2017 Summer National Meeting  
Philadelphia, Pennsylvania

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE  
Monday, August 7, 2017  
3:30 – 5:00 p.m.  
Philadelphia Marriott Downtown—Grand Ballroom EF—Level 5

ROLL CALL

Al Redmer Jr., Chair  
Lori K. Wing-Heier, Vice Chair  
Leslie R. Hess  
Marguerite Salazar  
Katharine L. Wade  
Dean L. Cameron  
Jennifer Hammer  
Nancy G. Atkins  

Maryland  
Alaska  
Arizona  
Colorado  
Connecticut  
Idaho  
Illinois  
Kentucky  

Roger A. Sevigny  
Maria T. Vullo  
Teresa D. Miller  
Larry Deiter  
Todd E. Kiser  
Osbert E. Potter  
Mike Kreidler  

New Hampshire  
New York  
Pennsylvania  
South Dakota  
Utah  
Virgin Islands  
Washington

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

AGENDA

1. Hear Presentation on the Blue Cross and Blue Shield System’s Activities Related to Addressing the Opioid Issue—Kim Holland (Blue Cross and Blue Shield Association—BCBSA)

2. Hear Presentation from FAIR Health, Inc.—Rachael McKeon, Robin Gelburd and Michelle Scott (FAIR Health, Inc.)

3. Consider Adoption of its June 15 and Spring National Meeting Minutes—Commissioner Al Redmer Jr. (MD)

4. Consider Request for Extension of Model Law Development for the Health Insurance Reserves Model Regulation (#10)—Commissioner Al Redmer Jr. (MD)

5. Hear Federal Legislative and Regulatory Update—Brian Webb (NAIC)

6. Receive Joint Long-Term Care Insurance (B/E) Task Force Report and Consider Adoption of its 2017 Charges—Commissioner Al Redmer Jr. (MD)

7. Consider Adoption of its Subgroup, Working Group and Task Force Reports—Commissioner Al Redmer Jr. (MD)
   - Consumer Information (B) Subgroup—Angela Nelson (MO)
   - CO-OP Solvency and Receivership (B) Subgroup—Commissioner Doug Ommen (IA)
   - Medical Loss Ratio Quality Improvement Activities (B) Subgroup—Director Dean L. Cameron (ID)
   - Health Care Reform Regulatory Alternatives (B) Working Group—Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
   - Health Actuarial (B) Task Force—Director Patrick M. McPharlin (MI) and Kevin Dyke (MI)
   - Regulatory Framework (B) Task Force—Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
   - Senior Issues (B) Task Force—Commissioner Teresa D. Miller (PA)

8. Discuss Possible Development of “Pharmacy 101” Education Sessions—Commissioner Al Redmer Jr. (MD)
9. Discuss Any Other Matters Brought Before the Committee—Commissioner Al Redmer Jr. (MD)

10. Adjournment

W:\National Meetings\2017\Summer\Agenda\B Cmte rev1.docx
Agenda Item #1

Hear Presentation on the Blue Cross and Blue Shield System’s Activities Related to Addressing the Opioid Issue—Kim Holland (Blue Cross and Blue Shield Association—BCBSA)
BCBSA Efforts to Address Opioid Use Disorder

NAIC Health & Managed Care (B) Committee
August 7, 2017
Kim Holland, Vice President State Affairs
Combatting Opioid Use Disorder

- Opioid crisis continues to grow
  - $78.5 billion annually in direct healthcare costs
  - Overdose leading cause of accidental death in 2015, over 20,000 related to prescription opioids
  - Over 2M abuse prescription opioids; almost 600K abuse heroin
  - 91 Americans die every day from an opioid overdose
  - Americans consume over 75 percent of the world’s oxycodone (ex. Oxycontin) and 99 percent of hydrocodone (ex. Vicodin)

- Public officials looking for solutions
  - States and Congress considering legislation
  - White House Commission created
In five years:
The number of opioids prescribed will be dramatically reduced
The number of individuals receiving evidence-based treatment for substance use disorder and addiction will be dramatically increased
And, the number of deaths due to overdose will no longer be newsworthy
OUR GOAL

Leverage the resources and expertise within the BCBS System to turn the tide on substance use disorder and addiction through education and awareness; partnering with the provider community to advance evidence based treatment; and prevent fraud and diversion of prescription opioids.
OUR STRATEGY

PROMOTE UNDERSTANDING
Raise awareness of opioid risks and support well informed public policy through community engagements and partnerships

SUPPORT RESEARCH
Leverage resources and relationships to create a better system of care for substance use disorder and addiction

ENSURE PATIENT-FOCUSED CARE
Adhere to nationally accepted evidence-based guidelines in covering the care and treatment of individuals suffering from substance use disorder and addiction
# Combatting Opioid Use Disorder

## INITIATIVES

### PROMOTE UNDERSTANDING
- Sponsoring journalists’ education with Poynter Institute
- Sponsored *Governing* magazine policy handbook for public officials
- Co-sponsoring drug take-back boxes with Walgreens
- Planning underway for September “Doctor Day on the Hill” to inform Congress/staff of current challenges, opportunities, initiatives to address the epidemic

### SUPPORT RESEARCH
- Harvard research underway
- Health of America report and Health Index focus on opioids
- Brain Research Foundation partnership on novel research to reduce relapse rates

### ENSURE PATIENT-FOCUSED CARE
- Developed best practices including endorsement of CDC guidelines; benchmarking progress/outcomes
- Blue Distinction Program development initiated
- Aggressive anti-fraud efforts
The BCBS System-wide Best Practices to Prevent Prescription Opioid Misuse

1. Endorsing CDC Guidelines for Prescribing Opioids for Chronic Pain

2. Utilizing pharmacy management tools to monitor and prevent over-prescribing and diversion of prescription opioids

3. Adhering to nationally accepted evidence-based guidelines in covering the care and treatment of individuals diagnosed with opioid use disorder.

4. Engaging with community partners to prevent and detect fraud and diversion of prescription opioids
Agenda Item #2

Hear Presentation from FAIR Health Inc.—Rachael McKeon, Robin Gelburd and Michelle Scott (FAIR Health, Inc.)
A FAIR Health Overview
FAIR Health Mission

Origins
Established as conflict-free, independent, national not-for-profit

Mission
To bring clarity to healthcare costs and health insurance information

Impact
Widespread recognition from diverse stakeholder groups, including state leaders

Action
Fulfills mission with robust data products, award-winning consumer tools and research platform
FAIR Health Board of Directors

Nationally Recognized Thought Leaders

Stephen Warnke (Chair)
Ropes & Gray, LLP

NancyMarie Bergman
Bells Nurses Registry

Sherry Glied
New York University

Christopher F. Koller
Milbank Memorial Fund

Peter Millock
Nixon & Peabody, LLP

Nancy Nielsen
State University of New York at Buffalo

James Roosevelt, Jr.
Verrill Dana, LLP

Sara Rosenbaum
George Washington University

John W. Rowe
Columbia University
Stakeholders We Serve

- Government
- Researchers/Universities
- Payors
- Employers
- Healthcare Systems/Facilities
- Healthcare Professionals
- Bill Review Companies
- Consumers
- Unions
- TPAs
- Auto Liability
- Benefits Planners
- Consultants
- Pharma
- Actuaries
- Brokers
- DME Companies
- Think Tanks
- Investment Analysts
- Litigation Support
- Medical Societies
- Trade Associations
- Workers’ Compensation
- Institutes/Foundations
- Healthcare Information Technology (HIT)
The FAIR Health Private Claims Repository

>23B
Procedures from 2002 to the Present from Medical and Dental Claims

>150M
Covered Lives

493
Geozip Regions Reflecting Local Billing Patterns

Proprietary and Confidential
Insights into the Private Claims Repository

Coverage
- All 50 States and District of Columbia,
- US Territories – Puerto Rico, Guam, US Virgin Islands

60 Contributors
- National and regional payors
- Third-party administrators

Private Insurance Claims
- Fully insured and self-insured/ERISA plans
- Cover 75% of privately insured US population

Quality Testing and Control
- Data validated with expert-vetted tests for completeness, volume, accuracy, etc.
- Recognized statistical outlier methodologies
FAIR Health: Certified CMS Qualified Entity

• One of only five organizations across the country entitled to receive Parts A, B and D Medicare data for all 50 states

• Issue probing reports on key aspects of healthcare industry/provider performance

• Powerful synergies between our private claims data and Medicare collection of claims

• Four complete years of data: 2013-2016
QE Medicare Data Expands FAIR Health Resources

• Public Products
  o For consumers, licensees, researchers, government, etc.
    ▪ Enhanced FH® Benchmarks – national, regional, specialty
    ▪ New FH Benchmarks – Rx Pharma, venue-specific

• Custom Comparative Analytics
  o Combined FH NPIC® and Medicare data
  o Internal use by:
    ▪ Federal and state government agencies
    ▪ Medicare-participating providers/suppliers
    ▪ National and state nonprofit medical societies
    ▪ National and state nonprofit provider/supplier associations
    ▪ National, state and local nonprofit hospital associations
    ▪ Insurers contributing data to FAIR Health
# Applied Uses of FAIR Health Data

## Management & Operational Support
- Plan, Benefit and Provider Network Design
- HR/Benefits Administration
- Premium Rate Review
- ACO/Bundled Payment Modeling
- Support Public/Private Exchanges
- Management of CDHPs/HSAs
- Value “Add-Ons” for Plan Members
- Strategic Planning
- Market Research

## Fee Schedules & Reimbursement
- Medicaid Reform
- In-/Out-of-Network Provider Fee Schedules
- Balance Billing Negotiations with Providers
- Dispute Resolution
- Reference Pricing
- Auto Liability Fee Schedules
- Workers’ Compensation Fee Schedules
- Medicare Gap Fill

## Public Health & Consumer Engagement
- Consumer Transparency Tools
- Educational Materials
- Public Health/Education Campaigns
- Support Open Enrollment
- Advocacy Materials
- Syndromic Surveillance
- Design Interventions

## Policy & Research
- Consumer Protection Laws
- Health Economics and Policy Research
- Evaluate Legislative and Regulatory Action
- Analyze Health and Cost Disparities
- Statutory Benchmark for State Programs
- Epidemiologic Heat Maps
- Study Treatment Protocols
## State Applications

<table>
<thead>
<tr>
<th>State</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| Alaska      | • Workers’ compensation fee schedule  
• Out-of-network claims pricing under the state health insurance plan                                                                    |
| Arizona     | • Dental claims reimbursement for disabled pediatric patients                                                                           |
| California  | • Emergency care for low-income patients  
• Incorporated in State Assembly Resolution regarding opioid crisis                                                                       |
| Connecticut | • FAIR Health 80th percentile benchmark designated as UCR for emergency services                                                        |
| Georgia     | • Worked with the state to update and distribute their workers’ compensation fee schedule                                               |
| Kentucky    | • Data support workers’ compensation fee schedule                                                                                       |
| Mississippi | • “Usual and customary” charges under workers’ compensation fee schedule are based on the FAIR Health 40th percentile                   |
| New Jersey  | • Authorized personal injury protection (auto liability) reimbursement standard  
• Department of Banking and Insurance recognizes FAIR Health as consumer information source                                              |
| New York    | • Medical indemnity fund for birth-related neurological impairments  
• Benchmark for consumer cost transparency and dispute resolution                                                                         |
| North Dakota| • Data used to inform the state’s workers’ compensation fee schedule                                                                     |
| Pennsylvania| • “Usual and customary” standard in the workers’ compensation program is based on the FAIR Health 85th percentile                        |
| Texas       | • Department of Insurance links consumers to FAIR Health for help with surprise bills                                                   |
| Wisconsin   | • Certified for use for workers’ compensation fees                                                                                      |
• 80th percentile of charges for a particular service in a particular geographic area
• As reported in a benchmarking database maintained by a conflict-free not-for-profit organization not affiliated with an insurer or similar organization
• Plans are not required to reimburse at 80th percentile level but must articulate how they reimburse in comparison to UCC
  o Supports “apples to apples comparisons”
  o Supports dispute resolution
• FAIR Health is the only data source officially recognized as UCC
Connecticut: FAIR Health 80th percentile is the UCR standard for payments for out-of-network emergency services
Official Source of Transparency

QUESTIONS AND ANSWERS ON THE 2015 INVITATION
(November 24, 2014)

Question: Will participating insurers be permitted to continue using FAIR Health’s treatment cost calculator in 2015, as permitted to do so in 2014, in order to satisfy the requirement that the out-of-pocket costs be transparent?

Answer: The answer to this question is hereby amended on 11/24/14. Use of FAIR Health’s treatment cost calculator for out-of-network services would satisfy the Invitation’s requirement that out-of-pocket costs be transparent. Contact Fair Health if you wish to set up a link in order to establish an appropriate licensing arrangement.

I got a surprise bill. What can I do about it?

- Call the doctor or provider that sent the bill and discuss your concerns. In most cases, Texas law requires providers to provide an itemized bill on request, so review the charges carefully. Some providers might accept a lower payment. You can compare the amount you were charged to the average market price using TDI’s Health Insurance Reimbursement Rates Consumer Information Guide or websites such as fairhealthconsumer.org.
- Call TDI’s Consumer Help Line at 1-800-252-3430 to discuss your options. There are two main ways TDI can help:
  1. Mediation: Texas law allows many consumers to seek mediation for bills that exceed $500. TDI has helped 94 percent of these consumers lower their bills in the first stage of the process.

FAIR Health

FAIR Health is a national corporation whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive consumer resources. The website offers educational articles and videos about the healthcare insurance reimbursement system on topics such as

- Understanding Your Explanation of Benefits (EOB);
- "Plain speak" to help consumers better understand the healthcare system;
- "Reimbursement 101" to help navigate the twists and turns of healthcare reimbursement; and
- A glossary of common health terms intended to help educate consumers.
FAIR Health data cited as benchmark for permissible charge rate for emergency physician services.

Section 127452.

....

(b) An emergency physician shall limit expected payment for services provided to a patient at or below 350 percent of the federal poverty level and who is eligible under the emergency physician's discount payment policy .... When FAIR Health, Inc. makes available the rate of payment received by physicians and surgeons from commercial insurers for the same services in the same or similar geographic region, the amount of expected payment under this section shall be no greater than the median or average of rates paid by commercial insurers for the same or similar services in the same or similar geographic region.
California Assembly Joint Resolution 19
Bill Title: Opioid awareness and dependency prevention

June 05, 2017

LEGISLATIVE COUNSEL'S DIGEST

AJR 19, as introduced, Arambula. Opioid awareness and dependency prevention.

This measure, the California Opioid Awareness and Dependency Prevention Resolution, would urge public and private health care payers, state and federal regulators, agencies, and departments, the President of the United States, and the Congress of the United States to support physician and surgeon choice of treatment to prevent opioid dependency and would urge the President of the United States and the Congress of the United States to move forward with legislation to establish multimodal therapy guidelines for managing postsurgical acute pain.

WHEREAS, As acknowledged in a recent FAIR Health, Inc. white paper entitled “The Impact of the Opioid Crisis on the Healthcare System,” health insurers spent $446 million on opioid treatment in 2015, and health insurers have seen their payments to hospitals, laboratories, treatment centers, and other providers skyrocket 1,375 percent from 2011 to 2015 for patients diagnosed with an opioid dependence or opioid abuse disorder, and health insurers also saw treatment costs rise from $32 million to $446 million over the same period, with the average yearly cost per patient rising from $3,435 to over $19,000 to battle opioid dependence; ...
Dispute Resolution

FAIR Health data: choice of both parties to resolve disputes

- Facilitated settlement of suit involving disputed claim reimbursements in 38 states and Washington, DC

- 80th percentile benchmark agreed upon as a standard for “usual and customary” charge for five years


- Other cases settled in Oregon, Washington
FAIR Health Data/Analytics Offerings

**FH® BENCHMARKS**
- Medical
- HCPCS
- Anesthesia
- Inpatient Facility
- Outpatient Facility
- ASC
- Medicare Gapfill Plus™
- Dental
- Allowed Amounts

**FH NPIC® CLAIMS DATA**
- HIPAA Safe Harbor
- Statistically De-Identified
- Limited Dataset for Researchers

**EPISODES OF CARE**
- FH Episodes of Care Analytics™
  - Powered by Your Data
- FH Episodes of Care Benchmarks
  - Powered by FH Data

**CUSTOM ANALYTICS**
- Reports, Dashboards, Visualizations, ETC.
• FAIR Health will organize three years of your claims data into risk-adjusted episodes of care and produce actionable analytics that can be used to:
  o Enhance efficiency of provider networks
  o Establish budgets
  o Evaluate performance
  o Reduce potentially avoidable complications (PACs)
  o Assess clinical and economic risks

• FAIR Health is the only independent nonprofit certified by the Altarum Institute to operate its PROMETHEUS Payment model

• Choose from three packages
  o Episode level detail
  o Provider level detail
  o Member level detail
An innovative new resource for value-based reimbursement and related cost studies

• Through an intuitive and interactive interface, users are able to perform the following functions with clarity and precision:
  
  o Estimate costs based on:
    ▪ Beginning-to-end treatment of an acute or chronic condition
    ▪ Patients’ comorbidities
    ▪ Risk profiles
    ▪ Likely duration of care
  
  o Price benefit plans
  
  o Set reimbursement rates
  
  o Negotiate with providers to build and maintain networks
  
  o Evaluate business acquisitions, expansion and contraction and more (e.g., hospital systems, networks)
FAIR Health Analytic Reports

- **July 2016**: The Opioid Crisis among the Privately Insured
  *The Opioid Abuse Epidemic as Documented in Private Claims Data*

- **Sept. 2016**: The Impact of the Opioid Crisis on the Healthcare System
  *A Study of Privately Billed Services*

- **June 2017**: Peeling Back the Curtain on Regional Variation in the Opioid Crisis
  *Spotlight on Five Key Urban Centers and Their Respective States*

- **Jan. 2017**: Obesity and Type 2 Diabetes as Documented In Private Claims Data
  *Spotlight on This Growing Issue among the Nation’s Youth*
Sampling of Publications

United States Government Accountability Office
Report to Congressional Requesters

September 2011

HEALTH CARE
PRICE
TRANSPARENCY

Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care

UGENT CARE FACILITIES: GEOGRAPHIC VARIATION IN UTILIZATION AND CHARGES FOR COMMON LAB TESTS, OFFICE VISITS, AND FLU VACCINES

JEFF DANG, PhD, ERIC OKUROWOSKI, MBA, ROBIN GELBURD, JD, LORRAINE LIMPHAN, BA, AND NICOLE IRY, MPH

ABSTRACT — The rapid growth of urgent care facilities (UCFs) and other types of convenient care centers has been attributed to increasing consumer demand for more convenient and affordable healthcare. UCFs typically treat non-emergency, acute conditions and are increasingly serving as an alternative to "traditional" care settings, such as physician offices and emergency departments (EDs). A study was conducted to characterize geographic variation in utilization and charges for common lab tests, office visits, and flu vaccines by care settings. Based on claims data from FAIR Health's National Private Insurance Claims (FHIPIC®) database, the results suggest that utilization and charge patterns for common procedures vary significantly by care setting across geographic region and over time but the variations are generally small in magnitude. For example, across geographic regions, charges for the flu vaccine are found to be higher when performed in a physician's office in contrast to being performed in a UCF.

KEYWORDS: healthcare claims data, urgent care facilities, convenient care centers

Introduction

There has been a notable increase in the number of urgent care facilities and other types of walk-in "convenient care" centers, such as retail clinics, in the United States over the past decade.1-3 Rising healthcare costs, primary care physician (PCP) shortages, overcrowding in hospital emergency departments, and consumer demand for more convenient and affordable care, have all been attributed to the significant and rapid growth of this alternative care delivery model.4-7 The growth of the convenient care industry seemingly addresses commonly cited issues that restrict access to care, such as long appointment wait times and limited availability outside of business hours.8-10 This study examines geographic variation in utilization and charges for services in different care settings, including UCFs, which have been only marginally studied.11-15 Retail clinics and UCFs are said referred to as convenient because they offer many of the same services at competitive costs.16 The Association of America and FAIR Health, the ED facilities that are often located in pharmacies, offer less comprehensive care services.11-15 The variations in outcomes are increasingly seen as a threat to traditional care settings.17-20

Connecticut Medicine
Diabetes Rates Rise Among US Youth, Especially Minorities

Christina Mattina and Mary Caffrey

Results from the first decade a major study by the CDC and the National Institutes of Health (NIH) show diabetes incidence is rising rapidly among US youth, but especially among racial and ethnic minorities.

The findings from the Search for Diabetes in Youth Study (SEARCH), which began in 2000 and will continue until at least 2020,1 were published in the New England Journal of Medicine (NEJM) in mid-April,2 and were consistent with a claims study reported by FAIR Health earlier this year.

---

PAYER DATA

Obesity and Type 2 Diabetes in Young People: A Matter of National Concern

Robin Gelburd, JD

TYPE 2 DIABETES (T2D) was so rare in children that it was once called adult-onset diabetes to distinguish it from type 1 diabetes (juvenile diabetes). A growing body of evidence has shown, however, that the prevalence of T2D is increasing among the nation’s young people and that a major contributor to this increase is the epidemic of obesity in the same population.12 Our recent white paper, “Obesity and Type 2 Diabetes as Documented in Private Claims Data: Spotlight on This Growing Issue Among the Nation’s Youth,”3 examines these trends.
Website and Mobile App

**Website**
- [fairhealthconsumer.org](http://fairhealthconsumer.org)
- [consumidor.fairhealth.org](http://consumidor.fairhealth.org)

**Mobile App**
- **MOBILE APP**
- *FH® Cost Lookup / FH® CCSalud*

Images showing the user interface of the website and mobile app.
Navigating your medical care shouldn’t make you sick.

You can plan for this.

Get essential information on costs for thousands of procedures, learn insurance basics and find local providers for common conditions.
For patients who pay cash, a growing number of online pricing tools, such as Healthcare Bluebook, Pratter, ClearHealthCosts, FAIR Health, are available to determine and compare costs for outpatient hospital procedures in your zipcode.

Page 268
Honored for Innovation and Utility

- **White House Summit on Smart Disclosure**
  - FAIR Health consumer website recognized as example of Smart Disclosure for consumers by White House; FAIR Health invited to present at National Archives before 75 federal agencies

- **Agency for Healthcare Research and Quality (AHRQ)**
  - FAIR Health Cost Lookup listed as “Quality Tool” on AHRQ Health Care Innovations Exchange

- **Utilization Review Accreditation Commission (URAC)**
  - FAIR Health received the award for Best Practices in Health Care Consumer Engagement and Protection at the 2013 Quality Summit

- **Strategic Health Care Communications**
  - FAIR Health awarded the eHealthcare Leadership Awards for five consecutive years, since 2012

- **appPicker**
  - FAIR Health mobile app selected as one of best healthcare apps in 2014

- **Employee Benefit News (EBN)**
  - FAIR Health President Robin Gelburd recipient of 2016 Dig|Benefits Technology Innovator Award

- **Kiplinger’s Personal Finance**
  - FAIR Health recognized as best healthcare cost estimator in 2016
FAIR Health Value Proposition

- Largest private claims collection in the country – a quasi-national APCD
- Independent, mission-driven nonprofit
- Conflict-free, unaffiliated with any stakeholder
- Uncompensated, diverse and expert board of directors
- Robust network of independent advisory committees
- CMS Qualified Entity
- Award-winning consumer platform
- Physical custody of the claims
- Data access to all stakeholders
- All operations performed by expert in-house staff
- Codified in statutes; cited in regulations; referenced in official policy memoranda
- Successful business plan for sustained economic self-sufficiency
Thank You

Robin Gelburd, President
212-370-0704
rgelburd@fairhealth.org

For more information, visit:
• fairhealth.org
• fairhealthconsumer.org / consumidor.fairhealth.org
• Mobile App: FH® Cost Lookup / FH® CCSalud
Agenda Item #3

Consider Adoption of its June 15 and Spring National Meeting Minutes
—Commissioner Al Redmer Jr. (MD)
Draft: 6/20/17

Health Insurance and Managed Care (B) Committee
Conference Call
June 15, 2017

The Health Insurance and Managed Care (B) Committee met via conference call June 15, 2017. The following Committee members participated: Al Redmer Jr., Chair (MD); Lori K. Wing-Heier, Vice Chair (AK); Marguerite Salazar represented by Peg Brown (CO); Katharine L. Wade represented by Mary Ellen Breault and Paul Lombardo (CT); Dean L. Cameron (ID); Jennifer Hammer represented by Paulette Dove (IL); Nancy G. Atkins (KY); Roger A. Sevigny represented by Michael Wilkey (NH); Maria T. Vullo represented by Troy Oechsner (NY); Teresa D. Miller (PA); Larry Deiter represented by Gretchen Brodkorb and Melissa Klemann (SD); Todd E. Kiser represented by Tanji Northrup and Tomasz Serbinowski (UT); and Mike Kreidler represented by Molly Nollette (WA). Also participating were: Kevin Dyke (MI); and Fred Andersen (MN).

1. Adopted Revisions to VM-25

Mr. Dyke said that, on June 2 via conference call, the Health Actuarial (B) Task Force adopted revisions to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the Valuation Manual, for group long-term disability (GLTD) interest rate reserving requirements. He explained that with impending changes to the calculation of the single premium immediate annuites valuation interest rate, the proposed the revision is allow for the calculation of the calendar year maximum valuation interest rate for certain claim reserves to remain unchanged. Mr. Dyke characterized the revision as being technical in nature.


2. Adopted Actuarial Guideline—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves

Mr. Dyke said that, on June 2 via conference call, the Health Actuarial (B) Task Force adopted Actuarial Guideline—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG LTC).

Mr. Andersen explained that AG LTC is intended to increase the uniformity, transparency and accuracy of long-term care insurance (LTCI) reserves starting with year-end 2017 filings. He said the draft guideline was first exposed in August 2016 and has received substantial vetting over the subsequent months in sessions at the NAIC national meetings and on conference calls. Mr. Andersen noted that the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans’ (AHIP) have expressed support for the guideline. He also noted the Long-Term Care Actuarial (B) Working Group’s unanimous adoption May 26 via conference call.

Mr. Andersen said the guideline, in summary: 1) requires the use of appropriate assumptions, including regarding future rate increases, underlying LTCI reserves; 2) clarifies the use of aggregation of LTCI and other blocks’ reserves; 3) provides documentation requirements for assumptions and reserve results; and 4) provides the means for the reserve analysis to be available to regulators in all states in which a company is licensed. He said regulatory actuaries believe it is important for AG LTC to be effective for year-end 2017 financial reporting in order to attain significant improvement in the uniformity, transparency and accuracy of LTCI reserves. Mr. Andersen noted that industry representatives have expressed support for this goal.

Mr. Oechsner noted the extensive work that has been done on the AG LTC and agreed that uniformity and transparency is important. However, he expressed concern that the AG LTC permits insurers to account for increased that are not yet approved. Mr. Andersen noted that New York does not permit insurers this practice, but he also noted that every other state permits it with no parameters on how it should be done. Mr. Andersen said Section 4E of AG LTC provides such structure. He explained that the Working Group worked extensively on the Section 4E language to obtain the necessary support. Mr. Anderson said some think it is too strong, while others think it is too weak, but he believes it enjoys wide support.

3. Discussed its Proposed Summer National Meeting Agenda

Jolie Matthews (NAIC) said the Committee plans to hear a presentation from the Blue Cross and Blue Shield Association (BCBSA) on what the Blue Cross and Blue Shield System is doing to help address the opioid issue. She said the Committee also plans to hear a presentation from Fair Health to learn more about the company and the services it provides to the insurance industry and consumers. Ms. Matthews said the Committee also plans to hear oral reports from its task force, working group and subgroup chairs regarding their activities. She said Committee also plans to hear a federal legislative and regulatory update from NAIC staff. Ms. Matthews noted that the Committee’s agenda could change before the Summer National Meeting.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Health Insurance and Managed Care (B) Committee met in Denver, CO, April 9, 2017. The following Committee members participated: Al Redmer Jr., Chair (MD); Lori K. Wing-Heier, Vice Chair (AK); Leslie R. Hess (AZ); Marguerite Salazar (CO); Katharine L. Wade (CT); Dean L. Cameron (ID); Jennifer Hammer (IL); Brian Maynard represented by Jeff Lamb (KY); Roger A. Sevigny represented by Jennifer Patterson (NH); Maria T. Vullo (NY); Teresa D. Miller (PA); Larry Deiter (SD); Todd E. Kiser represented by Nancy Askerlund (UT); Osbert E. Potter (VI); and Mike Kreidler (WA). Also participating were: Perry Kupferman and Lan Brown (CA); Stephen C. Taylor (DC); Lisa Parker and Eric Johnson (FL); Karl Knable (IN); Kevin Dyke (MI); Angela Nelson and Mary Mealer (MO); Felix Schirripa (NJ); Terry Seaton and Paige Duhamel (NM); Laura Miller (OH); Laura Cali Robison (OR); Michael Humphreys (TN); Jan Graeber (TX); and Julie Blauvelt and Bob Grissom (VA).

1. **Heard an Update on the Manatt and RWJF Work Related to “Transparency for Consumers and Regulators”**

Joel Ario (Manatt Health Solutions) and Katherine Hempstead (Robert Wood Johnson Foundation—RWJF) updated the Committee on the RWJF/Manatt Data Transparency Project (Project) and the System for Electronic Rate and Form Filing’s (SERFF) role in data transparency with respect to qualified health plan (QHP) filings as part of the project’s goal to enhance data transparency. Mr. Ario said that supported by the RWJF, Manatt conducted nine stakeholder interviews in the fall of 2016, and reviewed resources to assess the current state of data transparency and identify opportunities for improvement. He said the stakeholder reviews included reviews with federal officials; state insurance regulators in Maine, Nebraska, New York, Oregon and Pennsylvania; SERFF staff; and web developers. Mr. Ario discussed the Project’s next steps to increase data transparency, including providing suggestions on how the National Association of Insurance Commissioners (NAIC) and SERFF working with the states can improve data transparency, such as: 1) making SERFF access a more standardized and consumer-friendly feature on state insurance department websites; 2) developing a priority list for naming conventions and other data standardization that would improve data quality and consistency; and 3) offering states multiple options for how data is made public.

2. **Heard a Federal Legislative and Regulatory Update**

Sean Dugan (NAIC) provided an update on federal legislation and regulatory actions of interest to the Committee. He first discussed activities in the U.S. House of Representatives. Mr. Webb said the House is using the budget reconciliation process as a vehicle to repeal and replace the federal Affordable Care Act (ACA), noting its proposed American Health Care Act (AHCA), which was pulled from consideration prior to an impending vote. Mr. Dugan explained how the budget reconciliation process’ scope is limited. He said that under the U.S. Senate’s reconciliation rules (the so-called Byrd Rule), only provisions that directly and significantly affect the federal budget may be included in a budget reconciliation package without a challenge. Other items that do not directly or significantly affect the federal budget can be added but would be subject to a point-of-order, which requires 60 votes to overcome. Mr. Dugan also said there are rumors that some in the House are considering using the continuing resolution (CR) that must be passed to continue to fund the federal government as a vehicle for funding the ACA cost-sharing reduction (CSR) payments. He said that, if true, the funding would provide needed stability for the individual market at least for 2018.

Mr. Dugan highlighted several bills that have passed the House, including: 1) the Small Business Health Fairness Act of 2017 (H.R. 1101), which would allow small employers to create association health plans (AHPs) that are not regulated by the states and are not required to meet state solvency standards; 2) the Healthcare Choice Act of 2017 (H.R. 314), which would allow consumers to purchase coverage from any carrier in any state, preempting state licensing rules; and 3) the Competitive Health Insurance Reform Act (H.R. 372), which would eliminate the anti-trust exemption for health carriers provided under the federal McCarran-Ferguson Act. He said the NAIC opposes all three pieces of legislation. Mr. Webb also noted that the three bills stand little chance of passing the U.S. Senate.

Mr. Dugan said that with respect to ACA repeal and replace, the Senate is waiting for the House to take action. However, he highlighted a few bills that seek to repair certain aspects of the ACA, including the situation where there are no carriers offering coverage in a state through the health insurance exchange. In this situation, the proposed legislation would permit consumers to receive the subsidies if they obtain coverage in the individual, off-exchange market.
Draft Pending Adoption

Mr. Dugan also discussed the federal Center for Consumer Information and Insurance Oversight’s (CCIIO) market stabilization proposed regulation. He said that in an effort intended to help stabilize the individual market, the proposed regulation would: 1) allow carriers to require consumers to pay any unpaid premiums before re-enrolling for a new year; 2) shorten the 2018 open enrollment period; 3) require verification of special enrollment period (SEP) eligibility and limit plan choices; 4) widen the de minimis variation for actual value of the metal levels to allow for more innovation; 5) remove federal regulators from the network adequacy review process; and 6) make it easier for carriers to comply with the ACA’s essential community provider (ECP) requirements. He said the CCIIO is expected to release the final regulation by the end of the month. Mr. Dugan also noted that the Trump administration issued a bulletin allowing transition plans (so-called “grandmothered” plans) to continue through Dec. 31, 2018. These plans were set to end Dec. 31.

3. Heard an Update from the CHIR on its Work Related to the ACA

JoAnn Volk (Georgetown Health Policy Institute, Center on Health Insurance Reforms—CHIR) provided an update on the CHIR’s work related to the ACA through the State Health Reform Assistance Network, which is being conducted with funding from the Commonwealth Fund and the RWJF. She said this work includes new analyses and publications related to: 1) current and potential federal legislative ACA-related proposals, such as association health plans, and the possible implications of such proposals to consumers and the states; 2) potential federal administrative actions, such as proposals to eliminate essential health benefits (EHBs) and the loss of cost-sharing reductions in the ACA marketplace, and the possible implications of such actions to consumers and the states; and 3) state legislative and regulatory action. Ms. Volk said the CHIR’s future work will include examining such issues as: 1) insurance sales across state lines; and 2) expanding health savings accounts (HSAs). She said the CHIR also plans to update its small group market paper, which was initially published in 2015. Ms. Volk said the CHIR is also working to complete its 50-state review of state balance-billing requirements.

4. Heard a Stakeholder Discussion on Issues and Concerns with ACA Repeal and Replacement Proposals

a. Health Industry

Candy Gallaher (America’s Health Insurance Plans—AHIP) discussed the AHIP’s federal legislative and administrative priorities for promoting a more stable individual health insurance market. She said AHIP’s legislative priorities for accomplishing this include: 1) continued and uninterrupted CSR funding; 2) create the Patient and State Stability Fund, as recommended in the proposed federal American Health Care Act (AHCA); and 3) eliminate the health insurance tax that increases premiums. On the administrative side, Ms. Gallaher said AHIP priorities include: 1) finalizing the federal Center for Consumer Information and Insurance Oversight’s (CCIIO) proposed market stabilization rule as soon as possible; 2) making good on the 2016 reinsurance payments and clarifying the continued enforcement of the ACA’s individual mandate; and 3) beginning as soon as possible on regulatory changes for 2019. She also discussed AHIP’s recommendations for promoting a stable individual health insurance market for state insurance regulators and policymakers, including: 1) offering stable competitive markets to enable insurers to offer consumers choices and affordable premiums; 2) evaluating different state-specific mechanisms to help make premiums more affordable; and 3) supporting effective pre-enrollment verification for special enrollment period coverage to help minimize mid-year adverse selection.

Paul Brown (Blue Cross and Blue Shield Association—BCBSA) reiterated many of Ms. Gallaher’s comments regarding priorities for promoting a more stable individual health insurance market. He also alerted the Committee to potential legislative threats to state authority, including: 1) the Small Business Health Fairness Act of 2017 (H.R. 1101), which would allow small employers to create AHPs that are not regulated by the states and are not required to meet state solvency standards; 2) the Healthcare Choice Act of 2017 (H.R. 314), which would allow consumers to purchase coverage from any carrier in any state, preempting state licensing rules; and 3) the Competitive Health Insurance Reform Act (H.R. 372), which would eliminate the anti-trust exemption for health carriers provided under the federal McCarran-Ferguson Act. He noted that the NAIC has opposed all three pieces of legislation.

b. Actuaries

Shari Westerfield (American Academy of Actuaries—Academy) discussed the Academy’s concepts that support a sustainable individual market. Those recommendations included: 1) individual enrollment at sufficient levels to balance the risk pool; 2) a stable regulatory environment that facilitates fair competition; 3) sufficient insurer participation and plan offerings to provide competition and consumer choice; and 4) slow spending growth and high quality of care. She also discussed the status of the current individual market and the challenges to market stability. Ms. Westerfield discussed potential federal legislative and administrative activity that could adversely affect market stability, such as not enforcing the

© 2017 National Association of Insurance Commissioners 2
Draft Pending Adoption

ACA’s individual mandate or not funding the CSR reimbursements. She also highlighted several Academy publications related to these issues.

c. Consumers

Claire McAndrew (Families USA) discussed how the potential repeal, replacement and/or repair of the ACA’s provisions has created an atmosphere of uncertainty for consumers with respect to guarantee issue of coverage, mental health coverage and losing access to certain other EHBs. She suggested that the states need to help ensure that any further reforms, if enacted, do no harm to consumers, minimize market disruption and maintain common-sense consumer protections. Ms. McAndrew also discussed the importance of consumer participation in the individual health insurance market and the importance of ensuring that consumers are not being discouraged from enrolling in the market because they are concerned about potential federal legislative and regulatory changes.

Timothy Stoltzfus Jost (Virginia Organizing) expressed support for efforts being made to ensure individual market stability. However, he expressed concern with some aspects of the CCIIOs’ proposed market stabilization rule, including the shortening of the 2018 open enrollment period. Mr. Jost also said the proposed rule shifts oversight over network adequacy standards to the states, but few states have adopted the NAIC’s revised Health Benefit Plan Network Access and Adequacy Model Act (#74). He said the NAIC should encourage all the states to move promptly to update their laws and regulations to ensure that insurers provide consumers with access to adequate provider networks. Mr. Jost said weakening of the enforcement of the individual mandate and a potential redetermination of the short-term, limited duration coverage to once again allow 364-day short-term policies may lead to a flood of limited benefit policies. He said the NAIC needs to redouble its efforts to revise the Accident and Sickness Insurance Minimum Standards Model Act (#170) and the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) to address this issue. Mr. Jost also offered several other recommendations for the NAIC to carry out, such as: 1) actively working with insurers to stay in the individual health insurance market; 2) regulating minimum benefit plans to reduce the ability of deceiving consumers that such plans are comprehensive major medical insurance; and 3) ensuring access to ECPs.

5. Adopted its March 16 and Feb. 15, 2017, and 2016 Fall National Meeting Minutes

The Committee met March 16 and Feb. 17. During those meetings, the Committee took the following action: 1) adopted revisions to the Health Insurance Reserves Model Regulation (#10); 2) discussed its 2017 activities; and 3) heard updates from its task forces on their 2017 activities.

Director Wing-Heier made a motion, seconded by Commissioner Miller, to adopt the Committee’s March 16, 2017 (Attachment One); Feb. 17, 2017 (Attachment Two); and Dec. 11, 2016 (see NAIC Proceedings – Fall 2016, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

6. Adopted the Health Actuarial (B) Task Force’s Request for an Extension of Model Law Development for Model #10

Jolie Matthews (NAIC) said the Health Actuarial (B) Task Force is requesting an extension of model law development for Model #10 to revise the model to reflect appropriate long-term care insurance (LTCI) reserving standards.

Commissioner Kreidler made a motion, seconded by Commissioner Miller, to adopt the Health Actuarial (B) Task Force’s request for extension for model law development for Model #10. The motion passed unanimously.

7. Heard Senior Issues (B) Task Force Recommendations for Federal Policy Options and Approaches to the Financing of LTC Needs

Commissioner Miller explained that the list of federal policy options for congressional consideration developed by the Long-Term Care Innovation (B) Subgroup is just one step in the hope of increasing the number of affordable asset protection product options available in the long-term care (LTC) market, potentially paving the way for the private market to play a more meaningful role in financing the LTC needs of society. She said it is not a silver bullet and that other options and ideas must be examined.

Commissioner Miller said Long-Term Care Innovation (B) Subgroup exposed the document for a 30-day public comment period. She said the Subgroup received comments and discussed those comments via conference call. She said the Subgroup adopted the recommendations April 3 via conference call, and the Task Force adopted them April 8. Commissioner Miller explained that due to the high-level interest from the U.S. Congress in receiving these recommendations, the Task Force
Draft Pending Adoption

would like the Committee to consider adoption during this meeting in order for them to be referred to the Government Relations (EX) Leadership Council for its consideration in order for the NAIC to forward the recommendations to Congress in early May.

Commissioner Miller made a motion, seconded by Director Wing-Heier, to adopt the Senior Issues (B) Task Force’s recommendations for federal policy options and approaches to the financing of LTC needs (see NAIC Proceedings – Spring 2017, Senior Issues (B) Task Force, Attachment Six) for forwarding to the Government Relations (EX) Leadership Council for its consideration. The motion passed unanimously.

8. **Adopted its Subgroup, Working Group and Task Force Reports**

Commissioner Kreidler made a motion, seconded by Commissioner Miller, to adopt the reports of the Committee’s subgroups, working group and task forces: the Consumer Information (B) Subgroup, including its Dec. 16, 2016 (Attachment Three) minutes; the Health Care Reform Regulatory Alternatives (B) Working Group (Attachment Four); the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
Agenda Item #4

Consider Request for Extension of Model Law Development for the Health Insurance Reserves Model Regulation (#10)—Commissioner Al Redmer Jr. (MD)
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

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.
   Amend Health Insurance Reserves Model Regulation (#010) to reflect appropriate reserving standards.

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

   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)
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)

Explanation, if necessary:
NA

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
Agenda Item #5

Hear Federal Legislative and Regulatory Update—Brian Webb (NAIC)

NO MATERIALS
Agenda Item #6

Receive Joint Long-Term Care Insurance (B/E) Task Force Report and Consider Adoption of its 2017 Charges—Commissioner Al Redmer Jr. (MD)
Long-Term Care Insurance (B/E) Task Force
Proposed Charges

The Joint Long Term Care Insurance Task Force of the Health Insurance (B) Committee and the Financial Condition (E) Committee is charged with coordinating all aspects of the NAIC’s work regarding the long term care insurance (LTCI) market. In addition to coordinating current B and E Committee projects, the Joint LTCI Task Force should pursue the following general objectives:

1. To more rigorously assess the financial solvency of LTCI writers;
2. To evaluate the sufficiency of current financial reporting and actuarial valuation standards;
3. To assess state activities regarding the regulatory considerations on rate increase requests on blocks and to identify common elements for achieving greater transparency and predictability;
4. To coordinate state actions aimed at revising state guaranty fund laws;
5. To monitor the development of regulatory policy regarding short duration LTCI policies; and
6. To consider product innovations and the development of potential state and federal solutions for stabilizing the LTCI market.

Provide periodic reports to the B and E Committees, and the Executive Committee, regarding key issues and progress toward the general objectives set forth above. Conduct meetings in regulator-only session, as appropriate.
The Long-Term Care Insurance (B/E) Task Force met via conference call July 19, 2017. The following Task Force members participated: Al Redmer Jr., Co-Chair (MD); Eric A. Cioppa, Co-Chair (ME); Mike Kreidler, Vice Chair, Jim Odiene and Doug Hartz (WA); Dave Jones represented by Perry Kupferman and Tyler McKinney (CA); Marguerite Salazar represented by Michael Conway (CO); Katharine L. Wade represented by Mary Ellen Breault and Paul Lombardo (CT); David Altmaier (FL); Mike Rothman represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Angela Nelson (MO); Bruce R. Range represented by Rhonda Ahrens (NE); John G. Franchini represented by Terry Seaton (NM); Teresa D. Miller represented by Joe DiMemmo (PA); Elizabeth Kelleher Dwyer (RI); TBD represented by Doug Slape (TX); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Jacqueline K. Cunningham represented by Doug Stolte (VA).

1. **Heard a Presentation Regarding Proposed LTC Run-Off Facility**

Commissioner Redmer introduced Luann Petrellis (PricewaterhouseCoopers) and Richard Newton (International Solutions LLC), who provided a summary of their proposed long-term care (LTC) run-off facility by talking the members of the Task Force through two presentations (Attachment 7).

Ms. Petrellis focused her summary on the need for this industry to have better tools available to address the difficulties of the LTC line of business, but will require regulators working with the industry. She noted the run-off option allows a tool that can assist in multiple ways, including economies of scale through consolidation, disclosure and transparency, and claim and reserving practices. However, it is not intended to address the issue of funding.

Mr. Newton reiterated some of the points made by Ms. Petrellis, but focused his summary on discussing the work International Solutions did in 2015 with Rhode Island to provide the first transfer mechanism in the U.S., although such is only based on commercial business. It was noted that it was based on the United Kingdom (UK) Part VII transfers, under which hundreds of successful deals had been done since being introduced in 2001. In the case of the UK and other countries, the option is available to all types of products. He noted that, in these cases, investors see the facility provides a better use of capital and gives regulators more options. Mr. Newton noted that International Solutions had discussed the use of this type of facility for various products with U.S. state insurance regulators, including, more specifically, LTC insurance. He stated that the goal is to develop a global facility for LTC, both for solvent and troubled LTC companies.

Ms. Petrellis described how the insurance business transfer is a novation from one carrier to another carrier, by using a closely monitored transparent review process that multiple states can use to protect policyholders’ rights. This includes extensive financial statement disclosure, notice requirements and independent valuation requirements, as well as approvals from the regulators for both the transferring and transferred insurer. Finally, it requires a judicial approval process where policyholders have the ability to be heard and where they are not adversely impacted. It can be used for both monoline and multi-line companies. In addition, uniform and consistent administration of policies provide fair treatment, as well as security and greater certainty.

Jose Montemayor (Black Diamond Capital Partners) provided the perspective of a former state insurance regulator. He discussed how such a process was used with asbestos liabilities in the context of Equitas back when he was leading an NAIC delegation in the context of a chief examiner. In addition, this has been used in the context of state-run workers’ compensation programs, including in Texas, where he used a similar facility to help deal with the Texas program at the request of then Texas Governor George W. Bush. He stated that LTC insurance requires a similar approach, but noted that it would require close cooperation between regulators, the industry and private capital. He emphasized that this type of approach is greatly needed, as the policyholders are individuals in great need of assistance.

Ms. Petrellis described how the concept of a LTC facility would work for both solvent and troubled insurers. She emphasized how the facility can provide uniform service to all policyholders, while also balancing the needs of the insurance companies. Mr. Newton described how the facility would attempt to deal with an underfunded situation by attracting investors that, if set up correctly, will bring liquidity and reinsurance to the business. It would utilize market tools such as hedges and swaps to mitigate future exposures that might not be as easily achieved within individual insurers. He described how a standard valuation would be an important aspect of the facility, as it would require all companies to comply with the tool. He
described how PricewaterhouseCoopers had used this type of valuation tool in the Penn Treaty situation. He noted the key to this tool is its requirement for the use of consistent assumptions. Ms. Petrellis described how actuarial nonforfeiture options could be provided to policyholders in a uniform and consistent way. She described what she considered the “thorny” issue of rate increases, which would have to be taken into consideration within the concept, but that it would result in supported reasonable rate increases that would attempt to find the appropriate balance of fairness. Mr. Newton agreed, noting this would be an important aspect of the how the facility would work.

Mr. DiMemmo asked what rights or approvals the policyholders would have in order to transfer their policy to an assuming carrier. Ms. Petrellis replied it did not require policyholder consent, as the novation occurs from a court order. She stated policyholders have the ability to be heard if they believe they were adversely impacted in any way, but it would be up to the court. She stated that the terms and conditions of the policyholder remain intact; only the obligor would change. Mr. DiMemmo asked how this would be different than what occurs when an assuming insurer purchases the business. Mr. Newton described that it does provide for a novation, but that this is different in that it allows companies to move their portfolio of liabilities to an assuming carrier with all of the protections that go with it, including the policyholder cannot be worse off. Ms. Petrellis emphasized this can allow business that cannot otherwise be segregated from other business.

Mr. DiMemmo asked Mr. Newton and Ms. Petrellis if they had worked with the National Organization of Life and Health Guaranty Associations (NOLHGA) on this type of option. Mr. Newton and Ms. Petrellis stated that their proposal does not deal with funding, noting that particular issue would have to be determined by the regulators. Peter Gallanis (NOLHGA) discussed that NOLHGA had worked closely with Mr. DiMemmo on the transfer of blocks of business using some of the elements that are being described. He noted there was not enough time to discuss that topic, including how it was used in Penn Treaty, but noted that it might be helpful to receive a briefing at some point in the future that could discuss how they worked through problems by working with knowledgeable regulators and outside experts. He stated, in particular, the issue of funding is an important one for insolvent run-offs, as it is something they had worked on a great deal. Superintendent Cioppa stated that such a presentation in the future from NOLHGA would be helpful, and asked Mr. Gallanis to work with NAIC staff in setting this up for the future.

Patrick Cantilo (Cantilo & Bennett, LLP) asked for clarification regarding the distinction between what is referred to as “no material changes” in the contract. He asked if the court imposes material changes to the contract provided the policyholders are in no worse condition given the relative financial condition of the insurers, or whether it relates to no material changes to the policy. He described the so-called Carpenter test, which considers the financial condition of the impaired insurer, or another approach where there are no changes to the policy. He asked if the court could involuntarily impose contractual changes. Ms. Petrellis and Mr. Newton both said it could not; rather, the insurers are provided options. Bonnie Burns (California Health Advocates) expressed similar concerns, and noted the way in which a policyholder would be protected would be important to people who represent consumers to ensure that “no worse off” really means no worse off in regard to their benefits.

Ms. Petrellis responded that policyholder protections are paramount and the transfer protects them through multiple safeguards. This includes the required use of an independent expert to ensure policyholder protection throughout the process, including transferring and non-transferring policyholders, noting that this is an extensive process supported by in-depth reports. Also included is a thorough regulatory review and a judicial review. Ms. Burns stated that for the types of products used in the UK, they seemed to be policies that had a tangible value, and noted that LTC policies are quite different. She described Partnership policies, which include the impact on Medicaid contracts, as one example. She stated she sees the value to companies and regulators, but wants to make sure policyholders are protected, noting that “the devil is in the details.” Superintendent Cioppa stated that policyholder protection is paramount. Brendan Bridgeland (Center for Insurance Research) agreed with Ms. Burns and stated there would need to be more mechanisms in place to protect consumers. He stated he heard the court process protections, but said it sounds like such would require travel and other similar expense issues that do not provide any real protection given the specifics common to such policyholders.

Commissioner Kreidler stated that this is an intriguing approach and one that should be considered seriously to determine if and how, and to what extent, it could be incorporated into the Task Force’s ongoing work and recommendations.

2. Received an Oral Report on Recent Activities of the Financial Analysis (E) Working Group

Superintendent Cioppa asked Mr. Slape, as chair of the Financial Analysis (E) Working Group, to provide the Task Force with a summary of some of the work the Working Group is currently completing. Mr. Slape provided background information on the Working Group, including how it was created in 1989 composed of 18 states where the member must
have at least 10+ years of experience at a financial deputy level or similar senior experience. He discussed how the Working Group meets three times a quarter, as well as annually in Kansas City, MO, to discuss, among other things, potentially troubled insurers and insurance groups, in part based on dedicated NAIC staff who produce various information for the Working Group. He discussed how the Working Group is generally focused on nationally significant companies, noting that it monitors companies through ongoing communication with the domestic regulator. This allows the Working Group to use its experience to offer suggestions and best practices from lessons learned that the domestic regulator may not have dealt with. When warranted, companies will be brought in to meet with the Working Group and, in some cases, the Working Group might provide expertise to troubled companies, given the Working Group has experience with such situations that a new company management team typically does not have.

Mr. Slape discussed that during its annual meeting, the Working Group discusses industry trends, including identifying any that are potentially adverse or might warrant communication and coordination with other NAIC groups. He stated that the Working Group has had numerous discussions over the past 20 years regarding potentially troubled LTC insurance companies, and has had numerous discussions regarding the trends among LTC insurance companies. He discussed how these trends have been noted to regulators in industry risk alerts. He stated that within the past few years, LTC companies have dominated the Working Group’s agenda, including half during this most recent year-end. He stated the vast majority of situations deal with companies that have closed blocks of business. He said the Working Group reviews the Long-Term Care Experience Reporting Forms, but during the most recent annual Working Group meeting held earlier this year, the Working Group discussed the need to gather more information from at least the LTC insurers with the largest blocks of LTC business.

He then described how the Working Group began the development of a data request to the domestic states of these insurers. Mr. Slape described how the data and qualitative information requested falls into three regulatory “buckets”: 1) reserves; 2) lapses; and 3) capital. He stated that, with respect to reserves, while the Long-Term Care Experience Reporting Forms provide good information on LTC reserves, the Working Group wants to make sure it has a complete picture of the total LTC reserves, including making sure that includes information at the policy level, the types of reserves and information on nonforfeiture reserves. He stated that the Working Group is also looking at information on asset adequacy analysis reserves, premium deficiency reserves and the impact on reserves for future rate increases. He emphasized the need to consider the masking of data at the policy level because totals can mask individual problems. Mr. Slape stated that, with respect to lapses, the Working Group is looking for some basic information, just to make sure it has a better understanding of this area because it does appear to be an area where original and current assumptions are expected to be significant. Mr. Slape stated that, with respect to capital, the Working Group is looking for qualitative information from the companies on the relationship between their reserves and their capital to give a better high-level picture of the ability of the industry as a whole to continue to absorb losses. Mr. Slape stated that this information on a trend basis might allow the Working Group to understand where a company might be headed. He stated that information on rating agency requirement expectations is also being requested in this area, noting how some agencies will notch companies that have material LTC business. He discussed that the information is currently being reported by the states, noting that the Working Group would be collecting and analyzing the information over the next month to where they can provide some aggregated industry analysis because all of the information is confidential. Mr. Slape stated that, after such analysis, to the extent the Working Group needs to request more data from some of the companies, it would contact those applicable states. It was noted that the industry analysis from the Working Group would be the primary item to be discussed on the Task Force conference call scheduled for Sept. 6.

Mr. Andersen noted that, with respect to reserves, a new actuarial guideline is in the process of being adopted by the NAIC that would make the reserves more accurate and transparent. He also noted that the vast majority of the LTC policies are with large, diverse and profitable companies.

3. Discussed Other Matters

Superintendent Cioppa repeated comments he had made during the July 14 conference call, at which time he suggested any regulators wanting to assist in the work of the Task Force to contact either he or Commissioner Redmer so they could consider adding them to the membership of the Task Force.

Having no further business, the Long-Term Care Insurance (B/E) Task Force adjourned.

© 2017 National Association of Insurance Commissioners
The Long-Term Care Insurance (B/E) Task Force met via conference call July 14, 2017. The following Task Force members participated: Al Redmer Jr., Co-Chair (MD); Eric A. Cioppa, Co-Chair (ME); Mike Kreidler, Vice Chair, Jim Odiorne and Doug Hartz (WA); Dave Jones represented by Perry Kupferman (CA); Katharine L. Wade, Mary Ellen Breault and Paul Lombardo (CT); David Altmaier represented by Eric Johnson (FL); Mike Rothman represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Angela Nelson (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); John G. Franchini represented by Terry Seaton (NM); Teresa D. Miller represented by Joe DiMemmo (PA); Elizabeth Kelleher Dwyer (RI); Doug Slape, Jan Graeber and James Kennedy (TX); Todd E. Kiser represented by Tomasz Serbinowski (UT); Jacqueline K. Cunningham represented by Doug Stolte and Bob Grissom (VA).

1. Discussed and Adopted its Proposed Charge

Commissioner Redmer stated his appreciation for the regulators agreeing to be part of the Task Force and welcomed other regulators to contact him if they would like to assist. Commissioner Redmer described how he developed the Task Force’s proposed charge jointly with Superintendent Cioppa and Commissioner Kreidler, noting that it represents what he considers a good starting point for discussions. In making such statements, he indicated that he believes the NAIC membership already supports the Task Force as being the one coordinating body of various workstreams of the NAIC on long-term care (LTC) insurance, as discussed at the Spring National Meeting.

Commissioner Redmer next described the purpose of the first part of the proposed charge, which focuses on financial solvency. He stated that, from his perspective, it will be helpful for the Task Force to have a backdrop for the solvency of the industry as other issues dealing with LTC insurance are being considered. He noted that the Financial Analysis (E) Working Group already reviews the solvency of individual insurers, and probably already has opinions of the LTC industry as a whole. But, earlier this year, the Working Group began a project to obtain more granular information that he is hopeful can be summarized to meet this objective.

Commissioner Redmer next described the purpose of the second part of the proposed charge, which focuses on financial reporting and actuarial valuation standards. He suggested it might be helpful to request viewpoints from the Long-Term Care Actuarial (B) Working Group and the Financial Analysis (E) Working Group on the adequacy of the current data received by state insurance regulators.

Commissioner Redmer next described the purpose of the third part of the proposed charge, which focuses on rate increases. He noted that, because it deals with rates, it would be appropriate for the Task Force to first receive information from the work of the Long-Term Care Pricing (B) Subgroup. He stated that a general discussion in this area would be helpful in understanding what is and is not achievable. Commissioner Redmer noted, however, that as he looks at the material for the July 19 conference call, he sees where part of the proposal involves the issues of rate increases, and so a general charge in this area as proposed seems appropriate.

Commissioner Redmer next described the purpose of the fourth part of the proposed charge, which focuses on guaranty funds. He stated that the Receivership Model Law (E) Working Group has begun work on issues dealing with LTC receivership, and would be doing most of the work in this area. He stated, however, that there were at least a couple of fairly significant items that may require input from the Task Force.

Commissioner Redmer described the purpose of the last two aspects of the proposed charge, which focus on short duration LTC policies and state/federal solutions for stabilizing the market. He noted that the Short Duration Long-Term Care Policies (B) Subgroup is already addressing part of this, and the same could be said for the Long-Term Innovation (B) Subgroup and the Long-Term Care Benefit Adjustment (B) Subgroup with respect to the other part of this. Therefore, unless those groups need direction or assistance, he suspected those groups would already be addressing these items.
Bonnie Burns (California Health Advocates) asked if the Task Force would also be following the work of the Long-Term Care Benefit Adjustment (B) Subgroup. Ms. Burns also asked if the Receivership and Insolvency (E) Task Force actions would also be part of work being monitored. Commissioner Redmer responded the Task Force would likely be hearing reports from all groups that are involved in LTC insurance workstreams. Mr. Kennedy stated that the charge of the Receivership Model Law (E) Working Group would cover changes to receivership or guaranty fund laws. Ms. Burns said her concern is related to the fourth part of the proposed charge, which relates to state actions aimed at revising state guaranty fund laws and does not seem to deal with receivership issues. Commissioner Redmer stated the receivership issue would be considered for a future conversation.

Commissioner Kreidler suggested the comment by Ms. Burns was a good one, but suggested considering the charges for adoption at this time. David Link (Kaiser Permanente) asked about the process for considering issues; i.e., whether issues should be addressed to this task force instead of the applicable subgroup, working group, task force or committee. Commissioner Redmer suggested any issues be first addressed to the applicable group, then only later to the Task Force as it receives reports from the various NAIC groups actually conducting the work.

Commissioner Wade made a motion, seconded by Commissioner Kreidler, to adopt the Task Force’s proposed charge (Attachment One-A). The motion was unanimously adopted.

2. Discussed Next Steps

Commissioner Redmer said the Task Force plans to meet via conference call July 19 to discuss a proposal from two consultants. Then, at the Summer National Meeting, the Task Force will meet again to receive oral reports from the chairs of the various NAIC groups that have workstreams related to LTC insurance.

Having no further business, the Long-Term Care Insurance (B/E) Task Force adjourned.
Agenda Item #7

Consider Adoption of its Subgroup, Working Group and Task Force Reports
—Commissioner Al Redmer Jr. (MD)—MATERIALS PENDING

- Consumer Information (B) Subgroup—Angela Nelson (MO)
- CO-OP Solvency and Receivership (B) Subgroup
  —Commissioner Doug Ommen (IA)
- Medical Loss Ratio Quality Improvement Activities (B) Subgroup
  —Director Dean L. Cameron (ID)
- Health Care Reform Regulatory Alternatives (B) Working Group
  —Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
- Health Actuarial (B) Task Force
  —Director Patrick M. McPharlin (MI) and Kevin Dyke (MI)
- Regulatory Framework (B) Task Force
  —Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
- Senior Issues (B) Task Force
  —Commissioner Teresa D. Miller and Jessica Altman (PA)
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee has not met this year due to the uncertainty related to the repeal, replacement or amendment of the federal Affordable Care Act (ACA). The Subgroup last met Dec. 16, 2016 via conference call. During its call, the Subgroup discussed the continuing need for consumer resources and tool to help consumers improve their health care literacy and the challenges with developing a consumer-oriented piece in the face of the uncertain future of the ACA. The Subgroup plans to meet again via conference call after the uncertainty with the ACA has been resolved.
Conference Calls

CO-OP SOLVENCY AND RECEIVERSHIP (B) SUBGROUP

Summary Report

The CO-OP Solvency and Receivership (B) Subgroup continues to meet periodically and last met July 20 via conference call. During these meetings, the Subgroup met in regulator-to-regulator session 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. Pursuant to its charge, the Subgroup continues to provide a forum for state insurance regulators to discuss and share information on the status of CO-OPs created under the federal Affordable Care Act.
MEDICAL LOSS RATIO QUALITY IMPROVEMENT ACTIVITIES (B) SUBGROUP

Summary Report

The Medical Loss Ratio Quality Improvement Activities (B) Subgroup has not met this year. During its last meeting March 10, 2016, via conference call, the Subgroup heard from interested parties and requested additional information and/or data from the stakeholders who were seeking changes to the definition of “quality improvement activities” in the medical loss ratio formula. To date, the Subgroup has not received additional information to substantiate the requests for changes to the definition and is not scheduled to have another conference call or meeting until such data is received.
Agenda Item #8

Discuss Possible Development of “Pharmacy 101” Education Sessions
—Commissioner Al Redmer Jr. (MD)

NO MATERIALS
Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—Commissioner Al Redmer Jr. (MD)