I.

Section 20. Rules Related to Quality of Care Reporting

To be completed at a later date.

Section 21. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 22. Effective Date

This regulation shall be effective on [insert date].
Conference Calls

NETWORK ADEQUACY MODEL REVIEW (B) SUBGROUP

Summary Report

The Network Adequacy Model Review (B) Subgroup met Aug. 7, July 31, June 19, June 12, June 5, May 29, May 22 and May 8 via conference call. During these meetings, the Subgroup:

1. Reviewed its charge to consider revisions to the Managed Care Plan Network Adequacy Model Act (#74).
2. Heard testimony from various stakeholders on their issues and concerns with network adequacy and possible ways to address them.
3. Heard a summary of Washington State’s newly revised network adequacy regulations.
4. Discussed a work plan to complete its work on Model #74 by the Fall National Meeting.
5. Requested comments, including specific proposed revisions to Model #74, by July 3.
6. Began discussion of the comments received on Model #74.
The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Aug. 7, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Peg Brown (CO); Christina Goe (MT); Martin Swanson (NE); Gayle Woods (OR); and Molly Nollette (WA). Also participating were: Brenda Wilson (MD); and Tom Record (ME).

1. **Discussed Comments on Section 3—Definitions**

The Subgroup continued its section-by-section review of the comments received on the *Managed Care Plan Network Adequacy Model Act* (#74) using the chart developed by NAIC staff.

   a. **“Facility”**

   Mr. Wieske said the comments received on the definition of “facility” suggest adding word “pharmacies.” He said he believes pharmacies do not fit into what is traditionally thought of as a “facility” in the context of Model #74. Ms. Goe and Ms. Nollette agreed. Timothy S. Jost (Washington and Lee University School of Law) said that if pharmacies are not to be included in the definition of “facility,” how will they be included in the provider network. Mr. Wieske said there are two ways they could be reflected in a provider network. One way would be through a carrier provider contract with a pharmacist, as a health care professional and through health carrier’s prescription drug formulary management requirements. After additional discussion, the Subgroup decided not to include “pharmacies” in the definition of “facility.”

   b. **“Health care professional”**

   Mr. Wieske said the comments received on the definition of “health care professional” suggest specifically listing “pharmacists” in the definition. Chris Petersen (Morris, Manning & Martin), representing the Pharmacy Care Management Association (PCMA), suggested that the Subgroup not accept this suggested revision. He said pharmacists are considered health care professionals, but not in the context of Model #74 because a health carrier would contract with the pharmacy and not the pharmacist. The Subgroup agreed.

   c. **“Health care provider”**

   The Subgroup discussed whether to add the word “pharmacy” to the definition of “health care provider.” After discussion, the Subgroup agreed to add that word to the definition. The Subgroup also agreed to return to the issue of how and in what manner a “pharmacy” or a “pharmacist” is to be reflected in provider networks.

   d. **“Health care services”**

   Mr. Wieske said the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) and the Biotechnology Industry Organization (BIO) each submitted comments on this definition. Mr. Wieske asked NAIC staff if this definition is a standard definition used in NAIC models. Jolie Matthews (NAIC) confirmed that the definition of “health care services” is a standard NAIC model definition. Mr. Wieske said the definition already includes services for “health promotion, maintenance and general wellness,” which DIFP suggests adding. He said the BIO’s suggested revision could possibly lead to unintended consequences if the definition was revised to be that specific as to the services the term encompasses. Ms. Goe said the DIFP’s suggested revision is too broad and could include exercise programs.

   Sabrina Corlette (Georgetown University Health Policy Institute) asked how habilitative services were included in the current definition. Mr. Wieske said he believed such services are included. Ms. Brown agreed, stating that she believes habilitative services are encompassed in the language used in the definition referring to the treatment or relief of a health condition. Ms. Goe expressed support for retaining the existing definition without revision. After additional discussion, the Subgroup decided to leave the definition unchanged.
Mr. Wieske said the DIFP suggests revising the definition to note that the federal Affordable Care Act (ACA) uses the term “issuer” rather than “health carrier.” Ms. Matthews said that instead of adding DIFP’s suggested language, she would suggest that a drafting note be added. After discussion, the Subgroup agreed to accept Ms. Matthews’ suggestion.

d. “Health indemnity plan”

Mr. Wieske said both the Maine Bureau of Insurance and the DIFP suggest in their comments deleting the definition of “health indemnity plan” because the term is not used in Model #74. He said the NAIC consumer representatives suggest revising the definition to reflect that such plans are not within the scope of Model #74. Ms. Goe said Model #74 needs this term in order to explicitly state what type of health benefit plans do not fall within the scope of Model 74. Mr. Wieske agreed. Mr. Jost suggested that, if the term is retained, the Subgroup might want to consider using a term other than “indemnity” in order to avoid confusion with some types of excepted benefit plans. Mr. Wieske agreed and suggested calling such plans “non-network” plans. Ms. Wilson expressed support for using the term “non-network” plan. Candy Gallaher (America’s Health Insurance Plans—AHIP) suggested that “indemnity plan” might not need to be defined, because the Subgroup could include its meaning in any language added to Section 4—Applicability and Scope. After additional discussion, the Subgroup decided to retain the term as a placeholder for possible inclusion in Section 4—Applicability and Scope. The Subgroup deferred making a decision on whether to use the term “non-network” plan instead of “indemnity” plan.

e. “Intermediary”

Mr. Wieske said the Maine Bureau of Insurance’s comment on the definition of “intermediary” suggests several revisions to the term. He suggested, however, that the Subgroup defer making any decision on this definition until it reviews Section 7—Intermediaries, which is the substantive provision in Model #74 where the term is used. Mr. Wieske said he found the language in Section 7 to be confusing and in need of clarification. The Subgroup agreed with his suggestion.

f. “Managed care plan”

Mr. Wieske noted that, because of change in the title of Model E74, the definition of “managed care plan” required that it be revised to “network plan.” He asked for comments on the NAIC consumer representatives’ suggested revision. Beth Abbott (Health Access California) said the suggested revisions were an effort to try to envision the health care service delivery system in the future. Mr. Wieske expressed support for the list of health care service delivery system entities included in the NAIC consumer representatives’ suggested revision for the drafting note. Ms. Brown expressed concern that the NAIC consumer representatives’ suggested revision applies only to health maintenance organizations (HMOs) because of the following language: “a defined set of providers under contract with the carrier.” Ms. Gallaher said the suggested revision also failed to include language from the existing definition related to consumer choice in deciding whether to use a participating provider. After discussion, the Subgroup decided to leave the definition’s substantive language unchanged. The Subgroup also decided to add in some manner the list of health care service delivery system entities.

The Subgroup deferred making any decision regarding the comments received on the definition of “network.”

g. “Network”

Mr. Wieske said the Maine Bureau of Insurance, the DIFP and the NAIC consumer representatives submitted suggested revisions for the definition of “participating provider.” Mr. Record said Maine’s suggested revision removes unnecessary language. Narda Ipackchi (American Health Care Association and the National Center for Assisted Living—AHCA/NCAL) said the language “with an expectation of payment” should be retained. Beth Berendt (Berendt and Associates, LLC) cautioned that the suggested language could impact the hold harmless provider contract provision. After additional discussion, the Subgroup decided to leave the definition unchanged, but return to it after it completes its review of the comments.

No comments were received on the definition of “person.”
k. “Primary care professional”

Mr. Wieske said the Maine Bureau of Insurance and the NAIC consumer representatives submitted suggested revisions for the definition of “primary care professional.” Ms. Goe suggested that the definition remain unchanged. Mr. Wieske agreed, stating that Maine’s suggested revision could require the primary doctor to provide health care services that the doctor may not have sufficient expertise to perform.

Mr. Wieske said the Subgroup would meet Aug. 21 via conference call to continue its discussion of the comments.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
Network Adequacy Model Review (B) Subgroup
Conference Call
July 31, 2014

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 31, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Christina Goe (MT); Laura Arp and John Rink (NE); Kim Everett (NV); Gayle Woods (OR); and Jennifer Kreitler (WA). Also participating were: Bob Wake (ME); Molly White (MO); and Ted Hamby (NC).

1. Discuss Comments Received on Model #74

Mr. Wieske suggested that the Subgroup review the comments received on Managed Care Plan Network Adequacy Model Act (#74) section-by-section using the chart developed by NAIC staff. He said that, during this review, whatever suggested revisions the Subgroup accepts would be incorporated into a red-lined document. After the Subgroup completes its review, it will request additional comments on the proposed revisions to Model #74 as reflected in the red-lined document. He said this process would provide at least two opportunities for all stakeholders to comment on the proposed revisions prior to the Subgroup considering adoption of the revised model and forwarding it to the Regulatory Framework (B) Task Force for its consideration. The Subgroup agreed to Mr. Wieske’s suggestions.

a. Section 1—Title

Mr. Wieske said the Maine Bureau of Insurance, the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) and the NAIC consumer representatives offered suggested revisions to Section 1—Title. He suggested that the Subgroup consider another suggested revision based on Wisconsin’s regulation, the Defined Network Plan Adequacy Model Act. Mr. Wake said he believes all of the suggested revisions have merit. His main goal in making his suggestion is to delete the reference to “managed care.” He said the underlying question is what to call the entity that the model plans to regulate, whether it is the “plan” or the “network.” Ms. Everett agreed. Ms. White expressed concern with using the word “defined” in the title, as suggested by Mr. Wieske, because the meaning of “network” could change over time. As such, the model’s title should remain broad to allow for such changes. Stephanie Mohl (American Heart Association) said the NAIC consumer representatives’ suggested revision deletes the word “adequacy” because they believe that “access” is a broader term.

Ms. White suggested that the Subgroup consider revising the title to “Health Benefit Plan Network Access and Adequacy Model Act.” Beth Berendt (Berendt and Associates, LLC) cautioned against moving the focus away from “adequacy,” because the federal Affordable Care Act (ACA) references network “adequacy.” She suggested that the Subgroup defer making a decision on this issue until it finishes its review of all of the comments. After discussion, the Subgroup agreed to accept Ms. White’s suggested revision to the title. The Subgroup also agreed to revisit this suggested revision after it completes its review of the comments.

b. Section 2—Purpose

Mr. Wieske noted that any revisions made to Section 1—Title would have to be reflected in Section 2—Purpose, as well. The Subgroup discussed the DIFP suggested revision. Ms. Woods asked why the word “quality” was omitted. Ms. White said she had suggested omitting the word “quality,” because she did not see any provisions in Model #74 related to quality. In addition, she does not believe that state insurance regulators have the appropriate expertise to determine the quality of medical care. Mary Beth Senkewicz (District of Columbia Health Benefit Exchange Authority) said the NAIC has a model related to quality: the Quality Assessment and Improvement Model Act (#71). Mr. Wieske said he understands Ms. White’s concerns, but suggested that the word “quality” be included. After discussion, the Subgroup agreed to his suggestion.

Ms. Goe expressed concern with the current language in Section 2, stating that the purpose and intent of Model #74 is to ensure the adequacy and accessibility of health care services by establishing requirements for written agreements between health carriers and participating providers. She said this language by itself is not sufficient to ensure network adequacy. Mr. Wieske said some of the contracting requirements, such as the continuity of care requirements, relate to ensuring network adequacy. He suggested, however, that the Subgroup could return to this section after it completes its review and possibly add language to address Ms. Goe’s concerns. Candy Gallaher (America’s Health Insurance Plans—AHIP) noted that, in the
past, when developing other NAIC models, NAIC groups have left the scope and purpose sections blank, as a placeholder, until work on the model’s substantive provisions was complete. Given this, she suggested that the Subgroup accept the DIFP’s suggested revision with the word “quality” included, as a placeholder, and the Subgroup return to this section later. After discussion, the Subgroup agreed to Ms. Gallaher’s suggestion.

Mr. Wieske pointed out the suggested revision offered by the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) to include language suggesting that one purpose of Model #74 is to ensure adequate provider reimbursement to maintain such networks. Mr. Hamby said North Carolina has shied away from getting involved in provider reimbursement issues. Mr. Wake agreed. Narda Ipakchi (AHCA/NCAL) said that, perhaps, the word “ensure” was not the right word to use in this context. She said the AHCA/NCAL’s intent is to add language to support the concept of health carriers honoring their contacts with network providers. Ms. Berendt agreed that state insurance regulators do not typically regulate provider reimbursement rates. However, she could envision certain circumstances that might require state insurance regulators to evaluate whether the health carrier and provider are negotiating in good faith. After discussion, the Subgroup agreed to omit the AHCA/NCAL suggested language, but return to this section to possibly consider alternative language after the Subgroup completes its review.

Mr. Wieske said the Blue Cross and Blue the Shield Association (BCBSA) suggests adding language to refer to “all plans and products.” He said he is not sure what BCBSA’s intent was for including this language. David Korsh (BCBSA) said he believes the proposed language is meant to be clarifying, in that model provisions apply to all plans Model #74 is intending to regulate. After discussion, the Subgroup decided that inclusion of such language is unnecessary.

The Subgroup next discussed language offered by the Children’s Hospital Association (CHA). It was noted that the CHA’s suggested revision includes language related to qualified health plans (QHPs). Ms. Berendt said certain provisions in the ACA, such as the inclusion of essential community providers (ECPs) in provider networks, only applies to QHPs being offered in the health insurance marketplaces; this requirement does not apply to health benefit plans offered in the outside market. Mr. Wieske suggested that the Subgroup defer making any decision on this proposed language until after the Subgroup finishes its review of the substantive provisions of Model #74. After discussion, the Subgroup agreed to Mr. Wieske’s suggestion.

c. Section 3—Definitions

Turning to the Section 3—Definitions, the Subgroup noted that the DIFP’s suggestion to delete the definition of “closed plan” is because the term is not currently used in Model #74. Mr. Wieske asked the Subgroup members if anyone thought that the revisions to Model #74 would include any provisions that would require a different regulatory approach to a “closed plan” versus any other type of health benefit plan to warrant retaining this definition. Ellen Pryga (American Hospital Association) asked if closed plans are still allowed, given changes in both state and federal coverage requirements since Model #74 was adopted in 1996, particularly the requirement that all plans cover emergency services. Mr. Wieske said that, despite such state and federal coverage requirements, he believes health carriers still can offer closed plans. After discussion, the Subgroup decided to delete the definition for “closed plan.” The Subgroup also agreed to delete the definition of “open plan” because that term also is not currently used in Model #74.

No comments were received on the definitions of “commissioner” or “covered benefits.”

Mr. Wieske pointed out the CHA’s suggested revision to the definition of “covered person” to clarify that the term applies to persons of all ages, including children. After discussion, the Subgroup decided not to accept the CHA’s suggested revision because it is unnecessary.

The Subgroup next discussed the definition of “emergency medical condition.” Mr. Wieske pointed out the DIFP’s suggested revision for this term. Ms. White said her suggested revision is intended to reflect the federal definition for the same term, which includes the “prudent layperson” standard and language concerning a pregnant woman being in active labor. After discussion, the Subgroup agreed to accept the DIFP’s suggested revision. The Subgroup also discussed the DIFP’s suggestion to add a drafting note to the definition of “emergency services” suggesting that the states might want to exclude the definition of “emergency medical condition” and instead refer to another place in state law where that term already may be defined. After discussion, the Subgroup decided to defer consideration of adding the drafting note.
2. **Discussed Next Steps**

Mr. Wieske said the Subgroup would meet Aug. 7 via conference call to continue its discussion of the comments. He noted that the Subgroup would not be meeting at the Summer National Meeting. Mr. Wieske said he would provide an update on the Subgroup’s activities at the Regulatory Framework (B) Task Force’s meeting at the Summer National Meeting.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call June 19, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Peg Brown (CO); Martin Swanson (NE); Kim Everett (NV); Gayle Woods (OR); Brian Hoffmeister (TN); and Molly Nollette, Kate Reynolds and Jennifer Kreitler (WA). Also participating were: Linda Sheppard (KS); and Cory Harvey (LA).

1. **Heard Briefing on Washington State Network Adequacy Rule**

Mr. Wieske said the Subgroup would hear from Washington state on its recently adopted revised network adequacy regulation. He said that if there is sufficient time following the presentation, the Subgroup would discuss its next steps to begin considering revisions to the Managed Care Plan Network Adequacy Model Act (#74).

Ms. Reynolds described Washington state’s rulemaking process, ending with the regulation’s final adoption in March. She said Model #74 was used as a base for the revised regulation. Ms. Reynolds said the regulation applies to health benefit plans in the outside market and qualified health plans (QHPs) in the health insurance exchanges. She described the major provisions of the regulation, which includes general standards of what an adequate network looks like. Ms. Reynolds explained that the regulation provides for a single case provider reimbursement agreement, which can only be used to address unique circumstances that typically occur in out-of-network and out-of-service-area situations. She noted that single case provider reimbursement agreements may not be used to fill holes or gaps in the network.

Ms. Reynolds said the regulation includes additional evaluation tools for the insurance department. She highlighted new requirements in the regulation related to the geographic network reports as being of particular interest. Ms. Reynolds also highlighted a new section regarding tiered networks. She also highlighted additional sections that provide new consumer tools and enhanced network transparency, including a new section on provider directories. Ms. Reynolds said the insurance department prepared a cost-benefit analysis for the regulation.

Ms. Kreitler described the steps the Washington State Office of the Insurance Commissioner (OIC) has taken to implement the revised regulation. She said that, as soon as the regulation was finalized, the OIC knew it would have to create a new team to review all of the information it would be receiving. In addition, the new team would be charged with reviewing specific information within the time frames required under the regulation. Ms. Kreitler explained that the OIC decided to stop using SERFF as a reporting system and launched the Network Access Portal in April to handle the reports required to be submitted under the regulation. She said the OIC issued a Network Access User Guide to assist issuers in complying with the regulation. Ms. Kreitler also discussed other implementation projects already completed, or in the process of being completed, including the Alternative Access Delivery Request Form C and the Provider Network Form A.

Mr. Wieske asked how many staff the OIC needed to implement the revised regulation and if new employees had to be hired. Ms. Nollette said additional staff were needed, but they were needed generally to assist with implementing the federal Affordable Care Act (ACA), not the revised regulation. Ms. Woods asked about the number of OIC staff reviewing the filings required under the regulation. Ms. Nollette said there are possibly three staff people conducting the reviews, but the OIC is still in transition; as such, it is hard to be precise as to the number of staff.

Mr. Wieske asked how the OIC is determining compliance with the regulation. Ms. Nollette said that, pre-ACA, the OIC conducted a review upon initial network development and, thereafter, reviews were conducted upon notice from the issuer of a material provider change or based on consumer complaints. She said the OIC is moving away from these methods of ensuring compliance. The OIC intends to ensure compliance with the revised regulation by conducting yearly reviews with intermittent evaluation.

Candy Gallagher (America’s Health Insurance Plans—AHIP) said industry is still concerned with some of the provisions in the revised regulation’s provisions. She said the regulation imposes many more requirements on issuers than other stakeholders. Beth Berendt (Berendt and Associates, LLC) agreed with Ms. Gallagher’s comments about concerns with some of the revised regulation’s provisions. She urged the Subgroup to exercise caution with respect to Washington state’s revised regulation, because some of its provisions have raised considerable issues for providers.

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Stephanie Mohl (American Heart Association) asked how Washington state confirms the accuracy of the provider directories. Ms. Nollette said the revised regulation requires issuers to certify at the time they submit each Provider Network Form A that the provider network information is accurate as of the last date of the prior month it is posted on the issuer’s website. In addition, issuers are required to file on a monthly basis an updated, accurate Provider Network Form A and when a material change in the network occurs.

Mr. Wieske asked if any other regulators wanted to comment on their network adequacy laws or regulations. Mr. Harvey said Louisiana enacted a network adequacy law in 2013 based on Model #74. He noted that Louisiana did not include in its law the contracting provisions in Section 9 of Model #74. Mr. Harvey said he is not sure whether state insurance departments have the appropriate expertise to know if a network is adequate or whether any time or distance requirements included in the regulation are reasonable. Mr. Wieske said that one option state insurance departments could use would be to require issuers to certify network adequacy. He said state insurance departments also can check compliance on the back end based on consumer complaints or through a market conduct examination.

Ms. Gallagher said that, in many states, regulatory oversight in this area is shared with another state agency that could have the appropriate expertise. She also reiterated AHIP’s position that Model #74’s current provisions are quite robust and it has served as a source of guidance for the states’ oversight of network adequacy standards since its adoption in 1996. Ms. Gallagher said Model #74’s framework has allowed for new product types to emerge, care management and care coordination to be recognized, and continuity of care standards to be established consistent with the intent of care coordination. She urged the Subgroup to take this into consideration before reaching any conclusions about what needs to be revised.

David Korsh (Blue Cross and Blue Shield Association—BCBSA) reiterated BCBSA’s suggestion that the Subgroup solicit participation from the states with dual regulatory structures for oversight of issues related to network adequacy. Mr. Wieske said the Subgroup is open for anyone to participate and would welcome comments from other state agencies at any time.

2. **Discussed Next Steps**

Mr. Wieske said the Subgroup would not be meeting for a few weeks in order to allow sufficient time for comments to be submitted on any general and/or specific suggestions for revisions to Model #74. He said comments should be submitted to NAIC staff by July 3. Bill McAndrew (Illinois Hospital Association) asked if the Subgroup would be meeting at the Summer National Meeting. Mr. Wieske said the Subgroup would not be meeting at the Summer National Meeting. The Subgroup will continue to meet by conference call only. Mr. Wieske said he would provide an update on the Subgroup’s activities at the Regulatory Framework (B) Task Force’s meeting at the Summer National Meeting. Ms. Sheppard asked when the Subgroup anticipates finishing its work. Mr. Wieske said he hopes the Subgroup will be finished with its work by the Fall National Meeting.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call June 12, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Peg Brown (CO); Christina Goe (MT); Martin Swanson (NE); Kim Everett (NV); Gayle Woods (OR); Linda Johnson (RI); Brian Hoffmeister (TN); and Molly Nollette (WA).

1. Heard Testimony from Insurer and Business/Employer Stakeholders

Mr. Wieske said the Subgroup would hear from insurer and business/employer stakeholders regarding their network adequacy issues and concerns. He reminded interested parties that they would have an opportunity to ask questions of the presenters in order to clarify a particular viewpoint, but not to argue against their position.

a. U.S. Chamber of Commerce (Chamber)

Katie Mahoney (U.S. Chamber of Commerce) said it is important that the Subgroup consider the perspective of the employer as it begins its work to revise the Managed Care Plan Network Adequacy Model Act (#74) because the majority of people in the United States with private health insurance coverage receive that coverage through their employer. She said employers, based on the health plans their employees select, know the value and importance of flexibility and plan variety. In weighing their plan options, employees place a greater priority on affordability of coverage versus network expanse. Ms. Mahoney said almost a quarter of employers offering health benefits have high performance networks in their largest health plan. She also provided statistics illustrating small employer preference for narrow network plans and the possibility that, by 2015, limited network preferred provider organization (PPO) products would comprise 50% of national employer business. Ms. Mahoney offered additional comments regarding growing consumer demand for coverage that offers efficient networks and consumer willingness to make the tradeoff between network breadth and affordability.

Ms. Mahoney provided background information concerning the Chamber and its member companies. She noted that more than 96% of Chamber member companies have fewer than 100 employees, but Chamber member companies also include some of the nation’s largest companies.

Ms. Mahoney outlined a number of Chamber priorities and concerns for the Subgroup’s consideration. She explained that provider network design is one of the few cost-saving tools still available to health insurers and employers after the enactment of the federal Affordable Care Act (ACA). Ms. Mahoney said high-quality networks are not new. Health carriers have been narrowing network offerings since the mid-1990s. She said that, as the ACA is implemented, there are only so many ways insurers and employers can change plan designs and attempt to reduce increasing costs. Narrowing the networks is one option that they can use to create efficiencies. Ms. Mahoney said that, as such, it is important to still permit such networks with the flexibility they provide to enable employers to provide coverage options for their employees with more affordable premiums.

Mr. Wieske asked Ms. Mahoney if she was aware of any tools that employers use to compare networks and understand the differences in network design in order to know which type of network could work for them. Ms. Mahoney said that, most likely, such tools will differ based on an employer’s level of sophistication. She also noted that it may not be a single tool and, for some employers, may include benefit consultants.

b. America’s Health Insurance Plans (AHIP)

Candy Gallaher (AHIP) said Model #74 has served as a strong robust framework for the creation and maintenance of network standards since its adoption. She also noted that Model #74 has allowed room for innovation and new network products and served as the model for state policy and oversight and foundation for accrediting organization standards. Ms. Gallaher said that, within Model #74’s framework, health plans have developed networks that lower costs, promote quality, include important consumer protections and offer consumer choice. She said that, in the many programs and processes designed to meet network adequacy requirements of both state insurance regulators and the accrediting organizations, health plans currently work to provide: 1) access to networks that are sufficient in number and type of providers access; 2) up-to-date
provider network information for consumers to use prior to plan selection and after plan selection; and 3) important consumer protections, such as continuity of care options.

Ms. Gallaher also discussed how innovations and market changes provide new choices and benefits for consumers that the Subgroup should keep in mind as it begins its review of Model #74. She noted that, over the past several years, health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers. Ms. Gallaher said the Subgroup should not hinder this development, such as revising Model #74’s network adequacy standards in a way that would require insurers to accept any willing provider in their provider networks. She also discussed the importance of other stakeholders, particularly providers that, in addition to insurers, must do their part to help assure affordable quality care for consumers. Ms. Gallaher provided examples of these shared responsibilities, including: 1) providers agreeing to accept the same terms and conditions of payment under a health plan’s continuity of care policy as if in-network; 2) prohibiting providers from balance-billing patients for any amounts that exceed the in-network contracted rates; and 3) in-network hospitals supporting efforts to provide in-network access to services from hospital-based specialists.

Mr. Wieske asked Ms. Gallaher if AHIP has developed any tools to help a consumer to compare networks and understand the differences in network design in order to know which type of network would be best suited for the consumer’s health care needs. Ms. Gallaher said AHIP is in the process of developing a consumer guide. She noted that, currently, there is information on each insurer’s website that provides consumers with information related to a plan’s cost-sharing and other costs. In addition, consumers can access the plan’s provider directory directly from the insurer’s website.

Mr. Swanson asked Ms. Gallaher if she knew the cost to insurers if they were required to implement all of the suggestions recommended by the consumer stakeholders during the Subgroup’s May 29 conference call. Ms. Gallaher said she did not know, because it would depend on what insurers currently are doing and whether the suggestions would impact their administrative costs.

Mr. Wieske said it would be interesting to hear from industry about any best practices health plans may have to deal with certain network access issues. He cited the examples of rural areas where there are no network providers and the situation where the health plan initially has an adequate network, but later, due to certain unexpected changes in the network, may have an inadequate network.

c. BlueCross and BlueShield Association (BCBSA)

Kim Holland (BCBSA) said BCBSA believes it is critical that network adequacy standards give health plans the flexibility to balance access — the core attribute of network adequacy — with affordability and quality. She urged the Subgroup to keep this in mind as it begins reviewing and refining Model #74.

Ms. Holland said BCBSA also believes affordability and quality are not mutually exclusive because consumers deserve both. She said flexibility in designing networks gives health plans the ability to offer consumers the choice of lower premiums by excluding high-price providers and negotiating lower rates with others. Ms. Holland said that managed care products of today that feature narrowed or tiered network designs are fundamentally different from the limited provider networks of the 1990s. She explained that the savings resulting from the flexibility to design these new kinds of network products has made health care coverage affordable for millions of people who might not otherwise have been able to buy it without compromising the quality of care they receive.

Ms. Holland said that, in addition to the overarching importance of maintaining flexibility, the BCBSA urges the Subgroup group to consider the following four principles. First, she said network adequacy standards should ensure that provider directories and access tools include adequate information so that consumers can make informed decisions when purchasing a plan and when seeking care. Ms. Holland said that, to help consumers find providers customized to their preferences, Blue Plans are offering robust tools that show not only providers’ specialty, languages spoken, and whether accepting new patients, but also their patient ratings, special awards and certifications, and clinical quality metrics. Also, provider directories are increasingly available in multiple forms; e.g., electronic, hardcopy and Braille, as well as smartphone apps like Anthem BlueCross and BlueShield’s mobile provider finder.

Ms. Holland noted, however, that maintaining accurate provider information is a two-way street between health plans and providers. She said health plans devote considerable resources to updating information about providers’ quality and availability, giving members timely notice as soon as they learn that providers are leaving the network. However, more needs to be done to educate and encourage consumers to use the tools that plans make available. She said a large Blue plan found
that only about 10% of exchange purchasers who went to the plan’s website used the available provider directory tool. To help address this issue, Ms. Holland suggested that the NAIC engage the community of regulators, health plans and consumers in a discussion about ways to promote and facilitate consumer health literacy.

Secondly, Ms. Holland said health plans need the flexibility to develop workable policies to designate an out-of-network provider as an in-network provider when a consumer’s extraordinary circumstances prevent treatment by an in-network provider, such as when a plan has not been able to contract with the small number of pediatric subspecialists available in a state or region to care for a child with special health care needs. She noted that Blue Plans routinely, as policy, extend in-network benefits to patients requiring care that only an out-of-network provider can appropriately render.

Ms. Holland said the third principle the Subgroup needs to consider is that network adequacy standards need to be flexible to reflect local conditions such as geography, demographics, patterns of care and trends in provider acquisitions and consolidations that can affect a plan’s ability to contract with providers. She explained that health plans that serve areas where populations are sparse and health care providers are few and far between would find it especially difficult to meet specific quantitative standards, such as maximum travel time and distance. Also, large rural states may have no physicians in particular specialties available for hundreds of miles in any direction. Ms. Holland cautioned the Subgroup that time and distance standards that do not take into consideration such geographic and market realities would reduce consumer choice and preferences.

Finally, Ms. Holland urged the Subgroup to keep in mind that evidence has shown that the vast majority of individuals who select plans do so intentionally based on affordability and their health care needs. She said the vast majority of these individuals are treated by physicians and hospitals that provide quality care and do not experience any problems with the payment of their claims. Ms. Holland said BCBSA’s goal is simple: to ensure that its customers as patients have the right care at the right time in the right setting at the right price. This cannot be accomplished without engaging in new and more productive relationships with health care professionals who share its vision for affordability and quality. She said any regulation that impedes BCBSA’s ability to engage in such effective partnerships will impede its ability to provide consumers the choice of a broad array of products that meet their individual needs and preferences.

Mr. Wieske asked Ms. Holland about an issue that has been raised concerning the confusion some consumers may have experienced during the last open enrollment period when trying to determine which providers are in Blues Plan networks. He said this issue has arisen with respect to Blue-affiliated plans when one health plan has a broad provider network in the outside market, but the same Blue-affiliated plan offers a qualified health plan on the exchange that has a narrower network. He asked if the insurer has some responsibility in this situation to ensure that the consumer is not confused and knows which providers are in which network. Ms. Holland said there is a health plan obligation to make sure the consumer is adequately informed and the Blues Plans have and are doing all they can to assist consumers and provide them with the tools to make such determinations.

d. American Association of Payers, Administrators and Networks (AAPAN)

Robert Holden (AAPAN) said he also was speaking on behalf of the American Association of Preferred Provider Organizations (AAPPO) and the National Association of Specialty Health Organizations (NASHO). He said AAPAN member plans fill a gap, in that they meet the accrediting standards of both the National Committee for Quality Assurance (NCQA) and URAC. Mr. Holden said AAPAN supports transparency regarding which providers are in the network. He said, however, that AAPAN has a concern regarding provider directories particularly with respect to any regulatory changes that could adversely impact how AAPAN plan members currently maintain the directories and how they communicate with network providers. Mr. Holden also noted that AAPAN member plans are actively working through innovative market strategies to fill the gaps in rural areas and other areas to meet demand.

2. Discussed Next Steps

Mr. Wieske said the Subgroup will hear from any regulators that wish to discuss their network adequacy standards during its next conference call, which is scheduled for June 19. If there is sufficient time, the Subgroup also will discuss how it would like to proceed in beginning its work to review and consider revisions to Model #74. Mr. Wieske requested that anyone who has any suggestions for revising Model #74, particularly specific revisions to the model language, that they submit those suggestions to the Subgroup for its consideration. Jolie Matthews (NAIC) said she would distribute a copy of Model #74 in Word format to facilitate this process. Ms. Goe suggested that the Subgroup review the written testimony provided by
Commissioner Monica J. Lindeen (MT) to members of the U.S. House of Representatives’ Energy and Commerce Committee’s Subcommittee on Health on June 12, because it includes specific suggestions for revising Model #74.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call June 5, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Peg Brown (CO); Christina Goe (MT); Martin Swanson (NE); Gayle Woods (OR); and Molly Nollette (WA). Also participating was: Lee Backus (DC).

1. **Heard Provider Stakeholder Testimony**

Mr. Wieske said the Subgroup would hear from provider stakeholders regarding their network adequacy issues and concerns. He reminded interested parties that they would have an opportunity to ask questions of the presenters in order to clarify a particular viewpoint, but not to argue against their position.

   a. **American Medical Association**

Daniel Blaney-Koen (American Medical Association—AMA) discussed the AMA’s principal concerns about narrow provider networks and its impact on patient access to care. He said the AMA is concerned about: 1) their effect on costs to patients who have to go outside the network to obtain care; and 2) the lack of sufficient transparency regarding providers in the network, the cost of obtaining in-network care and the cost of obtaining out-of-network care. Mr. Blaney-Koen said narrow provider networks are not necessarily bad, but when designing such networks, health carriers should consider other factors not just cost.

Emily Carroll (AMA) outlined several priority issues to the AMA concerning network adequacy. She said it is critical that state insurance regulators establish themselves as the primary enforcers of network adequacy standards. Ms. Carroll said it is also important that network adequacy include consideration of the capacity of providers in the proposed network to accept new patients. She also said that, generally, there needs to be greater transparency regarding costs, coverage and the criteria used to evaluate providers for inclusion in a network.

   b. **American Academy of Pediatrics**

Dan Walter (American Academy of Pediatrics—AAP) said AAP believes every child deserves a medical “home.” He stressed that children are not merely “small adults.” Mr. Walter said provider networks should be designed with these perspectives in mind. He also said all efforts should be taken to ensure relationships are maintained with current providers, including the need to ensure that children’s hospitals are included in the network. In addition, access to a comprehensive array of primary care, specialty care and ancillary services in the network is critical. Mr. Walter explained that network administration is critical and should include: 1) procedures for obtaining out-of-network care that are not burdensome for families and provide significant family education regarding the steps required to obtain out-of-network care; 2) information to providers of their network status on any qualified health plan (QHP) in which they are included in-network; 3) QHP competitive contract offers of payment rates that are comparable to other insurance plan payment rates for similarly covered services; and 4) strong, transparent monitoring and enforcement mechanisms.

Mr. Wieske asked for clarification regarding Mr. Walter’s comments concerning competitive contract offers. Mr. Walter said he was referring to reports that pediatricians in a number of areas have been offered QHP contracts with significantly lower payment rates than commercial plans in the outside market. Such contract offerings should not be considered good faith efforts to ensure network adequacy.

   c. **American Hospital Association**

Molly Collins Offner (American Hospital Association—AHA) suggested that the Subgroup consider aligning the Managed Care Plan Network Adequacy Model Act (#74) with the network adequacy provisions of the federal Affordable Care Act (ACA) to ensure greater consistency in the requirements. She recommended that the Subgroup keep the following principles in mind as it works on the model revisions: 1) patients and providers are best served when there are a variety of options;
2) health carriers should be restricted in making changes in a network because network changes made during the plan year cause confusion for both patients and providers, particularly those patients with chronic conditions; and 3) network adequacy standards should result in reasonable networks that enable patients to obtain necessary services at a reasonable distance and in a reasonable time. Ms. Offner suggested that, in order to resolve the issue of hospital-based physicians not being in-network when the hospital is in-network, health carriers should be required to inform their enrollees when hospital-based physicians may not be in the network. She also encouraged state insurance regulators to more strongly enforce network adequacy standards, along with more consistent oversight and monitoring, to ensure continued compliance. Ms. Offner said she would be submitting written testimony for the Subgroup’s consideration that would provide additional detail on the issues she has discussed and additional concerns of the AHA, including concerns related to tiered networks and essential community providers.

Mr. Wieske asked for clarification concerning Ms. Offner’s suggestion to restrict the ability of health carriers to make mid-year provider network changes. Jeffrey Goldman (AHA) said AHA is suggesting such a restriction in situations where the proposed provider network change would have a significant impact in the service area. He said a determination on whether the proposed change is significant would be on a region-by-region basis. In addition, Mr. Goldman said consumers in the affected region should be allowed to change plans.

Sabrina Corlette (Georgetown University Health Policy Institute) asked Mr. Goldman if the AHA believes New York’s new law—Article 6, Emergency Medical Services and Surprise Bills—would address the issues related to hospital-based providers not being in-network. Mr. Goldman said the AHA has reviewed the law, but has taken no position on it.

Mr. Wieske suggested that, perhaps, it is the hospital’s obligation to inform patients when a hospital-based provider is not in the network. Mr. Goldman said AHA is suggesting that it is the health carrier’s obligation, because sometimes these providers are not hospital employees. Mr. Backus said that when consumers are enrolling in a health plan, they make their decision based on cost and are not necessarily considering future health care needs. As such, health carriers should do all they can do to inform consumers that certain hospital-based providers may not be in the network. However, he believes hospitals have some obligation to inform consumers, as well.

d. Seattle Children’s Hospital and Children’s Hospital Association

Mark Del Beccaro (Seattle Children’s Hospital) expressed the concerns of Seattle Children’s Hospital and the Children’s Hospital Association about the growing number of narrow networks and their impact on the ability of children to access the care they need when they need it by providers with the appropriate expertise. He said that, to ensure children have that access, insurance networks should include a full range of providers from primary care to the most complex specialty care. Dr. Del Beccaro said that, in addition, to adequately serve children, provider networks must include one or more pediatric hospital providers, when available, that maintain comprehensive pediatric specialty services if such providers and facilities are willing to contract under reasonable terms and conditions. He added that children’s hospitals should be in a health carrier’s provider network before the network is determined to be adequate.

Dr. Del Beccaro explained that pediatric specialty services are unique and are not readily available in community hospitals that are geared toward providing care for adults. He said non-children’s hospitals do not have the necessary expertise to adequately care for children who need specialty care. Dr. Del Beccaro cited an example of how narrow networks that do not include pediatric hospital providers in the network could ultimately be more costly and provide lower quality care when a child who needs specialty care is initially provided care at a community hospital and then the child is later referred to a children’s hospital for the needed specialty care. He said that by excluding children’s hospitals from provider networks, health carriers are blocking large numbers of children from access to the primary providers of specialty care for children. In addition, narrow networks are creating scenarios where knowledgeable parents of children with complex medical needs will select health plans with more comprehensive pediatric networks, thereby allowing health carriers with narrow networks to avoid assuming risk and to discriminate based on health status. Dr. Del Beccaro also suggested the need for greater transparency regarding the potential costs associated with obtaining out-of-network care, including the cost-sharing requirements.

e. Boston Children’s Hospital

Josh Greenberg (Boston Children’s Hospital) emphasized that provider networks for children are very different from those for adults. He expressed agreement with Mr. Walter’s comments regarding the importance of medical “homes” for children. Mr. Greenberg also noted the potential for cost-shifting, as Dr. Del Beccaro noted when narrow networks do not include
providers that provide specialty care for children. He also noted the potential danger to a child if the child is not treated by providers with the appropriate expertise, which can drive up costs and could lead to a poor outcome.

Mr. Wieske asked Mr. Greenberg if he is suggesting that, because children’s medical problems are more unique than adults, in designing networks, health carriers should focus on providers that provide specialty services to children as subset within the network. Mr. Greenberg agreed there should be such a focus.

Bill McAndrew (Illinois Hospital Association) agreed with the need to consider whether hospitals should be responsible for informing patients that a hospital-based provider is not in the network. However, he noted that, for some hospitals, taking on this responsibility could be an administrative burden. It could also expose hospitals to potential liability if the information they provide is wrong. As such, his organization would be concerned if regulators decide that hospitals should provide this information.

Mr. Wieske said the Subgroup will hear from insurer and business stakeholders during its next conference call, which will be held June 12.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
Network Adequacy Model Review (B) Subgroup
Conference Call
May 29, 2014

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call May 29, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Peg Brown (CO); Christina Goe (MT); Martin Swanson (NE); Gayle Woods (OR); and Molly Nollette (WA). Also participating was: Tyler Brannen (NH).

1. Heard Accreditor Organization Testimony

Mr. Wieske said the Subgroup would hear from accreditor organizations regarding their network adequacy accreditation standards and how they work with state insurance regulators to help ensure network adequacy.

Kylanne Green (URAC) explained URAC’s patient/consumer-focused approach related to network adequacy in its network management standards. She said URAC’s standards are flexible to account for the differences in organization approaches to ensure network adequacy. Ms. Green noted that, as part of URAC’s accreditation process, it confirms that an organization has established a system that constantly monitors its existing network to verify that it is meeting the clinical needs of its enrolled population. She said URAC standards also require that consumers be provided access to formal complaint and appeal processes within the organization. Ms. Green also discussed additional consumer protection requirements included in URAC’s standards. Ms. Green noted that applicants for URAC accreditation are reviewed to ensure that a robust internal system is in place to support compliance with applicable state and federal network adequacy regulations, as well as the contractual requirements of clients and purchasers.

Susan DeMarino (URAC) explained in more detail URAC’s network management standards, including specific network management standards to ensure that an organization defines its scope of services with respect to the types of services offered within the provider network and the geographic area served by the provider network. She said other network management standards address access and availability, provider selection criteria, and out-of-network and emergency services. Ms. DeMarino said URAC’s network management standards include requirements concerning provider directory updates.

Mr. Wieske asked if URAC reviewed organizations differently based on whether they are small or large, or regional or multistate. Ms. DeMarino said URAC has a standardized accreditation review process for validating whether an organization has complied with a particular standard. However, URAC approaches each organization differently in what may work for that specific organization to comply with the standards based on the goals set by the organization.

Lynn Quincy (Consumers Union) asked if organizations self-attest to compliance with URAC’s network management standards. Ms. DeMarino said URAC reviews an organization’s policies and procedures documents against its standards as part of its effort to validate what the organization has attested to URAC that it is doing. She also noted that URAC has a compliance program under which, after an organization is accredited, URAC re-validates an organization’s compliance with its standards. Ms. DeMarino said URAC also requires organizations to annually self-attest to their compliance with URAC standards.

Mary Beth Senkewicz (District of Columbia Health Benefit Exchange) asked if URAC had any requirements in its network management standards that require organizations to directly assist new enrollees to select a primary care provider. Ms. DeMarino said URAC has a requirement in its member relations and customer service standard to address any provider access issues, but URAC does not have any specific standards requiring an organization to actually assist a new enrollee in selecting a primary care provider and obtaining an appointment. Mr. Swanson asked about the length of URAC’s grievance appeal process. Ms. DeMarino said the time it takes to complete a grievance appeal will differ for each request. She explained URAC’s procedures when an organization is found to be out of compliance with URAC standards. Mr. Wieske asked about URAC’s procedures for revising existing standards and adding new standards. Ms. DeMarino said URAC has a three- to four-year review cycle for its existing standards. She said URAC will revise or add new standards more quickly if there are regulatory changes that make such changes necessary.
Ms. Horne asked if URAC was seeing any progress in improving the accuracy of provider directories and whether URAC has found any best practices in this area that other organizations could benefit from knowing. Ms. DeMarino said URAC has seen its accredited organizations getting better electronic updates, but it is still observing challenges its organizations are experiencing in obtaining information from providers.

Carolyn Kurtz (Accreditation Association of Ambulatory Health Care—AAAHC) provided a general overview of AAAHC’s work and history of accrediting ambulatory health care organizations. She noted that AAAHC is the third recognized accreditor for qualified health plans (QHPs) under the federal Affordable Care Act. URAC and the National Committee for Quality Assurance (NCQA) are the other two QHP-recognized accreditors. Ms. Kurtz outlined AAAHC’s accrediting standards and accrediting procedures, including its focus on the patient. She noted AAAHC’s experience with underserved populations.

Tom Tassone (AAAHC) described AAAHC’s network adequacy standards. He said that AAAHC’s procedures in accrediting a health plan organization includes a review of its policies and procedures to ensure, among other things, compliance with state and federal law, as well as AAAHC’s standards. Mr. Tassone noted that AAAHC’s standards are flexible to account for the differences among the states. He said AAAHC’s standards include core standards related to: 1) network transparency; 2) clear consumer disclosure, particularly related to narrower value networks; and 3) network pricing—out-of-network costs versus in-network costs. Mr. Tassone noted that AAAHC has a process for monitoring continued compliance with its standards.

Kristine Thurston Toppe (NCQA) explained that narrow networks are not necessarily problematic. It depends on how a health carrier has designed it. She said that in designing networks, health carriers need to consider both quality and cost, but not cost alone. She said NCQA’s network adequacy standards are similar to many state requirements. Ms. Toppe said NCQA is releasing proposed standards that she believes will address some issues consumers raised regarding network access and transparency. She noted that time and distance standards that have been used to help determine network adequacy in the past are not the best approach to network adequacy because such standards fail to look at quality.

Elizabeth Abbott (Health Access California) asked if NCQA’s network adequacy practices and standards translate directly into regulatory requirements that state insurance regulators can use. Mr. Wieske asked what NCQA sees as the role of the regulator versus the role of the accrediting organization in setting network adequacy standards. Ms. Toppe said NCQA views its role as a partnership with the states. She said NCQA’s network adequacy practices and standards could be helpful in revising the Managed Care Plan Network Adequacy Model Act (#74). Ms. Kurtz agreed with Ms. Toppe, noting that network adequacy requirements vary from state-to-state. Aaron Turner (URAC) also agreed. He encouraged state insurance regulators and consumers to view URAC and the other accreditor organizations as neutral third parties and to consider and use as another regulatory tool.

Stephanie Mohl (American Heart Association) asked if the accreditor organizations’ network access standards differed on whether the plan is a QHP or a plan outside the health insurance marketplaces. Ms. DeMarino said URAC’s standards are generally the same, except there is a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey requirement for QHPs. The CAHPS survey measures members’ satisfaction with their care in areas such as claims processing, customer service and getting needed care quickly. Ms. Toppe said NCQA’s proposed standards will apply to both QHPs and plans in the outside market. Mr. Kurtz said AAAHC’s requirements were generally the same except for the CAHPS survey requirement for QHPs. Mr. Brannen asked if Ms. Toppe considered an accreditor organization’s standards to be a floor for plans to comply with a state’s network adequacy requirements. Ms. Toppe said that, generally, if a state has requirements related to NCQA’s accrediting standards, the plan must follow the state requirements. However, if NCQA considers its standard to be more consumer-friendly and there is no conflict with state law, the plan must adhere to the NCQA standard.

Mr. Wieske said the Subgroup plans to hear from provider stakeholders during its next conference call June 5.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
Network Adequacy Model Review (B) Subgroup
Conference Call
May 22, 2014

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call May 22, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Tom Abel and Dayle Axman (CO); Christina Goe (MT); Martin Swanson (NE); Kim Everett (NV); Rhonda Saunders-Ricks (OR); and Molly Nollette (WA).

1. Heard Opening Remarks

Mr. Wieske said the Subgroup decided during its May 8 conference call to devote several of its next conference calls to hearing from various stakeholders (including consumers, providers, insurers and business groups) on their concerns and issues related to network adequacy. The Subgroup will hear from consumer stakeholder groups during today’s conference call.

Mr. Wieske reminded interested parties that each stakeholder group will have an opportunity to present their views. As such, interested parties can ask questions of the speakers to assist them in understanding the speaker’s viewpoint and position, but speakers should not be criticized for expressing those viewpoints and positions.

2. Heard Consumer Stakeholder Testimony

Elizabeth Abbott (Health Access California) raised three important ongoing issues that consumers are experiencing related to network adequacy: 1) lack of transparency and accuracy in provider network information; 2) lack of reasonable access to covered benefits; and 3) increased risk of unexpected costs because of the first two issues mentioned. She noted that these issues predate the enactment of the federal Affordable Care Act (ACA). Ms. Abbott said the ACA’s enactment presented an opportunity to update the Managed Care Plan Network Adequacy Model Act to address these issues. She said the NAIC consumer representatives are designing a survey to distribute to the state insurance departments to obtain quantitative data to inform the process and provide a means to make evidence-based decisions as the Subgroup moves forward with its work to revise Model #74.

Lynn Quincy (Consumers Union) said transparency and accuracy in the provider network information available to consumers prior to selecting a plan has been problematic. She said consumers—and some providers—are confused by the networks. Ms. Quincy also noted the overall inaccuracy of provider directories, which make it difficult for consumers to make informed decisions when choosing a plan. Ms. Quincy said network provider directory problems are among the top post-enrollment complaints expressed by consumers. She also noted that some providers have also had issues with the directories, because they do not know which networks they have contracted with to provide services.

Mr. Wieske asked if Ms. Quincy had any suggestions or best practice tools that consumers should use in figuring out which providers are in which networks when they review a directory. Ms. Quincy said whatever is developed to address these issues it should be applied to qualified health plans (QHPs) and to health benefit plans outside the health insurance marketplaces. She also suggested that the Subgroup explore requiring health carriers to provide a special enrollment period for consumers who relied on the information included in provider network directory as to whether their current provider is in the plan network and it turned out that the directory was inaccurate.

Alyssa Vangeli (Health Care for All – Massachusetts) also discussed network transparency issues that consumers have encountered when enrolling in a plan. She said consumers are having trouble determining the type of network plan, such as if the plan is a narrow network plan, tiered network or some other type of network plan design. Ms. Vangeli said this is problematic because consumers need to know what type of network plan in which they are enrolling in order to help ensure they will have access to the health care services and in-network providers they need. She said consumers also need to a way to better understand the quality of the providers in the network. Ms. Vangeli suggested that the Subgroup consider developing a definition of “narrow network” and require more disclosures to help to address these issues.
Stephanie Mohl (American Heart Association) discussed concerns related to access. She said network adequacy should mean that the provider network is sufficient to provide the covered services in a timely manner without the consumer having to travel an unreasonable distance. If the provider network does not provide such sufficiency, then the consumer should be allowed to obtain the covered services from an out-of-network provider at the same cost as an in-network provider. Ms. Mohl said network adequacy standards should include quantitative standards based on travel time and distance for covered services. State insurance regulators should have appropriate procedures to monitor consumer complaints and to ensure compliance with the standards.

Lincoln Nehring (Voices for Utah Children) said narrow networks and ultra networks are a problem if consumers do not know what this means to them as far as being able to obtain covered services they may need within a reasonable time. Mr. Nehring said consumers who have to travel across state lines are particularly at risk of encountering the problem of an inadequate network. He also said that the inclusion of essential community providers (ECPs) in networks has proven problematic, despite the ACA requirement that such providers be included in QHP provider networks. Children’s hospitals in particular have been excluded from provider networks despite QHPs being required to provide pediatric services. Mr. Nehring said access issues have been created when providers leave networks mid-year. This is particularly problematic for consumers in the middle of a course of treatment. He said some states have addressed some aspects of this issue by enacting continuation of coverage requirements. Mr. Nehring noted a similar concern with tiered networks when a provider is moved to a higher tier with higher cost-sharing requirements in the middle of a patient’s course of treatment, which could mean, in some cases, that the consumer must discontinue treatment with that provider because they cannot afford to pay the higher out-of-pocket costs.

He suggested that the states could include certain protections in their network adequacy standards to help address these issues and concerns, such as: 1) requiring carriers with plans that have narrow networks to also include broader plan networks for consumers to have the option of selecting; 2) imposing specific ECP requirements and enforce those requirements; and 3) prohibiting mid-year network changes or at least permit consumers to continue care with that provider at the same cost.

Jesse Ellis O’Brien (Oregon State Public Interest Research Group) said the transparency and access issues already discussed could lead to cost issues for consumers, particularly when those issues require consumers to obtain covered services from an out-of-network provider. He suggested several ways the Subgroup might want to consider to help shield consumers from being exposed to these additional costs, including: 1) requiring carriers to consider covered services obtained from an out-of-network provider as being provided by an in-network provider when the carrier does not have any in-network providers to provide the service within a reasonable distance from the consumer; 2) require carriers to consider ancillary providers who provide covered services at in-network health care facilities to be in-network providers even if they are out-of-network providers; and 3) prohibit carriers from switching in-network providers to a higher tier during the middle of the policy or contract year.

Mr. Wieske noted the difficulties regulators face when determining network adequacy and what options regulators have when a network might be considered insufficient. He asked if more robust enforcement tools are needed to ensure compliance with network adequacy standards. Mr. Wieske also asked how some of the suggestions (such as requiring wide networks or prohibiting switching providers to higher tiers or dropping providers mid-year) to address the transparency, access and cost issues would work and the potential costs to insurers and possible impact on premium rates.

Ms. Quincy said consumers are aware of the tradeoffs between premium rates and network adequacy. However, she believes that there should be a set floor for network adequacy below which regulators will not approve. Ms. Quincy said she believes having a floor would still permit the possibility of narrower networks that are developed based on quality, not cost.

Jackson Williams (Dialysis Patient Citizens) raised the issue of how narrow networks impact consumers requiring dialysis services. In some cases, the narrower networks have required consumers to travel to obtain dialysis services at locations unreasonably distant from where the consumer lives or works. Mr. Williams suggested that, perhaps, the solution to this issue would be to require carriers to have more robust networks for certain services, such as dialysis services. He also suggested that some of these issues have arisen because of the lack of transparency related to the network, which causes consumers to select a plan with a network that does not allow them to obtain the covered services they need in a reasonable manner.
Ms. Goe said she believes the discussion about narrow networks illustrates how different this issue is from state-to-state because Montana does not have any narrow networks. She said that, in order to find a solution to this issue, Subgroup will have to figure out a balance in setting network adequacy standards that will permit carriers to maintain low premiums, but still be able to include higher cost providers in their networks. Ms. Goe noted that this would not be an easy task because regulators have no control over health care costs. She said she appreciated the discussion concerning transparency, but she does not believe that resolving that one issue would resolve all of the issues. Mr. Wieske agreed.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
Network Adequacy Model Review (B) Subgroup
Conference Call
May 8, 2014

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call May 8, 2014. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne (CA); Dayle Axman (CO); Christina Goe (MT); Martin Swanson and John Rink (NE); Kim Everett (NV); Rhonda Saunders-Ricks (OR); Linda Johnson (RI); and Molly Nollette (WA). Also participating was: Megan Mason (MD).

1. Reviewed Managed Care Plan Network Adequacy Model Act (#74)

Jolie Matthews (NAIC) reviewed the provisions of the Managed Care Plan Network Adequacy Model Act (#74). She explained that Model #74 applies to all health carriers that offer a managed care plan. Model #74 defines a “managed care plan” broadly to mean a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. Ms. Matthews said this definition includes HMOs, as well as preferred provider organizations (PPOs).

She said Section 5—Network Adequacy sets out the network adequacy standards that health carriers that offer a managed care plan must maintain to assure that covered persons will have access to covered services without unreasonable delay. Ms. Matthews noted that this section does not include a specific requirement that a plan’s network include essential community providers. It also does not include specific requirements regarding the provision or accessibility of provider directories to covered persons or applicants. She said the federal Affordable Care Act (ACA) requires qualified health plan (QHP) issuers to include such providers in their QHPs. The federal regulations implementing the ACA’s network adequacy requirements include specific provisions concerning the availability of provider directories. Ms. Matthews said Section 5 includes additional requirements related to provider networks, such as requiring the carrier to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. Section 5 also requires health carriers to file an access plan with the commissioner for each of its managed care plans.

Ms. Matthews explained that Section 6—Requirements for Health Carriers and Participating Providers sets out requirements for both carriers and providers with respect to provider contract provisions, including hold harmless provisions and provisions related to the provision of health care services to covered persons in the event of a carrier or intermediary insolvency or other cessation of business. She said Section 6 also includes requirements that carriers have selection standards for participating providers (i.e., primary care professionals and specialty care professionals). These standards are to be used in the provider selection process by the carrier, its intermediaries and any provider networks with which the carrier contracts. Ms. Matthews noted that this provision specifically requires the standards to meeting the requirements of the Health Care Professional Credentialing Verification Model Act (#70).

Ms. Matthews said Section 7—Intermediaries sets out the requirements that must be contained in a contract between a carrier and an intermediary. She said “intermediary” is defined in Model #74 to mean a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network. Section 8—Filing Requirements and State Administration requires health carriers to file sample contract forms with the commissioner that it intends to use with its participating providers and intermediaries. Ms. Matthews said Section 9—Contracting describes general contract requirements, including the requirement that all contracts must be in writing and are subject to review.

Section 10—Enforcement provides that the commissioner may institute corrective action that a carrier must follow, or the commissioner may use any of the commissioner’s other enforcement powers, whenever it is determined that: 1) the carrier does not have a sufficient network in a geographic area; 2) the carrier’s access plan does not assure reasonable access to covered benefits; 3) the carrier has entered into a contract that does not comply with a provision in Model #74; or 4) the carrier has not complied with any provision in Model #74. Ms. Matthews said Section 10 also includes a provision stating that the commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination.
Timothy S. Jost (Washington and Lee University School of Law) asked how many states have adopted Model #74. He also asked when this list was last updated. Ms. Matthews said approximately six states have adopted some version of Model #74 and approximately 15 states have adopted something similar to Model #74. Candy Gallaher (America’s Health Insurance Plans—AHIP) said that, although Model #74 is old, its provisions are quite robust and includes important provisions concerning network adequacy, including contracting provisions. She said such provisions were why the U.S. Centers for Medicare and Medicaid Services (CMS) chose Model #74 as a threshold standard that qualified health plans (QHPs) could use in 2014 to satisfy the ACA’s network adequacy requirements.

Stephanie Mohl (American Heart Association) said the NAIC consumer representatives sent a letter to the Subgroup detailing their “Principles for Assuring Consumer Access to Care.” She agreed that Model #74 is quite comprehensive, but with the enactment of the ACA and the evolving nature of the issue, updating Model #74 is necessary to address these changes and new requirements.

2. **Discussed Next Steps**

Mr. Wieske said he believed that the Subgroup’s next steps should be to hear from various stakeholders on their issues and what they are seeing inside and outside exchanges related to network adequacy and any suggestions they may want the Subgroup to consider to address those issues and concerns. He suggested that the Subgroup devote the next several conference calls to hear such testimony. Mr. Wieske also suggested that the Subgroup conduct a survey of the states to determine what network adequacy requirements states are currently imposing on carriers both inside and outside the health insurance exchanges and how they monitor compliance and enforce the requirements. Ms. Mason cautioned that the Working Group needed to develop its survey questions carefully because the term “managed care” is defined differently from state-to-state.

Ms. Goe expressed support for Mr. Wieske’s suggestions, including conducting the survey. She expressed the hope that the Subgroup could determine how to address at least one issue she has seen involving product designs that carriers have been developing over the years since Model #74 was adopted that do not fall into any category as an HMO or a PPO, such as tiered network systems. Mr. Wieske agreed. After additional discussion, the Subgroup agreed to Mr. Wieske’s suggestions.

Ms. Gallaher said that, because of the bifurcated regulatory oversight of managed care plans in some of the states, the Subgroup needs to make sure those non-insurance department state agencies, such as the department of health, are included in the Subgroup’s discussions. Ms. Goe agreed with Ms. Gallaher, but said it should be up to each state insurance department to decide how, and in what manner, to include these non-insurance department state agencies in the Subgroup’s discussions.

Ms. Saunders-Ricks asked about the Subgroup’s timeline for finishing its work. Mr. Wieske said he anticipates that the Subgroup will work expeditiously, but he does not believe it would be finished by the Summer National Meeting. He said it is more likely that the Subgroup would complete its work by the Fall National Meeting.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
ERISA (B) Working Group
Louisville, Kentucky
August 16, 2014

The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met in Louisville, KY, Aug. 16, 2014. The following Working Group members participated: Christina Goe, Chair (MT); Linda Brunette (AK); Dan Honey (AR); Peg Brown (CO); Doug Ommen (IA); Linda Sheppard (KS); Korey Harvey (LA); Robert Wake (ME); Therese M. Goldsmith (MD); Angela Nelson and Molly White (MO); Ted Hamby (NC); John Rink and Martin Swanson (NE); Glenn Shippey (NV); Matt Elston (OH); Buddy Combs (OK); Melissa Klemann (SD); Doug Danzeiser (TX); Tanji Northrup (UT); Jason Siems (WA); and Richard Wicka and J.P. Wieske (WI).

1. Discussed Draft Stop Loss Insurance, Self-Funding and the ACA White Paper

The Working group discussed the Aug. 12 draft of the Stop Loss Insurance, Self-Funding and the ACA white paper (Attachment Five-A). Ms. Goe gave a brief overview of the topics discussed in the paper. She said that the paper does not touch on the wisdom of small employer self-insurance, but rather focuses on stop loss insurance and the regulatory issues it raises. Ms. Goe said that only a sample of stop loss policies were examined, and the paper is not intended to give an exhaustive list of stop loss provisions in the marketplace. She said that there is not a lot of uniformity in the marketplace, so employers need to be well-informed when choosing one. The paper also touches on how third-party administrators (TPAs) interact with employers and stop loss insurers. Additionally, the paper lists some regulatory approaches that states have taken with respect to stop loss insurance for states to consider. The paper does not recommend any particular approach and recognizes that the options that are suitable for a particular state will vary.

Timothy S. Jost (Washington and Lee University) said that he would be submitting written comments, but had some preliminary comments to share. He mentioned that an option that exists in some states that was not mentioned in the paper was the prohibition of the sale of stop loss insurance to small employers. He also suggested that the Working Group might consider drafting a bulletin that states could use to help educate small employers. Mr. Jost said that another issue to include in the paper is that stop loss insurance is not subject to any loss ratio requirements, so agent and broker compensation may look different. He said stop loss coverage together with TPA services is being marketed aggressively to some small employers by agents and brokers, and state insurance departments need to stay aware.

Robert Holden (Stateside Associates) spoke on behalf of the National Association of Third Party Claim Administrators. He said he planned to submit written comments on the white paper. He said that small employers using TPAs is not a new phenomenon. He said that just because an employer is small does not mean it is unsophisticated. He said that TPAs are there to help employers make the best possible decisions for their employees and to make sure self-funding with stop loss insurance remains a viable option. He said a bulletin to educate employers sounds like a good idea, and he would be happy to participate in its development. Ms. Goe said that the goal is to make sure everyone has access to the same information, and she is looking forward to input from all interested parties.

The Working Group requested comments on the white paper by Sept. 16 and anticipates meeting via conference call by the end of September. Additional drafts and open calls will be scheduled as needed.

Having no further business, Mr. Weiske made a motion, seconded by Mr. Swanson, to adjourn into regulator-to regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.

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STOP LOSS INSURANCE, SELF FUNDING AND THE ACA

I. Introduction

Since the passage of the Patient Protection and Affordable Care Act of 2010\(^1\) (ACA), there has been a lot of speculation about its potential impact. The goal of the law is to make affordable, quality health insurance available to everyone through a combination of premium tax credits, an individual mandate and health insurance market reforms, including guaranteed issue, adjusted community rating, and a prohibition on preexisting condition exclusions. One concern about the potential impact of the ACA is that if employers, particularly small employers, with younger, healthier employees self-fund, thereby avoiding some of the requirements of the ACA\(^2\), it will leave the older, sicker population to the fully insured, small employer group market. Some have expressed the concern that if stop loss coverage is not adequately regulated, it can make the adverse selection problems worse by serving as a functionally equivalent product that competes directly with the community rated small group market, but is allowed to underwrite and rate based on health status and claims experience. These concerns must be balanced against concerns that the rising costs of small employer health insurance will lead some small employers to exit the small group market entirely.

Predicting the effect of the ACA on employers’ decisions regarding whether or not to self-fund is complicated by the lack of information about the prevalence of self-funding in the pre-ACA environment. There is little information about the number of employers that currently self-fund. States do not regulate self-funded employer plans\(^3\) and consequently have little information about them and the number of employers that self-fund.

In an effort to remedy this, Section 1253 of the ACA mandates that the Secretary of Labor prepare aggregate annual reports with general information on self-funded group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements), as well as data from the financial filings of self-funded employers (including information on assets, liabilities, contributions, investments, and expenses). The U.S. Department of Labor (DOL) engaged Deloitte Financial Advisory Services LLP to assist with this ACA mandate. Three years of Reports have been completed. The 2013 Report can be found at www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport033113.pdf

The primary shortcoming of this data, however, is that it does not include small employers (employers with 100 or fewer employees) that pay for any portion of benefits from their general assets (rather than a segregated trust). These small employers are exempted from all filing requirements. This includes an unknown number of self-funded small employers.

Many articles have been written discussing the potential for and consequences of small employer self-insurance in the post-ACA environment,\(^4\) however, at this point, the increase in small employer self-funding is not known. But there has been

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\(^1\) Public Law 111-148
\(^2\) See Appendix A for a discussion of the new ACA requirements on small employers as compared to self-funded plans.
\(^3\) See Appendix B for a discussion of the relationship between state law, ERISA and stop loss insurance.
\(^4\) See Appendix C for a bibliography of articles exploring the pros and cons of small employer self-insurance.
demonstrated interest in discussing self-funding in the small group market. One of the areas states are seeing evidence of this interest is in the stop loss insurance policies being developed for and specifically marketed to small employers.

This paper explores trends in stop loss insurance seen by state departments of insurance and the regulatory issues they raise. This paper also identifies issues about which state insurance departments need to be aware when regulating stop loss insurance policies. The insurance market is changing and regulators need to keep abreast of what is happening in the marketplace and work together to ensure that small employers understand their obligations under any self-funded arrangement and make sure that both the fully insured and self-funded markets operate in the interest of small employers, and their employees.

II. How Does Self-Funding Work and Where Does Stop Loss Insurance Fit In?

Unlike the employer who purchases a fully-insured plan from an insurance company, an employer who self-funds takes on all the responsibility and risk that a fully-insured employer has transferred to the insurance company. A self-funded employer determines what benefits to offer, pays medical claims from employees and their families, and assumes all of the risk. A self-funded employer may transfer some or all of its risk of loss to a stop loss insurer by purchasing a stop loss insurance policy, but the employer remains ultimately responsible if the stop loss insurer fails to perform or denies a claim based on the terms of the stop loss contract or if there are gaps in coverage or conflicts or inconsistencies between the stop loss policy as administered by the insurer and the employer’s obligations under the self-funded benefit plan.5

When the employer runs the entire program, the employer may face a number of issues. First, some employers have no expertise in estimating the cost of the program. The employer will need to estimate the cost for each employee and estimate the cost associated with changing any benefit. The employer may have little experience in processing medical claims or in creating mechanisms that control costs (like provider networks or in managing care for patients with complicated medical conditions). Even if the employer gains the skills necessary, the employer may lacks economies of scale, which makes it very expensive for the employer. Finally, self-funding leaves the employer at significant risk for shock claims (high dollar but low frequency claims, such as an organ transplant) and high utilization (low dollar but unusually high frequency).

In response to these issues, some employers have sought out alternative arrangements. For example, an employer may hire a company to manage its health benefit program typically referred to as a third party administrator (TPA). TPAs (including insurers with ASO contracts) can provide a variety of services. They may assist the employer in designing the benefit package, estimating the costs associated with the entire program or in adding a particular benefit, as well as ensuring that the health plan complies with applicable federal law and notice requirements. TPAs may also provide cost management services, like access to provider networks and the ability to conduct sophisticated care management programs like large insurers. Finally, a TPA will have staff available to help the employer deal with enrollment issues and process medical claims. For all these services, employers will pay a fee and provide the “checkbook,” i.e. the money necessary to pay the claims.

5 In the large group market, where community rating laws do not prohibit the practice, the issuer of a group insurance policy can also transfer risk back to the employer. An employer and an insurer may agree to a loss-sensitive rating plan where the employer gets a surcharge or refund at the end of the year depending on claims experience. These plans allow the employer to assume some or all of the financial risks and rewards of self-insurance, while the employees have all the protections of a fully-insured plan.
Employers can mitigate risk by using stop loss insurance. A stop loss insurance policy usually contains two components, a specific “attachment point” (or retention level”) that protects against claim severity and an aggregate attachment point that protects against claim frequency. The policy’s specific coverage provides protection in the case of a single covered individual with a high dollar claim or series of claims. Any costs exceeding the specific attachment point are covered by the stop loss policy. The aggregate coverage provides protection against the cumulative impact of smaller claims that may never meet the threshold of a specific attachment point. Once the employer’s total claims payments (not counting any claims paid by the specific coverage) reach the aggregate attachment point, the stop loss policy covers all remaining costs for the year (up to the policy limit, if any.) Except for very small employers, the aggregate attachment point will be significantly less than the sum of the specific attachment points.

Example:
An employer with 100 employees buys stop loss coverage with a $10,000 specific limit, and a $150,000 aggregate limit. After meeting the limits, coverage is at 100%.

Scenario 1:
In January, February, and March, 50 employees have claims of $3,000 or more
In June, one employee has back surgery costing $200,000
The aggregate limit would be met by $150,000 in claims. After that point, all covered claims would be paid by the stop loss insurer.

Scenario 2
In January, one employee has a premature baby costing $1,000,000.
In June and July, two employees have back surgery costing $150,000 each.
The rest of the employees have claims totaling $50,000.
The stop loss insurer would be required to cover all costs of the premature baby exceeding the $10,000 limit.
The stop loss insurer would cover the cost of each surgery over the $10,000 limit.
The employer would not meet the aggregate limit of $150,000 since the employer’s liability was limited to $80,000.

Stop-loss insurance does not, however, protect against timing risk. A fully-insured employer does not have this risk – the employer pays a fixed premium every month, established at the beginning of the policy term. A self-funded employer, by contrast, needs to pay claims when they are incurred, and the timing is beyond the employer’s control. If an employee has a catastrophic medical expense in January, the employer must pay the entire specific retention up front before the specific stop-loss coverage steps in for the remaining expense. If the plan reaches the aggregate attachment point at the end of September, the employer must pay the year’s entire aggregate retention in the first nine months. The unpredictable cash flow of a self-funded plan, even with stop-loss insurance, cannot be budgeted with confidence, especially by small employers, and accelerated claims liabilities could result in significant financial hardship. As part of the TPA agreement, the TPA may allow the claims account to go into deficit with agreement that the employer will fully fund the account over the course of the year. Sometimes these provisions are an in the form of an addendum added to the stop loss policy and may be referred to as an advanced claim funding loan agreement.
III. **Anatomy of a self-funded Health Plan combined with Stop Loss Insurance**

An employer designing a self-funded plan with a TPA and stop loss insurance will have to make a number of important decisions in designing the plan. The contract between the TPA and the employer must detail the services provided by the TPA. The employer must determine how much risk to insure with a stop loss policy. The employer must also determine the benefits to be covered by the self-funded plan. A smaller employer often relies on a TPA to advise on what benefits and protections for employees are required by federal law and to ensure the health plan is fully compliant with applicable laws. Employees covered under those health plans do not have the benefit of the regulatory oversight provided by state insurance departments that review and approve fully insured health plans. An employer that relies entirely on a TPA may not be aware that the health plan does not comply with the provisions of ERISA, HIPAA or the ACA that are applicable to self-funded health plans until there is a problem and a complaint is made. An employer may ultimately be held liable for a mistake made by the TPA in the design of the health plan.

The TPA contract must address a number of day-to-day operational issues. For example, the TPA contract must determine who creates and distributes the summary plan description and any other plan documents required notices. It governs the payment of claims. It specifies issues surrounding the funding of the account to pay claims. The document also covers run-in claims issues (claims incurred before the beginning of the contract year but not yet presented for payment) and run-out claims issues (claims incurred during the contract year but presented after the end of the year), and the transition process when the contract is renewed or terminated. It will also cover a myriad of other issues typically contained in insurance contracts.

The specific and aggregate attachment points of the stop loss insurance policy determine how much risk the business retains and how much risk is transferred to the insurer. How much the employer is willing to pay for lower attachment points will depend on how much risk the employer can afford to assume. The stop loss policy is subject to underwriting — both at the initial point of sale and upon renewal — so the insurer will examine the employer’s claims history, and may offer coverage at an increased rate or refuse to offer coverage to that employer group. In some cases, either as a condition of offering coverage at all or in return for a lower premium rate, stop loss insurers will offer a “laser specific” attachment point, meaning a higher attachment point for one or more individuals with pre-existing high cost medical conditions or other identified risk factors. For example, if an employee’s condition is in remission, the employer may be prepared to assume the risk of relapse to avoid a more costly premium increase. However, before taking that risk, the employer should first have the cash reserves to pay for a large claim incurred by that employee if a significant medical event occurs. The ACA prohibits self-funded employer health plans from discriminating based on health status or imposing annual or lifetime dollar limits on essential health benefits.

Self-funded plans have a great deal of flexibility in plan design; however, the ACA has limited that flexibility somewhat. The ACA requires that certain benefits be covered, such as certain preventive benefits; it also prohibits annual and lifetime dollar limits, limits employee cost sharing and places “minimum value” and affordability requirements on the health plan design. Still, an employer may wish to add or subtract benefits to accommodate a budget while still meeting the requirements of federal law, based on the needs of their employees. For the largest plans, almost any benefit can be added – for a price. Each benefit may be priced by the administrator based on how much it will raise the cost of the plan both from a claims

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6 Typically, the benefit plan, the TPA contract and the stop-loss policy all have the same one-year term, but there can be exceptions – for example, if the employer chooses to change its plan anniversary date.
perspective and stop loss insurance perspective. As employers get smaller, self-funded health plans (often designed by the TPA) tend to become more standardized.

For small employers, basic stop loss insurance reimburses the employer only for employee claims that the employer reports to the insurer during the policy year. The employer is only reimbursed for claims that were incurred and paid during the policy year. The policy may include “run-out” or “tail” coverage, which protects the employer against claims incurred during the policy year but not reported or paid during the policy year. The run-out period is a specified extended reporting period for claims incurred during the policy year but not submitted or paid until the after the end of the policy year. A few states require insurers to provide tail coverage, or at least to offer it on an optional basis. Insurers may also sell “run-in” or “nose” coverage, which protects against claims incurred during the prior policy year but paid during the current policy year.

Typically, the only restrictions on policy termination will be the restrictions required by state law for commercial-lines or casualty insurance policies in general – timely notice of cancellation or nonrenewal, and cancellation only for the specific grounds permitted by state law.

IV. Regulating Stop Loss Insurance

States have taken different approaches to the regulation of stop loss insurance and it is important to understand how stop loss insurance functions from a regulatory perspective. Stop loss insurance is a “third-party” line of coverage. This means the claimant who has suffered the primary loss – the medical event – is not insured under the policy. This is the fundamental distinction between stop loss insurance and group health insurance. Stop loss insurance insures only the employer; therefore the insurer has no direct contractual obligations to the plan participants. Plan participants rely on the employer, not the stop loss insurer, for benefit payments. Property insurance, by comparison, is “first-party” coverage: the claimant whose property has been stolen or damaged is the policyholder, and files a claim with his or her own insurance company.

While stop loss is a highly specialized line of insurance, it has much in common with the two most basic and ubiquitous types of third-party coverage—reinsurance and liability insurance. The similarities and differences are instructive to regulators when they consider how best to regulate stop loss insurance.

Stop loss insurance is sometimes referred to as a form of reinsurance, and the only real difference between stop loss insurance and reinsurance is the nature of the entity purchasing the coverage. Reinsurance covers a licensed insurer for its obligations under insurance policies, while stop loss insurance covers a self-funded employer for its obligations under a health benefit plan. For any given benefit plan, the actuarial risk – the usage of covered medical services by the plan participants during the plan year, is the same whether the plan is fully insured or self-funded.

Many of the distinguishing features of reinsurance regulation are based on the manner in which the ceding insurer and the underlying insurance transaction are regulated. In particular, reinsurers do not need to be licensed in the state where the ceding insurer is located, because the ceding insurer is already subject to comprehensive regulation, including oversight of its reinsurance program. Reinsurance is exempt from premium tax, because the underlying insurance transaction was already fully taxed at the “retail” level. These features do not apply to stop loss insurance.

The regulatory approach to reinsurance is based in part on the recognition that ceding insurers are relatively large and sophisticated business enterprises that do not need the same range of consumer protections as individuals who purchase insurance. Stop loss, likewise, is a commercial rather than a personal line of insurance and should be regulated accordingly, although consideration should be given to the differing situations of small and large employers.
Stop loss can also be viewed as a form of liability (casualty) insurance. The difference here is that traditional liability insurance protects the policyholder against liability for harm to third-party claimants when the policyholder is in some way responsible for the harm.\(^7\) By contrast, an employer that has not established a self-funded health plan has no responsibility for employees’ health care needs (except for work-related conditions that would be outside the scope of a health plan).

The two analogies lead to different conclusions as to which type of insurer should be authorized to write stop loss coverage. If stop loss insurance is treated like reinsurance, then it should be written by the same type of insurer that writes the underlying direct coverage, which would be a health insurer. On the other hand, if stop loss insurance is treated like liability insurance, then it should be written by a casualty insurer. Both types of companies participate in this market, and different states take different approaches. Some states treat it as a health insurance line, others as a casualty insurance line. Several states classify it as casualty insurance, but also authorize health insurers to write it.\(^8\) This distinction becomes critical when determining what state insurance laws will apply.

While stop loss insurance provides essential protection for self-funded employers against large losses, it can also be used for a completely different reason, to take advantage of favorable regulatory treatment. A stop loss policy with low enough attachment points functions like a group health insurance policy with premiums being split between TPA fees, stop loss insurance, and a fully-funded claims account, but without being subject to the same regulatory requirements as health insurance. Additionally, even though the ACA has imposed some new requirements on self-funded health plans, many other provisions including rating restrictions, essential health benefit requirements and state mandated benefit laws do not apply.

Regulators have responded by establishing risk transfer standards. Many states set thresholds for stop loss attachment points, with the goal of ensuring that employers buying this coverage retain enough risk that they remain truly self-funded. The NAIC adopted the *Stop Loss Insurance Model Act* (Model #92) in 1995, and revised it in 1999, which set the following minimum attachment points, and gives the Commissioner the authority to adjust them for inflation:

- specific: at least $20,000;
- aggregate (groups of more than 50): at least 110% of expected claims;
- aggregate (groups of 50 or fewer): at least the greater of 120% of expected claims, $4000 times the number of group members, or $20,000.

V. **Rate and Form Review of Stop Loss Insurance**

The regulation of stop loss insurance has historically, in many states, been focused primarily or exclusively on prohibiting excessive risk transfer so that stop loss coverage is only sold to bona fide “self-funded” employers. However, because of the manner in which the stop loss insurance market has developed, and because of the types of provisions found in some stop loss policies, the review of stop loss rates and forms\(^9\) also should focus on protecting the interests of stop loss

\(^7\) Although liability coverage is not strictly limited to tort liability, traditional contractual liability coverage still focuses on tort-like damages. It is typically triggered by cases where either the victim alleges a contractual duty or the tortfeasor alleges a duty to indemnify.

\(^8\) See 24-A M.R.S.A. § 707(3) (“An insurer other than a casualty insurer may transact employee benefit excess insurance only if that insurer is authorized to insure the class of risk assumed by the underlying benefit plan.”)

\(^9\) Many states do not have the authority to review stop loss rates and some do not review or approve stop loss forms.
policyholders, and the interests of health benefit plan members and others who might suffer collateral harm if the stop loss insurance has the potential to leave the self-funded employer unable to fulfill its fiduciary obligations.

Several aspects of the typical stop loss insurance policy are important to identify. Many of these aspects were mentioned in the previous section “Anatomy of a Stop Loss Policy.” Identifying these typical policy provisions is critical in assessing the financial exposure and risk of harm to a small employer, and ultimately to the member employees and dependents of the self-funded health plan. These aspects are also important in designing appropriate regulatory standards for the review of stop loss forms and rates.

- The self-funded employer remains legally responsible to pay the claims of its member employees and dependents. The employer is the plan fiduciary under ERISA. Fiduciaries can be personally liable if they fail to fulfill their fiduciary obligations under ERISA, and they are also liable if they know or should have known of any breach by a co-fiduciary. When a self-funded employer delegates some or all of its fiduciary responsibilities to service providers (like a TPA), the employer is required to monitor the service provider periodically to assure that it is handling the plan’s administration prudently.

- Both the timing and the amount of claims can vary significantly from month to month and year to year. Because small employers lack credible and predictable experience, there can be significant cash flow issues for the small employer in months where the claims experience is significantly higher than average and employers are required to contribute additional funds to the claims account.

- Some policies include policy provisions that mitigate the risk of high and low claims months by allowing claims accounts to include a temporary negative balance. This is essentially a loan from the TPA to the employer, and the contract should specify any repayment provisions including penalties and interest. Some stop loss insurance products marketed to small employers contain specific “advance funding” provisions, which may expose small employers to risk in the event they are unable to repay, especially if the repayment provisions are unduly punitive.

- Stop loss insurance policies typically cover claims incurred and paid during the policy period. The contract should specify coverage, if any, for claims incurred but not paid during the policy period, and for claims incurred outside the policy period. Employers should be aware of their liability for claims that are incurred, but not covered under the terms any “tail coverage” provided by the stop loss policy.

- Stop loss policies are written with one year terms. As a result, a stop loss policy’s contract terms and price can vary from year to year, due to re-underwriting. In some cases, the stop loss insurer may even decline to renew or may cancel the policy, sometime even mid-term. Because the policy is newly underwritten from year to year, when a stop loss insurer offers coverage to an employer whose employees have significant medical conditions, it may offer coverage at a much higher premium rate, with higher stop loss limits (both aggregate and specific), or may offer coverage with higher specific limits on some employees (known as a “laser specific”).

- Stop loss insurance premiums are developed based on an actuary’s determination of the expected losses of the self-funded group. In the case of a large self-funded group, the experience of the group is generally credible, and premium development proceeds in a manner similar to an insured large group. The experience of a smaller group

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(for example, employers with 51 to 100 employees) is not credible, or not fully credible, and some degree of actuarial judgment is needed to set a premium. In the case of a very small group (e.g. the 10 to 50 employees), a credible estimate of expected losses may not be realistic. In these circumstances, an actuary may be unable to determine, with a reasonable degree of actuarial certainty, the “expected claims” of the small employer, and therefore may be unable certify that the policy is in compliance with regulatory standards regarding establishing minimum specific or aggregate attachment points with reference to “expected claims”; e.g. an actuarial certification that the annual aggregate attachment point is no lower than 120% of expected claims.

All of the above factors increase the financial risk and uncertainty to the small employer. However, states generally do not regulate stop loss insurers in terms of the size of the employer policyholder, and some stop loss insurers, TPA’s and brokers may market to employers with as few as 10, or even 5, employees.

VI. **Additional Stop Loss Insurance Policy Provisions that merit regulatory consideration**

Stop loss insurance policies sometimes include provisions that are typically found in health insurance plans, such as medical necessity determinations, UCR determinations, experimental/investigational determinations, case management requirements and mandated provider networks. Because there is no fully insured health plan present, these arrangements may not be subject to any state regulatory standards. However, some states will disapprove these provisions in stop loss insurance policy forms on the grounds that these determinations must be made by the health plan fiduciary and are outside the scope of an insurance product whose primary purpose is to “reinsure” a risk incurred by the health plan fiduciary, the employer.

Some stop loss insurance policy filings include provisions that add a managed care element with respect to the plan participants by offering financial incentives for using certain providers. This type of provision is typically part of the health plan, not part of the stop loss policy and establishes a direct relationship between the stop loss insurer and the employer’s member employees and dependents that goes beyond the customary contract between the stop loss insurer and the employer. Rather than managing claims by capping the stop loss insurance benefits, and letting the plan sponsor handle benefit and network management, the stop loss insurer inserts itself into plan management activities, even though stop loss policies expressly state that the stop loss insurer is not the plan fiduciary and that the beneficiaries of the plan have no legal recourse against the stop loss insurer.

The care management theme continues in stop loss policy provisions that permits certain plan management fees to count as eligible expenses under the stop loss policy. Such fees include:

- Reasonable hourly fees for case management services provided by a nurse case manager retained by the plan sponsor or the TPA;
- Fees for hospital bill audit services;
- Fees for access to “non-directed” provider networks (policy does not define what non-directed networks are);
- Fees or costs associated with negotiating out of network bills.

The policy states that such fees can be considered eligible for stop loss reimbursement if the plan sponsor demonstrates to the stop loss insurer that the fees generated savings to the self-funded health plan. Stop loss reimbursement for such fees is limited by applying a percentage allowable, and a dollar maximum, per plan enrollee per hospital stay. These provisions might indicate that the stop loss insurer is actually simply footing the bill for case management and out of network claim negotiation and is engaging in plan fiduciary activities without acknowledging fiduciary responsibilities.
States insurance departments may consider the extent to which these and other types of innovative policy provisions might create a direct relationship between the stop loss insurer and the health plan beneficiaries that goes beyond the relationship between the stop loss insurer and the employer. If the stop loss coverage is no longer functioning as third party coverage, state policymakers and insurance regulators need to consider how best to address the issues raised, including whether such provisions are appropriate in a stop loss insurance policy at all, whether they need to be explicitly disclosed to the employer, and whether plan participants should be entitled to insurance law protections commensurate with the insurer’s involvement in the benefit payment process. These types of policy provisions must be carefully studied and appropriately regulated in order to ensure that they do not adversely affect the interests of policyholders, employees and their dependents and health care providers.

Samples of provisions found in stop loss insurance products reviewed by the drafters of this paper are detailed below. This was not an exhaustive review of available stop loss insurance products. However, even in this small sample, the policies reviewed were often significantly different from each other. The provisions described below were found in some policies, but not all, which demonstrates the fact that stop loss insurance products are not uniform and contain many variations. Some of these provisions may represent a significant risk to small employers, who may not have the resources to manage the complexities of some of these policies, or the financial resources to withstand the additional risk imposed by some stop loss policy provisions.

A review of current stop loss policies being submitted to state insurance departments for approval revealed the following provisions. If the small employer is unable to manage the risks posed by these provisions, and is thereafter unable to meet its obligations with respect to the health benefit plan, there is the potential for substantial harm to individuals and the public.

The provisions listed below were found in a few stop loss policies that were reviewed. The drafters of this white paper do not assert that these provisions are found in every stop loss policy.

- **Run out periods vary.** Some insurers offered run out periods as short as 3 months.
  - Some claims can take as long as 18 months to “run out” for reasons including mandatory internal and external appeal process, which all self-funded employers must offer as a result of the ACA.
  - Some stop loss insurers do not acknowledge that decisions of Independent Review Organizations (IROs) in the external appeal process are binding on them. In fact, some policies expressly state that the stop loss insurer has the final say regarding which claims it will acknowledge and pay. The claims that are externally appealed are often the most expensive and if the claim takes longer than 3 (or 6 or 12) months after the end of the policy period to resolve, the employer may be solely responsible for those costs.
  - On the other hand, at least one policy reviewed expressly acknowledged that decisions of IROs would be binding on them and that the tail may be extended in that case.

- **Some stop loss insurance policies do not include a standard benefit package, and some benefits such as prescription drugs, may not be covered unless the employer opts into the coverage.** Small employers should be made aware of these types of exclusions before they purchase a stop loss policy.
  - Other exclusions, though rare, included broad stop loss exclusions for certain types of mental illness. Employer health plans are required to follow ACA provisions and federal mental health parity laws and may be responsible for paying these claims even if the stop loss insurer excludes coverage.
Some stop loss policies have additional deductibles for transplants, or for individuals who have been identified as an “exceptional” risk.

- **Some stop loss insurance policies specifically excluded claims incurred by individuals who were “not actively at work” at the start of the stop loss policy period:** for instance, if the employee was already in the hospital. Federal regulations prohibit health plans from excluding claims from individuals who fall into this category. However, most applicable state and federal limitations on this exclusion may not apply to stop loss coverage.

- **Self-funded employer plans, like fully insured plans, may not apply lifetime or annual dollar limits to essential health benefits, and self-funded employers are also subject to employee maximum out of pocket limits.** Some stop loss policies currently on file include maximum annual benefits (per employee) of $1,000,000 per family or potentially less. While many stop loss policies that do not contain these types of limits, those that do may put the employer at risk.

- **Some stop loss insurers require small employers to use a specific third party administrator—usually the stop loss insurer owns that third party administrator (TPA) or has a special business relationship with that TPA.** Often, and especially in the case of products targeting small employers, these TPA’s are designing the health plan, preparing the Summary Plan Descriptions (SPD’s) and legally required notices, processing the claims, including making medical necessity decisions, and collecting all of the various required payments from the employer. Sometimes it appears that the stop loss insurer is directing the TPA’s activities to a greater extent than the employer is.
  - The language in the stop loss policy makes it very clear that the employer is the fiduciary for the health plan and is legally responsible for all plan decisions in the event that a legal action is taken against the plan—even though the employer likely had no knowledge and no actual control over the claims decision or the plan design resulting in the litigation.
  - Some stop loss policies have additional language stating that they are never legally responsible for decisions made by the TPA.

- **Some stop loss insurers will immediately terminate the coverage if the employer changes TPAs.** If the stop loss insurer owns or has a close business relationship with the TPA, then it may be the stop loss insurer who is managing the claims decisions. Employers should be aware that they are the fiduciary for the plan and legally they are ultimately liable for claims decisions made by the TPA.

- **Many stop loss insurance policies preserve the right of the stop loss insurer to make decisions about claims payment that may be different from those made by the health plan fiduciary or its TPA.** Some policies declare that the stop loss insurer will make its own medical necessity determination, separate from that made by the health plan. However, some insurance departments will not approve such medical necessity language. Therefore, other policies are more subtle in their approach, such as: the stop loss insurer controls the TPA; the stop loss insurance policy claims the right to physically examine any claimant (including autopsy); and the stop loss insurer requires the plan members to use certain networks or “centers of excellence,” especially for transplants. Medical necessity provisions that do not align with the health plan can leave employers exposed to great risk, and all employers should be particularly aware of these provisions and the possible consequences to the solvency of the self-funded health plan, and therefore the employer;
Some stop loss policies specifically state that no matter how the employer (the health plan fiduciary) and presumably any external review organization interprets the plan’s benefits, the stop loss insurer is free to interpret it differently. In other words, the stop loss insurer is not bound by the plan’s or the IRO’s decisions regarding which claims should be paid and for how much.

Some stop loss insurers insert their own definition of “experimental and investigational” and clinical trials in the policy language. Some provisions even exclude coverage for certain “routine claims” for covered persons in a certain types of clinical trials. The ACA requires self-funded health plans to cover “routine costs” for patients in a clinical trial for a life threatening disease.

Some stop loss insurance policies include a definition of “usual, reasonable and customary charge (UCR).” That definition may conflict with the UCR definition in the health plan.

- Some stop loss insurance policies have very strict provisions requiring prompt payment of claims by the employer. In one example, the stop loss insurer would not credit claims payments made by the employer (from the employer’s claim fund) towards the employer’s specific or aggregate retention if the claim payment was not made within 30 days of receiving adequate proof of loss.

- Many stop loss insurance policies have very strict provisions requiring immediate and anticipatory reporting of any possible or even suspected large claims. Employers are expected to submit “proof of loss” forms to the stop loss insurer “within 30 days” of the date the employer “becomes aware of the existence of facts which would reasonably suggest the possibility that the expenses covered under the health plan will be incurred which are equal to or exceed 50% of the specific deductible.” Failure to meet this requirement, which forces employers to report claims before they have even been incurred, may result in the nullification of the terms of the stop loss insurance policy.
  - In addition, most stop loss insurance policies reviewed in this sample required immediate reporting of medical conditions that developed or worsened for existing employees, new employees and their dependents. Failure to report (even before claims were incurred) could result in nullification of the stop loss insurance coverage.
  - Many employers may not have this information available to them until after claims have been submitted, particularly concerning dependents.

- All stop loss insurance policies require immediate notification of any new risk. That notification will then trigger various actions, up to and including mid-term rate increases, retroactive rate increases, and policy cancellation. Some policies even include detailed lists of conditions that must be reported even if they are only suspected and no claim has been incurred. All policies include provisions that trigger re-underwriting and rate increases if the employee census changes by more than 10% (or 20%).
  - Employers are legally prohibited from discriminating on the basis of health status, but stop loss insurers are not and many of the policies have provisions that will trigger immediate or even retroactive increased premium when the stop loss insurer receives greater than expected claims.

- Reasons (other than nonpayment of premium) for termination by the stop loss insurer prior to the policy anniversary date:
Some stop loss policies permit termination without cause by the insurer at any time with 30 days’ notice. Some states have laws prohibiting such clauses, but stop loss policies are not subject to the standard form review procedures in many states. The employer is at serious risk if the stop loss insurer is not committed to the risk for the same time period as the employer, especially if the employer has already borrowed money from the stop loss insurer to finance his share of the claims. This is particularly problematic in the case of aggregate coverage, which becomes illusory if the insurer can cancel the policy if it sees the aggregate attachment point approaching;

- Failing to meet “participation” requirements by keeping a specified number of employees (e.g., more than 10, or 51 or 200) in the plan;
- Failure by the employer to pay a claim within 30 days from the employer’s claim fund, or to report (within 30 days) the possibility of claims triggering a payment from the stop loss policy;
- Insolvency of the employer’s claim fund; or
- Change in the TPA.

Some stop loss insurance policies have rescission provisions. The ACA limits rescissions by health insurers, except in the case of fraud or intentional misrepresentation of a material fact. That provision does not apply to stop loss insurers. Many stop loss insurance policies allow for rescission on the basis of any mistake or misrepresentation, even if it was unintentional and made by only one employee or their dependent. Any rescission leaves an employer exposed to great risk, and all employers should be aware of all rescission provisions and the impact on the solvency of their self-funded health plan.

The cost of these arrangements is not always immediately apparent from the policy itself. The cost of these plans involves at least three and often four separate parts: 1) the TPA fee and related costs; 2) the stop loss premium itself (which is generally subject to change in some cases, even retroactively—usually there is no rate guarantee, even for the plan year); 3) the monthly claim fund contribution, which is the employer’s portion of the claims payment—for small employers, this is often divided into 12 equal monthly installments; and 4) there is usually also the potential (for small employers) of repayment of “advance funding.”

- Advance funding was an optional component of all plans reviewed. Employers without a sufficiently deep pocket may need to “borrow” money from the stop loss insurer so that they can pay their share of large claims incurred early in the year, before the employer’s claim fund contributions have accumulated. Of course, there are additional financing costs associated with borrowing this money.
- Before an employer can easily compare the cost of self-funding against the cost of private health insurance, he/she would have to have a clear and accurate picture of all the cost components of self-funding. There is no law requiring these costs to be made transparent to employers and no rate stabilization laws for stop loss insurance.

No rate guarantees. Most stop loss insurance policies state that premiums can increase at any time or even retroactively during the policy year when additional, unforeseen risk occurs, making financial planning very difficult, especially for a small employer.
Some stop loss insurance policies charge a “provisional premium rate.” The premium is then adjusted 6 months after the end of the policy period to reflect actual claims paid. The adjusted premium is a variable percentage of the claims paid by the stop loss insurer.

The concept of an “unforeseen risk” is problematic. The risk of plan participants developing medical problems during the year is precisely the risk the employer might reasonably believe it is insuring against when it buys a stop loss policy.

- **Advance funding arrangements have very strict repayment provisions.** Policy terms require that repayment of advance funding take precedence over every other type of debt, including claims payment. Failure to make prompt payments on advance funding will result in termination of the stop loss insurance policy. If the policy is terminated for any other reason, repayment of advance funding is required immediately. The policy language does not describe the interest that may be owed on advance funding options.

Early termination or rescission of the stop loss insurance policies for the reasons stated above could result in financial disaster for a small employer who is then left on the hook for claims that it did not anticipate paying, as well as immediate repayment of advancement funding received.

- **Most stop loss insurance policies contain explicit statements that the stop loss insurer is not the plan fiduciary,** but the policy does not define what a plan fiduciary is.

- **Many stop loss insurance policies contain provisions that are generally not allowed under state law,** such as venue restrictions (in favor of the insurer), attempts to limit the timeframe for filing a lawsuit against the company in violation of state laws on statutes of limitations, and subrogation provisions that do not comply with state law.

Regulators should review these provisions carefully to determine if they comply with state law.

VII. **Regulatory Options to Protect Policyholders, Consumers and Health Care Providers.**

A wide range of options are available to regulators to address concerns in a stop loss insurance policy issued in connection with a self-funded health benefit plan. Which regulatory options, if any, are suitable for a particular state will depend on many factors, including but not limited to the following:

A. The American insurance regulatory system is a state-based system, with an umbrella of uniform, national standards, coupled with significant discretion for each state to tailor its regulatory policies to the unique needs and environment of the state. A regulatory approach that is suitable in one state may not be feasible or effective in another state.

B. The legal authority to regulate stop loss insurance varies widely from state to state. States insurance departments may not impose insurance regulations on self-funded employers. In some states the regulatory agency is obligated to disapprove a policy form or rate if the agency determines it is not in compliance with laws and regulations, and is not in the public interest or “deceptively affects the risk purported to be assumed.” In other states a more limited review standard is in effect, but the agency may have the authority to adopt regulations establishing minimum standards for stop loss insurance. In some states, insurance departments may be able to address concerns through complaint or market conduct examination procedures that reference general insurer obligations in the Unfair Trade Practices Act, or the Claims Settlement Act.
Other states may determine that the potential for harm to the public is more prevalent in the case of small employers, whether the term is defined as 50, 100, or 200 employees.

C. While it is important to consider the potential harm these products might cause, without proper regulation, to employers, plan participants, and competition in the marketplace, it is also important to consider the costs of regulation, both the transactional costs of compliance and the loss of flexibility to meet employer needs if employers’ choices are unnecessarily restricted.

D. After considering how these factors apply in particular circumstances of their state, regulators might consider one or more of the following policy options adopted or considered by various states.

1. Disclosure. A small employer is unlikely to have a human resources manager or other designated employee whose job it is to manage the health plan and understand commercial insurance products. Because stop loss insurance products are not generally required to conform to state or federal health insurance law, including the ACA, there may be exposure to additional risk in some stop-loss insurance products that is not immediately apparent. Small employers may benefit from education on or disclosure of the risk they are assuming in “self-funding” a health plan, as well as protections that they should be looking for when they shop for a stop loss insurance policy. Approaches to disclosure that can be considered include the following:

   o Creation by the state regulator of a guide that details the issues a small employer will need to address in choosing to provide a self-funded health insurance plan.

   o Requiring uniform disclosure forms that ensure small employers receive all necessary information. A small employer stop loss regulation adopted in Utah includes a uniform stop loss application by the employer, a disclosure form with some uniform information, as well as policy-specific information relating to provisions where clear disclosure may be necessary (limitations on coverage, “monthly accommodations”, and terminal liability funding).

   o Requiring specific contract disclosures for key issues. A Vermont regulation requires disclosure of: (i) whether claims are paid on a “run-in”, “paid”, or “run-out” basis, and the meaning of those terms, (ii) whether a “terminal liability” option is available, and a clear description of the option, and (iii) a required notice concerning whether the policy restricts covered claims to those that are both incurred and paid during the policy period.

   o Require prominent, first page disclosure of terms that subject the small employer to additional risks. For example, the regulator may decide that an employer, especially a small employer, needs to know: (i) if the stop loss has an annual dollar limit on coverage, or (ii) if a claim will be denied if submitted outside a narrow window of time, the stop loss policy excludes certain categories of benefit claims, such as prescription drugs or mental health claims, rescission provisions, rate increase triggers and (iii) the cost of fees that are in addition to the stop loss premium.

   o Require disclosure of de-identified claims information. This disclosure allows small employers to shop for other stop loss coverage.
2. Risk transfer. The NAIC Stop Loss Insurance Model Act (Model No. #92) sets minimum attachment point requirements, which states should review to determine whether they are appropriate to market conditions in their states.

3. Minimum policy standards. In some situations where the state insurance regulator determines that disclosure alone does not adequately address certain risks, some specific minimum policy standards could be adopted to protect employers and ensure a level playing field for all insurers. Areas that some states might choose to address through minimum standards include:
   - “Lasering”; i.e. assigning different attachment points or deductibles, or denying coverage altogether, for an employee or dependent based on the health status of that individual.
   - Annual dollar limitations on coverage.
   - Provisions allowing the stop loss insurer to deny coverage for claims the employer is legally obligated to pay.
   - Early termination of the policy at the discretion of the stop loss insurer, or for grounds that would not be considered “good cause” under state laws applicable to other commercial lines insurance.
   - Provisions allowing mid-term rate increases.
   - Rescissions for reasons other than fraud or intentional material misrepresentation.
   - Misleading or deceptive terms and conditions.
   - Prohibiting employee recourse to the stop loss insurer in connection with a covered but unpaid claim.
   - Any other limitations on coverage that a state regulator may consider to be unfair, deceptive, or contrary to the public interest.

4. Form disapproval. State insurance regulators may need to seek additional authority through legislation or rules in order to “disapprove” some of these provisions. However, most state insurance departments already have broad authority to disapprove any policy provision that is misleading, deceptive or misrepresents the risk purported to be assumed.

5. Functional Analysis. Are the provisions in the contract consistent with stop loss insurance as third-party liability coverage? (See previous section “Regulating Stop Loss Insurance”) States might view stop loss insurance policy provisions that create a direct relationship between the stop loss insurer and the plan beneficiaries because of the insertion of “care management” requirements into a stop loss policy more suitable to health insurance than to stop loss insurance. For example:
   a. Provisions that require the policyholder to use the stop loss insurer or a TPA affiliated with the stop loss insurer for claims administration and care management functions.
   b. Provisions that confer on the stop loss insurer the authority to make its own determinations regarding medical necessity, UCR and other utilization review matters.
   c. Any other provisions that, in effect, substitute the judgment of the stop loss insurer for the judgment of the employer in connection with the administration of the health benefit plan and the payment of claims.

6. However, third-party coverage does not necessarily mean plan participants have no rights at all, but rather, that the nature of their rights is different and more limited because they have no contractual relationship.
with the insurer. For example, reinsurance treaties and liability insurance policies provide that the obligation to pay claims is not extinguished by the insolvency of the ceding insurer or liability policyholder. States might wish to consider whether similar protections would be appropriate for stop loss insurance.

7. Fair claims practices. Existing state laws prohibiting unfair claims settlement practices, including the prompt payment of claims when liability is clear, may be applicable to the stop loss insurer’s payment of the employer’s health claim obligations.

8. Utilization review statutes. Some state laws apply their utilization review statutes to third party administrators and possibly to stop loss insurers also, whether or not the benefit plans is insured or not.

9. Rate review. In states where insurers are required to obtain the approval of the state regulator prior to use of stop loss rate, a regulator may want to consider:
   a. Whether the rate is reasonable in relation to the benefits conferred, especially in the case of policy provisions which significantly limit the coverage of claims;
   b. Whether or not the rate is allowed to vary based on the claims submitted by the employer; and
   c. How the rate is determined in cases where the employer’s experience is not credible, especially in determining aggregate attachment points which may be calculated based on expected claims.

10. Rate and form filing requirements; actuarial certification and memorandum. In order to keep abreast of developments in the stop loss insurance market for small employers, and in order to properly review the filed rate and form, a state may wish to require that entities have information available for review on each employer, whether or not prior approval of the filing is required by law. For example:
   a. The number of policies issued to employers of certain group sizes.
   b. The SERFF tracking number for the policy form issued.
   c. The actuarial memorandum for each employer could include:
      i. The actuarial assumptions and methods used by the insurer in establishing attachment points for the policy issued to the employer, identified by group size;
      ii. The actuarial assumptions and methods used by the insurer to determine, with a reasonable degree of actuarial certainty, the expected claims of the employer.
   d. The actuarial memorandum for each employer (de-identified) could be accompanied by data for the stop loss insurer’s experience with respect to the employer, including the following data:
      i. Covered employee count, and covered lives count at the beginning of the policy term.
      ii. Covered life exposure years and employee exposure period for the experience period.
      iii. Specific attachment point.
      iv. Expected claims in the absence of the stop loss insurance coverage.
      v. Expected claims under the specific attachment point.
      vi. Aggregate attachment point.
      vii. Earned premium.
      viii. Claims paid under the policy broken out by specific losses and aggregate losses.
This information would be available for the regulator to review on any market conduct examinations conducted on the stop loss insurer. One other policy option, which would likely require Congressional action, is to consider requiring similar guaranteed issue requirements on the small employer self-funded market as exist in the fully insured small group market. Congress considered a similar plan which was called “Affordable Benefit Choices for Employers” or ACE plans. The proposal codified the AMS v. Bartlett decision, but added additional regulatory requirements on very small self-funded plans (down to 5 lives).

VIII. Conclusion

Since the passage of the ACA, health insurers, regulators, employers and insurance consumers have all been working to understand the changes in the insurance marketplace. State insurance regulators are charged with the regulation of insurance, including stop loss insurance. This paper explores some of the stop loss policy provisions observed by state departments of insurance and highlights some of the regulatory issues state insurance departments should consider. Regulators must be aware of what is happening in this rapidly evolving marketplace and work together to ensure that employer policyholders, especially small employers, understand their obligations if they choose to self-fund their employee health plan, in combination with the purchase of stop loss insurance. Stop loss insurance products vary significantly in the protections offered and also vary according to the laws of the state where the stop loss policy is issued. Certainly, insurance producers and the insurers themselves will assist employers in understanding these products. However, state insurance regulators have a legal duty to protect consumers and this issue presents an important opportunity to educate employees seeking information. In addition, insurance department staff involved in all parts of regulation should be aware of how stop loss insurance interacts with self-funded health plans, how the public may be affected, and which existing state insurance laws may apply to stop loss insurance products.
APPENDIX A

ACA and the Small Group Market

The ACA makes various changes to the insurance market that impact small group market plans, and the concern has been that some of these changes will lead to higher premiums. For Small businesses that are particularly sensitive to variability in revenue and expenses, a substantial increase in health benefit expenses is difficult to absorb. For some small employers faced with a significant increase in health insurance premiums, the options are limited to: (i) reducing operational expenses or investments, if possible, (ii) dropping coverage, and thereby permitting employees to access federal subsidies on a health benefits exchange, or (iii) exploring the possibilities of self-insurance.

Of particular note, the small group market is subject to disruption whenever regulatory requirements, including but not limited to mandated benefits, cause an increase in premium to the consumer employer. The ACA impact may include cost increases due to the requirement to cover essential health benefits (EHB) and changes in rating regulations—such as moving from rate bands to adjusted community rating. In 2016 there will be another major change to the market, when the threshold separating “small” groups from “large” groups is raised from 50 employees to 100 employees.

Depending on the state, changes to comply with EHB and federal rating regulations may not lead to significant changes in benefits or rates. When rate increases occur, the employer looks at the options available including self-insuring with the idea that controlling the benefit will lead to a lower cost plan. Small employer experience is more volatile since their experience is not credible, and for that reason responsible employers seek stop loss insurance to cover the unexpected claims cost. Balancing against the potential cost savings and expanded coverage from some employers moving to self-funded arrangements is the concern that self-funded employer health plans are most attractive to the lowest risk groups. As a result, there is some concern with adverse selection in the fully insured marketplace. But these concerns also applied to President Obama’s transition relief guidance that allow insurers to continue to offer existing plans to existing customers (called “grandmother” plans) through 2017.

Health insurance rates have increased due primarily to the age band compression, elimination of composite rating, some enrichment of benefits (Essential Health Benefits and the elimination of underwriting. Healthier younger groups are likely to pay more and older, less healthy groups often pay less under the new regulations.

With exception for grandfather and 2013 “transitional” plans, new rating rules will apply to plans offered in small group markets. Section 2701 of the ACA eliminates all rating factors other than age, geography, tobacco use, and whether the coverage is for an individual or family. With regards to age, the rate is not allowed to vary by more than 3 to 1. For tobacco use, the rate is not allowed to vary by more than 1.5 to 1.

Some of the specific provisions in the ACA impacting the small group market include:

- Community rating. Rates in the small group market may not vary by more than a 3:1 ratio, and variations based on tobacco use of members is limited to an additional 1.5:1 ratio. States already limited rate variations pre-ACA, but broader ratios applied in many states, resulting in greater rate variation pre-ACA. Medical underwriting. Rates may not vary because of the health status of the group, nor may groups be denied a plan for health-related reasons (the guaranteed issue principle). All states had guaranteed availability for small employers, but some group rating bands allowed small groups to be rated on the health status of the employees in that group.
Counting employees. Federal rules establish a standard method to count employees. In states where this federal counting method is used, some small employers will become large employers, and vice versa, resulting in winners and losers depending upon the demographic characteristics of the group.

Age rating curve. Federal rules establish a rate development methodology that requires per member build up using year-to-year rate factors. For those states and insurances that used a different rate development methodology, there are rating winners and losers. Small businesses are likely to see a greater incidence of rating winners and losers, because small group census tends to magnify the effect of rating rule changes.

Essential Health Benefits and cost sharing limitations. In those states where insurances were permitted to offer plans with fewer services and higher cost sharing than are now required by the ACA, higher premiums will be necessary to support a broader scope of services, and to support lower out of pocket costs and deductible. However, this depends on the plans that were common in that state’s marketplace. Depending on what was being marketed, in many states, the max OOP requirements are the same or even higher than 2013 plans. Most states are allowing a variance from the $2000/4000 deductible limitation.

Federal taxes and fees. The Affordable Care Act imposes on insurance insurances an insurance fee, a risk corridor fee, and a PCORF fee. Insurers have no choice but to include the cost of those taxes and fees in premium. The risk corridor fee also applies to self-funded plans.

In 2016, ACA laws and regulations require a change in the definition of “small group” from over 50 employees, to over 100 employees. In those states that have regulated the small group market, this change will impact groups of 51-100 employees in different ways - those groups with favorable demographics relative to the small group risk pool will see an increase in premium; those groups with unfavorable demographics relative to the small group rating pool may see a decrease in premium, or at least a lower annual premium increase. Employers in this 51-100 employee range may also have greater financial resources with which to consider the self-insurance option.

Whether a small business sees a financial benefit or a financial loss as a result of the ACA’s regulatory changes depends upon the characteristics of the small business, and the state market rules applicable to small group insurance before 2014. Broadly, the ACA’s regulatory changes may create financial incentives for the small employer to offer health benefits to its employees through a self-funded plan. The changing definition of the small group market in 2016 may create a new incentive for small groups between fifty one and one hundred lives.
APPENDIX B

ERISA and the Roles of State and Federal Regulation of Insurance

When we think of health insurance, in general, we think of the fully insured health plans typically offered to individuals and small employers by insurance companies. But the truth is that the employer market is very large and diverse and the majority of employers may use self-funded arrangements to finance health care for their employees. In short, employers can provide health benefits to their workers and their families in two ways, with very different financial and regulatory consequences:

- In a **fully-insured plan**, the employer buys a group health insurance policy from a licensed insurer, the policy documents define the plan’s benefits, and the insurer assumes full responsibility for providing those benefits to all covered individuals.

- In a **self-funded plan**, often colloquially referred to as a “self-insured plan,” the employer is fully responsible both for defining the plan’s benefits and for providing those benefits to covered individuals.

The legal framework for employee benefit plans is established by ERISA, which makes employee benefit plans subject to exclusive federal regulation and preempts state laws that relate to employee benefit plans. However, ERISA contains a “saving clause” that protects “any law of any State which regulates insurance” from preemption.\(^1\) Because of the saving clause, both the terms of a fully-insured plan and the insurer providing the coverage are subject to comprehensive regulation by the state insurance department. This includes rating and benefit standards for the insurance policy and regulatory supervision of the insurer’s compliance and financial strength.

By contrast, self-funded employers and their benefit plans are exempt from state insurance regulation. ERISA’s “deemer clause” prohibits states from deeming a self-funded employer to be an insurer.\(^2\) As a result, self-funded plans are subject only to federal requirements, which are much more limited than those established by state insurance laws. They reflect a philosophy that self-funded employers are not in the business of insurance, and that benefit plans are voluntary programs that should not be discouraged through the imposition of extensive regulatory requirements. Unlike insurance insurers, self-funded employers are not subject to any licensing or financial strength requirements or solvency monitoring.\(^3\) Unlike insurance policies, self-funded benefit plans are subject to very few minimum coverage requirements, although some ACA requirements now apply to self-funded as well as fully-insured plans. And by their nature, self-funded plans cannot be subject to rate regulation, because they have no “rates” – the cost of a self-funded plan is whatever it costs to provide and administer the benefits.

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\(^2\) ERISA § 514(b)(2)(B), codified at 29 U.S.C. § 1144(b)(2)(B). By its terms, the deemer clause prohibits states from deeming an employee benefit plan to be an insurer, but ERISA was subsequently amended to permit states to apply licensing laws and most other state insurance laws if an employee benefit plan is a “multiple employer welfare arrangement” (MEWA). ERISA § 514(b)(6), codified at 29 U.S.C. § 1144(b)(6). MEWAs and other multiple-employer plans are outside the scope of this paper.

\(^3\) By contrast, self-funded workers’ compensation plans are not subject to ERISA. ERISA § 4(b)(3), codified at 29 U.S.C. § 1003(b)(3) Nearly all states that permit workers’ compensation self-insurance require some form of licensure, either from the workers’ compensation regulator or the insurance regulator, and impose financial requirements.
Because of the central role played by ERISA, self-funded plans are often referred to as “ERISA plans.” This terminology makes sense for many purposes, but it suggests that ERISA applies only to self-funded plans, while state insurance laws apply only to fully-insured plans. In reality, ERISA applies to all employee benefit plans. Even if a plan is fully insured, certain features of the plan, such as the classification of eligible participants and the share of the premium that a participant pays for coverage, are established by the employer and are regulated under federal law by federal regulators. It is the group health insurance policy, not the fully-insured plan itself, that is regulated by the states.

In general, the line between federal and state authority is not based on the nature of the health plan, but on the nature of the regulated entity: states can regulate insurance insurances, but cannot regulate employers. The Supreme Court explained this principle in one of the first cases construing the impact of the saving clause, Metropolitan Life v. Massachusetts, in which an insurance company had challenged a state law mandating coverage of mental health benefits, arguing that this law “is in reality a health law that merely operates on insurance contracts to accomplish its end, and that it is not the kind of traditional insurance law intended to be saved by § 514(b) (2) (A).” However, the Court held that the saving clause does not distinguish between “traditional and innovative insurance laws.” Although the Court had held two years earlier that a New York law requiring employers to provide pregnancy benefits was preempted, the Court held that the Massachusetts law was different because it applied to the insurer, not to the employer. Employers that did not want to pay for the benefits mandated by state law were not required to buy insurance on the state-regulated market. The Court acknowledged “that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not,” but held that this was the line Congress had drawn.

While an employee benefit plan’s self-funded or fully-insured status is obviously an important characteristic of the plan, it is important to understand that this is only one element of the plan design, and the operational details of either type of plan will vary from plan to plan. Both insurers and self-funded employers can delegate or outsource various aspects of plan administration, as long as they retain responsibility for their subcontractors’ performance. Often, self-funded plans are administered by insurance companies, and their outward appearance is indistinguishable, to the untrained eye, from a fully-insured plan. Plan beneficiaries are given an “insurance card” with the name and logo of a major national insurance company, and the only indication that the plan might be a self-funded plan is the statement on the back that “Benefits are administered by … Insurance Company or affiliate.” When health care providers ask for “insurance information,” they are looking for the name of the insurer or TPA that administers the plan. If the plan operates as designed, the providers have no direct contact with the self-funded employer.

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14 The exception proves the rule. When the employee benefit plan is a MEWA, ERISA does expressly draw a distinction between fully-insured plans and plans that are not fully insured – and the distinction is that states have less regulatory authority over MEWAs if the MEWA is fully insured. ERISA § 514(b)(6)(A), codified at 29 U.S.C. § 1144(b)(6)(A). The reason is precisely because when a plan is fully insured, states’ primary regulatory focus should be on the insurance carrier rather than on the benefit plan.

APPENDIX C


Hall, Mark A. Regulating Stop loss Coverage May Be Needed To Deter Self-Insuring Small Employers From Undermining Market Reforms, Health Affairs, 31, no.2 (2012):316-323) http://content.healthaffairs.org/content/31/2/316.full.html


SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Aug. 16, 2014, Minutes ........................................................................... 7-239
The Senior Issues (B) Task Force met in Louisville, KY, Aug. 16, 2014. The following Task Force members participated: Scott J. Kipper, Chair (NV); Wayne Goodwin, Vice Chair (NC); Jim L. Ridling represented by Steve Ostlund (AL); Jay Bradford represented by Tomika Clark (AR); Dave Jones represented by Perry Kupferman and Tyler McKinney (CA); Marguerite Salazar (CO); Thomas B. Leonard represented by Maryellen Breault (CT); Kevin M. McCarty represented by Rich Robleto and Jack McDermott (FL); Gordon I. Ito represented by Colin Hayashida (HI); William W. Deal represented by Kathy McGill (ID); Andrew Boron represented by Yvonne Clearwater (IL); Stephen W. Robertson represented by Karl Knable (IN); Sandy Prager represented by Linda Sheppard (KS); Sharon P. Clark represented by Maggie Woods (KY); Eric A. Cioppa represented by Thomas Record (ME); Therese M. Goldsmith represented by Joy Hatchette (MD); Mike Rothman represented by Kristi Bohn (MN); Mike Chaney represented by Jay Fads (MS); Monica J. Lindeen represented by Christina Goe (MT); Bruce R. Ramge represented by John Rink and Martin Swanson (NE); Kenneth E. Kobylowski represented by Felix Schirripa (NJ); Adam Hamm represented by Rebecca Ternes (ND); Mary Taylor represented by Matt Elston (OH); Laura N. Cali represented by Gayle Woods (OR); Michael F. Consedine represented by Peter Camacci (PA); Angela Weyne represented by Ruben Gely (PR); Julie Mix McPeak represented by Chlora Lindley-Myers (TN); Julia Rathgeber represented by Jan Graeber (TX); Todd E. Kiser represented by Tanji Northrup (UT); Jacqueline K. Cunningham represented by Bob Grissom (VA); and Ted Nickel represented by Mollie Zito (WI).

1. Discussed its 2015 Proposed Charges

The Task Force discussed its 2015 Proposed Charges. Commissioner Goodwin suggested that a charge be drafted to emphasize the mission of the Task Force to stay abreast of developments affecting the State Health Insurance Assistance Program (SHIP) and supporting SHIPs housed within the state insurance departments. Commissioner Kipper noted that this has historically been a role of the Task Force. The Task Force agreed that such a charge should be drafted.

Mr. Ostlund also suggested that the charges be amended to reflect that the Task Force should work on implementation of the amendments to the Long-Term Care Insurance Model Regulation (#641), which will be considered for adoption by the Executive (EX) Committee and Plenary at the Summer National Meeting. The Task Force agreed that the charges should be updated as such.

Commissioner Kipper said the revisions would be drafted, and the Task Force would consider the revised 2015 Proposed Charges on an interim conference call.

2. Heard a Federal Update

Brian R. Webb (NAIC) reported that there was little congressional action in the past year on Medicare or long-term care-related issues. However, he reported that the NAIC has received numerous inquiries concerning long-term care insurance issues, including the issue of notice to third-party designee prior to lapse of long-term care insurance policies. Section 7 of Model #641 requires that such notice be sent by U.S. mail prior to lapse, but recent situations reported in news articles where the third-party designee did not receive such notice have generated interest in requiring that companies use certified mail or other forms of mail requiring a receipt to verify receipt by the third-party designee. Mr. Webb noted that the vast majority of states maintained the requirement contained in Model #641, but that a few states had either strengthened their regulation or were considering potential changes. Commissioner Kipper asked Mr. Webb whether the Task Force should consider addressing this issue. Mr. Webb responded that the magnitude of the problem was unclear, but that there was congressional and media interest. Commissioner Kipper asked the states that have modified their regulations to share information at the Fall National Meeting so that the Task Force could further consider this issue.

Mr. Webb reported that Congress continued to consider and discuss proposals to reform Medicare by combining the Medicare Part A and Medicare Part B cost-sharing, which would have implications for Medicare supplement (Medigap) insurance.
Mr. Webb reported that the U.S. Centers for Medicare & Medicaid Services (CMS) had recently begun publishing “Frequently Asked Questions and Answers” concerning the complicated intersection between Medicare and marketplace coverage. Notably, the CMS issued an FAQ Aug. 11 that said that, while insurers may not knowingly sell or issue a qualified health plan (QHP) to a Medicare beneficiary, issuers may not terminate enrollees whom they subsequently find out to be eligible for or enrolled in Medicare. If the issuer learns that an individual is a Medicare beneficiary prior to the effective date, the issuer may cancel the enrollment, and consumers can request a prospective termination. Mr. Webb commented that there are significant issues to be worked out relating to coordination of benefits between QHPs and Medicare. However, Congress is unlikely to take up any legislative fixes in the near future.

Ms. Goe commented that the current Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act does not address the state option to make Medigap coverage available to the under age 65 Medicare-eligible disabled population. She noted that when Montana’s high-risk pool closed, the state elected to amend its regulation to make Medigap coverage available to the under-65 Medicare-eligible population, and she was aware that several other states had done so as well, although some used different approaches. She suggested that expanding access to Medigap for this population may be a better approach than attempting to repeal the federal Affordable Care Act’s (ACA) anti-duplication rule. She said it would be helpful to the states pursuing such a change to have a suggested approach in modifying their regulations. Commissioner Kipper suggested the Task Force gather a list of state provisions to expand Medigap to under age 65 Medicare-eligible individuals.

3. **Heard an Update on Medigap First-Dollar Coverage**

Commissioner Kipper requested that Bill Schiffbauer (Schiffbauer Law Office) provide the Task Force with an update on the issue of Medigap first-dollar coverage, as it was a topic of ongoing importance to the Task Force. Mr. Schiffbauer commented that it was not a “front-burner” issue, as there is no imminent concern about congressional or executive action. However, he noted that misguided proposals to restrict or eliminate first-dollar coverage in the erroneous belief that such coverage drives unnecessary use of Medicare services continue to persist amongst policymakers. He suggested that the Task Force remain vigilant in its efforts to educate policymakers about the implications of various proposals to modify Medigap first-dollar coverage.

Mr. Schiffbauer reviewed the history of policy proposals to restrict or eliminate Medigap first-dollar coverage. He noted that even in the wake of reports of an improving solvency outlook for the Medicare program, *The Washington Post* had still recently editorialized in favor of eliminating Medigap first-dollar coverage.

Mr. Schiffbauer highlighted the important role the Task Force has played on this topic. He reminded the Task Force that many policymakers had been attracted to such proposals initially due to the fact that the Congressional Budget Office (CBO) had estimated meaningful cost savings to the Medicare program if first-dollar Medigap coverage was eliminated. However, the Task Force was able to ferret out the fact that the CBO’s estimates had been based on the assumption that these changes would happen retroactively and would reach back to change all existing contracts, which is problematic. Once policymakers realized that such a retroactive change was not workable, but without it the cost savings would be negligible, they quickly dropped support for these proposals.

Mr. Schiffbauer noted that the Task Force had sent consistent messages about these types of proposals over the years in various documents, such as in a white paper and in comment letters. He suggested that it may be helpful for the Task Force to consolidate these statements into one standing document to be referenced as new education on this issue is conducted. Commissioner Kipper agreed to consider reviewing a draft statement for the Task Force’s consideration. He said the Task Force would discuss this further on an interim call or at the Fall National Meeting.

4. **Reviewed Medigap New or Innovative Benefits Tracking**

Commissioner Kipper said that Section 9.1F of Model #641 permits state approval of new or innovative benefits that are outside of the otherwise standardized benefit packages. In adopting the 2010 Medigap plans, the NAIC adopted a drafting note calling upon the Senior Issues (B) Task Force to maintain a record of state-approved new or innovative benefits. It was intended that states regularly report this information to the Task Force and that this record be posted to the Task Force’s Web page to be available to regulators and interested parties. It is also intended that the Task Force periodically consider whether any of these state-approved benefits should be considered for addition to the list of standardized benefit designs.
Commissioner Kipper reported that states had recently been surveyed to provide updated information and that 31 states had responded. States were asked to review a draft chart and to notify Jane Sung (NAIC) if any corrections or additional information should be included. When the chart is finalized, it will be posted to the Task Force’s Web page and updated on a regular basis.

5. Discussed Long-Term Care Partnership Reporting

Commissioner Kipper said that in authorizing the expansion of the state Long-Term Care Partnership program, the federal Deficit Reduction Act of 2005 also called for companies selling these policies to report data to the U.S. Department of Health and Human Services (HHS). This data had been collected by HHS annually, and the data reports were shared with states. However, recently HHS has significantly reduced its support for the Partnership program. It has ceased technical assistance to state Partnership programs and halted updates to its federal website. Significantly, HHS has stopped federal data reporting and, therefore, the data is no longer being collected nor shared with states. Commissioner Kipper reported that the Task Force had begun receiving questions from states concerned about the impact of this loss of federal support and data collection.

Ms. Dwyer reported that, although Rhode Island is not statutorily required to provide federal data reporting, it found the federal data reports to be useful as they included information that was not available elsewhere. She asked that the NAIC explore the possibility of collecting this information instead of HHS in order to assist state Partnership programs and so that carriers could more easily report this information to a single source rather than respond to multiple new state requirements.

Commissioner Kipper said that this issue was also raised at the NAIC/State Government Liaison Committee by a state legislator and that he believed that this may become a topic of discussion amongst the National Conference of Insurance Legislators (NCOIL).

Ms. Goe inquired about the state fiscal impact of the data. Ms. Dwyer explained that without the data, states did not know how many individuals had Partnership policies and did not have information about who purchased these policies. She said that this was important due to the nature of the Partnership program, which later factored the policies into individuals’ assessment for Medicaid eligibility. Therefore, state human services departments or state Medicaid offices need to know who have purchased the policies and how many individuals have them.

Commissioner Kipper asked Julie Fritz (NAIC) to discuss the capability of the NAIC to collect such data. Ms. Fritz said that the NAIC does collect data from insurance carriers similar to the type of information she understood had previously been collected by HHS regarding Partnership policies. She believed that the NAIC could technically take this type of data reporting on but that the NAIC would have to explore the cost implications, as well as assess the priority level for collecting this information. She noted that there may be other ways to collect some of this information that should also be explored in such an assessment, such as potentially incorporating some basic information into the NAIC annual financial statement.

The Task Force agreed to continue to work to assess whether the NAIC should collect this data on behalf of states and how it could be accomplished. Commissioner Kipper also requested industry representatives to consider the utility of companies being able to report to the NAIC and to report back to the Task Force with their opinion.

6. Received a Report from the Long-Term Care Guidance Manual (B) Subgroup

Commissioner Kipper reported that the Executive (EX) Committee and Plenary would consider amendments to Model #641 to improve rate stability standards at the Summer National Meeting. At the Spring National Meeting, the Task Force had created the Long-Term Care Guidance Manual (B) Subgroup (with the Health Actuarial (B) Task Force) to begin work on revisions to the Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation to implement the amendments to the model regulation. He noted that some of the work was first being developed by the Health Actuarial (B) Task Force’s Long-Term Care Pricing (B) Subgroup.

Mr. Rink, chair of the Subgroup, reported that he had developed some draft materials and a checklist related to the new annual certification requirements. He expected to share these draft materials on open calls in the fall. He noted that Ms. Graeber, chair of the Health Actuarial (B) Task Force’s Long-Term Care Pricing (B) Subgroup, would be assisting him in his efforts. Mr. Rink said he hoped to have a framework in place for the annual certification requirement for the Task Force to discuss at the Fall National Meeting.
7. **Received a Report from Health Actuarial (B) Task Force**

Mr. Kupferman, chair of the Health Actuarial (B) Task Force’s Long-Term Care Actuarial (B) Working Group, reported that the Working Group met at the Summer National Meeting and had made progress on several long-term care insurance issues. He said that the Long-Term Care Pricing (B) Subgroup was continuing to work on revisions to the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* to implement the new amendments to Model #641. In addition, the Working Group had received information from the American Academy of Actuaries (AAA) on several areas of inquiry relating to long-term care insurance, which would assist in efforts to address reserving standards.

Mr. Kupferman also reported that the Working Group discussed comments received on an optional rate increase review proposal and discussed sharing information about this proposal with regulators. Ms. Goe asked about the Working Group’s decision about the form of the information for the optional proposal. Mr. Kupferman responded that the proposal was an operational approach and that the Working Group intended to make this information available to states as an option to consider, such as possibly in a white paper.

8. **Appointed a New Subgroup to Review Long-Term Care Insurance Consumer Disclosures**

Commissioner Kipper said he has received suggestions that the Task Force consider updating long-term care insurance consumer disclosures, as they have not been reviewed in some time and may need important changes. He suggested the Task Force take up such a review and appoint a new subgroup to begin this work.

Mr. Kupferman noted that concerns with consumer disclosures were most problematic at the time of rate increase and less so for disclosures required at the time of sale. Commissioner Kipper agreed, but said that both sets of consumer disclosures should be reviewed.

Mr. McKinney agreed to chair the new Subgroup appointed to review the long-term care insurance consumer disclosures. Florida, Oregon, North Carolina and Utah volunteered to join the Subgroup. Other states interested in volunteering should contact NAIC staff.

9. **Discussed Other Matters**

Commissioner Kipper noted that Derrick Claggett (CMS) was in attendance, but he did not have any items to report to the Task Force at this time.

Commissioner Kipper reported that Bonnie Burns (California Health Advocates) was unable to attend the Summer National Meeting, but she had submitted a comment letter for the Task Force’s consideration on several long-term care insurance topics. The letter made suggestions about premium increase notices, alternate plan of care, loss ratio requirements, and third-party notices and reinstatement. He asked that Task Force members review Ms. Burns’ letter and noted that she would be asked to discuss her letter on an interim conference call or future meeting.

Dotti Outland (UnitedHealth Group) raised a concern with required attestations for fixed indemnity coverage and Medicare enrollees. She was concerned about potential confusion by individuals enrolled in Medicare and suggested that there be greater coordination on this issue.

Having no further business, the Senior Issues (B) Task Force adjourned.