

## ATTACHMENT B

### Receivership Model Law (E) Working Group

The charges for the Receivership Model Law Working Group include evaluating the need for amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520) to address issues in connection with the insolvency of long-term care (LTC) insurers. The Working Group has identified the following options with respect to potential changes to Section 9 of the Model:

**Option 1** - Aggregate the life / annuity and health insurance accounts for the purpose of making Class B assessments with respect to LTC policies issued by an insolvent member insurer. Accounts remain separate for all other purposes.

**Option 2** – Eliminate separate accounts for life and health insurance and annuities entirely. Class B assessments with respect to *any* insolvent member insurer would be paid by all association members in accordance with the methodology provided by legislation.

**Option 3** - Include HMOs as members of the guaranty association. HMOs would be a third account under Section 6 of the Model. However, Class B assessments with respect to LTC policies issued by an insolvent member insurer would be apportioned among all three accounts in accordance with the methodology provided by legislation. This option will require changes to the Model to provide for the payment of claims against HMOs.

**Option 4** - Provide that Class B assessments with respect to LTC policies issued by an insolvent member insurer would be allocated among the life and health insurance accounts pursuant to a methodology and formula established by the Association, and approved by the Commissioner.

July 6, 2017

James Kennedy  
Chair, Receivership Model Law (E) Working Group  
National Association of Insurance Commissioners

**Re: Response Letter on Guaranty Association Issues Relating to Long-Term Care**

Dear Chairman Kennedy:

My clients, the Alliance of Community Health Plans (ACHP) and Kaiser Permanente (KP), appreciate the opportunity to provide responses to the comment letters on the proposed changes to the Life and Health Insurance Guaranty Association Model Act (#520).

**Good public policy, not “rough justice,” should be the Working Group’s immediate concern.**

ACLI’s explicit endorsement of “rough justice” as a “guiding principle” in its comment letter<sup>1</sup> should give this Working Group great pause for its inconsistency with NAIC’s tradition of careful development of thoughtful public policy in its working groups and task forces.

The Model was re-opened because the Penn Treaty liquidation so disproportionately assessed health insurers for this essentially unrelated business. Option 3 doubles down on that inequity, taking assessments even further away from a proper nexus to life insurance by including HMOs.

Long term care (LTC) is primarily custodial care triggered by the inability to perform certain activities of daily living. Although there are cases when some medical practitioners can be involved, the nature of LTC is to provide assistance to policyholders in their daily lives because of their inability to perform those activities. This is not why people buy major medical insurance coverage, and that medical coverage continues while LTC policies are independently in effect providing their own services.

Medicare, for example, draws a clear line between LTC and true health insurance:

Long-term care is a range of services and support for your personal care needs. Most long-term care isn’t medical care, but rather help with basic personal tasks of everyday life, sometimes called activities of daily living. Medicare doesn’t cover long-term care

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<sup>1</sup> ACLI letter of May 30, p. 2.

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(also called custodial care), if that's the only care you need. Most nursing home care is custodial care.<sup>2</sup>

The Working Group's first and highest priority should be ending rather than expanding the current mismatch between risk and responsibility.

ACLI is correct that, "It is in the best interest of companies doing business in a particular marketplace to participate in a guaranty association system that maintains that robustness."<sup>3</sup> Integrated managed care organizations like Kaiser Permanente and the 19 other health plans that are ACHP members, which collectively provide coverage in 28 states, do no commercial business in the "particular marketplace" of LTC and the health care they deliver has no bearing on the robustness of the LTC market.

A new LTC assessment has never been considered in ACHP members' actuarial assumptions or business models, whereas those currently participating in the guaranty associations for this line have done so for years with the expectation that they could receive similar benefit from fellow members. The contemplated new cross-subsidy would unfairly harm HMOs without their members having received any corresponding benefit in the years before the Penn Treaty assessments.

### **The proposed new charge demonstrates how miscast HMOs are for this role.**

ACLI proposes adding the following language to the charges: "*Such issues include the potential inclusion of HMOs as 'member insurers' of a state guaranty association.*"<sup>4</sup>

HMOs, however, are not defined as "insurers" in the NAIC Model Acts, where they are consistently treated distinctly, including in the NAIC Model HMO Act. Consider the description of Model #520 in the proposed request for model law development:

Model #520 sets standards to protect policy owners, insureds, beneficiaries, annuitants, payees and assignees against losses which might otherwise occur due to an impairment or insolvency of an insurer.

In contrast to this insurance-specific language, the NAIC HMO Model Act refers to an HMO member in its definitions section, and throughout, as either a "covered person" (Section 3 (H)) or as an "enrollee" (Section 3 (J)). Insurance contracts have "policy owners," "insureds," etc. In the HMO Model Act, HMOs ". . . undertake to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis..." (Section 3 (V)). These fundamentally different terms reflect fundamentally different relationships between the regulated entity and their consumers.

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<sup>2</sup> <https://www.medicare.gov/coverage/long-term-care.html>

<sup>3</sup> ACLI letter of June 16, "Guaranty Association Issues Relating to Long-Term Care Insurance," p. 3.

<sup>4</sup> ACLI letter of June 16, "Request for NAIC Model Law Development," p. 2.

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These differences carry over to the Working Group's primary jurisdiction, insolvency protection for licensed insurance companies. HMO consumers do not require protection "against losses" from an insolvency.

In typical one-year contracts, the enrollee of an insolvent HMO would lose coverage, but could purchase another policy for the remainder of that year. They would be responsible for any co-insurance, deductible or co-pay they might have accrued, but that would not be an insurance "loss," and they would be protected from any provider billing during the insolvency by the hold-harmless provisions in their contract – also required of HMOs in the HMO Model Act. Contrast this to the true losses sustained by LTC policyholders in an insolvency, who would have paid for many years or decades for benefits in the future, and find that the insurer's promises are no longer there.

The request also pertinently declares that "state law should provide for a regulatory framework such as that contained in the NAIC's model acts on the subject, *to ensure the payment of policyholders' obligations* subject to appropriate restrictions and limitations when a company is deemed insolvent" (emphasis added). While LTC policyholders will necessarily have unmet obligations well after an insolvency, HMO enrollees do not. This incongruity again illustrates the mismatch between Option 3 and the practice of managed care by HMOs..

## **The ACLI's competitive disadvantage arguments are misplaced.**

We are not aware of any tangible basis for ACLI's speculative assertion that traditional health insurers will abandon their established line of business for a fundamentally different HMO product based on the sole reason that HMOs are not being forced to share pain that they had no relationship to causing. Such speculation cannot really even be assessed.

A wholesale change from health insurance to managed care would be an extraordinarily complicated process. Following NAIC models, the states regulate HMOs and health insurers differently, usually under different statutory schemes, and often under different regulators.

ACLI asserts that both HMOs and health insurers are "essentially collections of provider networks." This may be an accurate (if loose) characterization of some HMOs, but it certainly does not properly describe ACHP's members.

Consumers have distinct preferences between these models, which HMOs and health insurers market to. Although some modern HMOs have evolved out of and maintain some of the practices of health insurers, KP, and many other organic HMOs that have always functioned as integrated managed care, do not view themselves, nor do their consumers view them, as interchangeable with health insurers.

Transferring an entire business to a licensed HMO model in order to avoid GA assessments, would be a revolutionary step that would risk extraordinary commercial consequences. It would face statutory requirements for a significant change in business model, and regulators would need to fully review the

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appropriateness of the change, and would require it to meet with significantly different HMO regulatory requirements. Such an industry-wide shift is hypothetical to say the least.

In contrast, ACHP members would suffer an unambiguous competitive disadvantage if Option 3 were adopted. Many are non-profit enterprises, and required by law to be so in some jurisdictions. They do not generally pay premium taxes and would not receive the offset that for-profit health insurers do in almost all jurisdictions.

Non-profit HMOs would have to pass GA assessments on to their members in higher premiums in a way that public policy allows the rest of the market to avoid. This would distort markets in states that require HMOs to be non-profit, and in California, where all HMOs regulated by the Department of Managed Health Care pay the state corporate tax rather than the premium tax.

Furthermore, as noted earlier, HMOs would not have gained the benefit that health insurers have had for years as members of the guaranty association. This new risk, with no real benefits for HMOs as they are currently structured, would come only with the detriment of a new financial burden imposed at the very time when the risk of assessments is at its highest in association history.

## **The working group should consider the market share of LTC policies that an insurance line sells.**

ACLI notes that the new and successful hybrid LTC products should be exempt from the guaranty association assessment for LTC because they are “attached” to an underlying and quite different life insurance product.<sup>5</sup> A necessary premise of this argument is that the substance of LTC policies can and should be taken into consideration. The reason for excluding the hybrid products is that they are not fully LTC, and therefore should not be assessed as life insurance for guaranty association purposes.

This is fundamentally inconsistent: Products which explicitly have a LTC component can be exempted from LTC guaranty association consideration on the health side, but health insurance lines that include no LTC at all must be assessed.

By contrast, the original Florida bill, HB 1273, contained an express provision to consider the market share of policies sold by an insurer. This sound approach should be followed by the Working Group in crafting a model that includes consideration of whether the line of insurance being assessed has policies that include LTC, which would hold the insurers who actually write the policies accountable for any significant failures.

Arbor Strategies notes in its comment letter that hybrid products comprise approximately 24% of the current LTC market, and 85% of new LTC insurance sold.<sup>6</sup> ACLI’s proposal leaves the increasingly

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<sup>5</sup> ACLI letter of June 16, “Guaranty Association Issues Relating to Long-Term Care Insurance,” p. 2.

<sup>6</sup> Arbor Strategies letter of June 16, p. 2.

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successful part of the market in the position that life insurance itself has been in: under-represented in their responsibility for a failure in the market where its members operate, and asking non-participants in that market to take the burden. This is poor policy now, and would be poor policy for the future.

## **The proposed inclusion of HMOs in all life and health guaranty associations would be a significant departure from existing practice.**

Including HMOs in all life and guaranty associations would be a significant change from the existing practices in nearly all states. Following the NAIC HMO Model Act, states generally require HMOs to provide their enrollees protection against insolvency structurally: one-year contracts; enrollees held harmless under the law against providers; additional deposits required with regulators when potential outside claims exceed a threshold; and guarantee issue products promptly made available in the rare event of insolvency.

These realities are reflected in the 28 states that have not required HMOs to be in a guaranty association. Seven states do have unique HMO specific guaranty associations, and Iowa and Wisconsin include HMOs in their life and health guaranty association, but keep HMO assessments completely segregated for HMO insolvencies.

The reference to Wyoming guaranty association's inclusion of HMOs along with health insurers is distinguishable. Since 1990 no HMO is listed among the 60 insolvencies on the association webpage, and all but nine were for a clearly delineated life insurance company. Even among those nine, only one has "health insurance" in its name, "Imerica Life and Health Insurance Company," and its primary health insurance business was in the then-emerging market for high-deductible policies. The remaining eight insolvent insurers also appear to have included some health insurance incidental to their general life portfolio.

So while Wyoming HMOs were paying out for these insolvencies (up to and including Penn Treaty), they received no benefit for doing so. If an HMO were to become insolvent in Wyoming, it is unclear, as has been mentioned on this working group's calls, what "claims" the association would cover, since HMOs are not based on the traditional insurance indemnity model.

## **The proposed inclusion of HMOs in all life and health guaranty associations needs considerable study before being mandated by the NAIC.**

Option 1 appears to be good public policy that matches risk with responsibility, given the current mischaracterization of LTC as a form of health insurance. Option 3 has no such obvious merit.

The Working Group calls have identified a number of significant practical problems that Option 3 would entail:

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- The competitive disadvantage and consumer harm that would be caused by non-profit HMOs, or HMOs that do not pay a state premium tax, not being able to offset their assessments against their premium taxes and having to pass the cost along to their members.
- States with HMO-specific guaranty associations would need to determine when and how to dissolve them, and how to proceed with such a transition.
- States will need to make sure that HMOs are not doubly responsible for insolvencies in their own market, and insolvencies in a different market entirely.
- How the assessment would affect Medical Loss Ratio requirements from both the federal government and the states.

Furthermore, Option 3 would bring in an entirely new class of interested parties whose interests have not yet been even superficially understood: providers whose contracts include the bearing of risk. These include both physicians and hospitals, and may include others as well.

Because the jurisdiction of this Working Group has focused on insurance, the Working Group has yet to hear from those entities, which in the world of HMOs are essential players, and in the world of state legislatures are potent stakeholders. It would be critical to engage them before proceeding, given their legitimate interests and likely substantial political relevance.

Demonstrating this different dynamic in the HMO model, California (which according to the independent Kaiser Family Foundation has the nation's highest penetration of HMOs, at nearly 60%) has established the Financial Solvency Standards Board within the Department of Managed Health Care to provide oversight of the hundreds of Risk-Bearing Organizations that are involved in managed care in that state.

Understanding and resolving these issues will take far longer than the Working Group's timetable for short term action. Unlike the obvious necessity of Option 1, Option 3 is not prudent without far more study.

## CONCLUSION

We would be pleased to participate in longer term discussions about the role of HMOs in a properly functioning guaranty association system, but we have deep concerns about what we respectfully suggest is a rush to a solution whose "rough justice" is bad public policy, thoroughly inconsistent with the HMO form and regulatory state, and not as politically feasible as it might appear.

Sincerely,



Nat Shapo



July 6, 2017

James Kennedy, Chairman  
Receivership Model Law Working Group  
National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
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**RE: Combined Approach  
Modifications to Option #3  
Comment Letters of Other Interested Parties**

Dear Chairman Kennedy:

The American Council of Life Insurers (“ACLI”)<sup>1</sup> appreciates this opportunity to provide comments to the Receivership Model Law Working Group (“RMLWG”) on: (1) Modifications to Option #3 that would need to be addressed in the *Life and Health Insurance Guaranty Association Model Act* or any other laws, and (2) Comment letters that were submitted by Kaiser Permanente, HealthPartners and Alliance of Community Health Plans (“ACHP”) to the RMLWG for its June 21 conference call.

**Combined Approach**

We would like to begin by first reiterating our support for a combined approach that we outlined in our June 16, 2017 letter to the RMLWG. This approach, which is also supported by a coalition of health insurers, incorporates modified versions of Option #1 and Option #3 that would broaden and shift the assessment base for future long-term care (“LTC”) insurance-related insolvencies, both of which are critical to the stability of the state-based guaranty association system. For reasons explained below, we believe that a concurrent expansion and reallocation is necessary. Specifically, this approach would:

- Broaden the LTC insurance-related assessment base to include health maintenance organizations (“HMOs”) who do business in a state and write major medical coverage (other than Medicare-only and Medicaid-only HMOs). HMOs must become “member insurers” of that state’s life and health insurance guaranty association. ACLI opposes the creation of a separate HMO guaranty association or a separate HMO assessment account for reasons described later in this letter.

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<sup>1</sup> The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with 290 member companies operating in the United States and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers’ products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 94 percent of industry assets, 93% of life insurance premiums and 97% of annuity consideration in the United States. Learn more at [www.acli.com](http://www.acli.com).

- At the same time the assessment base is broadened to include HMOs, shift a portion of LTC insurance-related guaranty association assessment liabilities from the health assessment account to the life insurance and annuity assessment accounts, so that life insurers will become responsible for 50% of the LTC-insurance related assessment liabilities.

In addition to the elements listed above, we believe that a combined approach should also:

- Allocate LTC insurance rider premiums to the underlying base policies and contracts for NAIC reporting purposes (e.g., *Schedule T; Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit*) and cover related rider benefits under the state guaranty association provisions that relate to the base contracts.
- Make any changes to the guaranty association assessment mechanism prospective (such changes would only apply to future insolvencies).
- Develop a national, comprehensive, uniform system of reviewing LTC insurance rate increase requests that allows actuarially-justifiable rate increases to be granted in a timely fashion, as it will greatly reduce the likelihood of other LTC insurance-related insolvencies.
- Focus additional attention on prompt corrective action and least cost resolution. Changes to the *Insurer Receivership Model Act* may be appropriate to advance these concepts more effectively in the resolutions of future insolvencies.

### **Modifications to Option #3**

ACLI agrees with Option #3's inclusion of HMOs as "member insurers" of a state's life and health insurance guaranty association, and views this element as critical and immediately necessary. A robust health insurance market is in the public's best interest, and HMO participation in the guaranty association system's safety net would help to ensure that robustness.

We do, however, support the following modifications to Option #3;

- HMOs should be included in the health insurance assessment account. The business models of HMOs and traditional major medical health insurers have become very similar over recent years, with few differences remaining between the types of coverage provided. It no longer makes any regulatory sense to treat HMOs differently from indemnity health insurers for guaranty association purposes. It should also be noted that the creation of a third account could create capacity issues within the HMO account even if LTC insurance-related assessments are apportioned among all three assessment accounts.
- Separating the guaranty association obligations of HMOs from those of indemnity health carriers could cause a competitive disadvantage and may encourage indemnity carriers to switch to an HMO platform. This, in turn, would erode the health insurance assessment base and potentially destabilize the overall state-based regulatory system and the already-fragile health care markets.

### **Comment Letters of Other Interested Parties**

We also have the following comments with regard to the letters that were submitted by Kaiser Permanente, HealthPartners and ACHP to the RMLWG for its June 21, 2017 conference call. We will address their arguments conceptually, rather than letter by letter.

- While it is true that under current NAIC model acts and regulations, HMOs are treated differently than traditional indemnity health insurers, this is more of a historical distinction, rather than one that is based on practical or significant differences, since HMOs and indemnity carriers both operate by using networks, preferred providers and various financial incentives. Following the implementation of the *Affordable Care Act*, there are few, if any, real differences among HMOs, preferred provider organization plans and exclusive provider organization plans.
- The fact that HMOs do not write LTC insurance is not sufficient justification for not including them in the life and health insurance guaranty association system. Only a few of ACLI's 290 member companies are licensed to sell LTC insurance, yet ACLI voted to support increasing the burden on life insurers for future LTC-insurance related guaranty association assessment liabilities so long as the assessment base is broadened to include HMOs. ACLI recognizes, and we hope the HMOs will as well, that without the proposed shifting and broadening of LTC insurance-related assessments, the guaranty association system and state-based regulatory structure would be at significant risk of failure.
- The continued exclusion of HMOs from the life and health insurance guaranty association system would perpetuate a significant competitive inequity between indemnity health insurers (who are subject to assessments) and HMOs (who are not). In addition, if HMOs are not included in the guaranty association system, major medical insurers will be incentivized to switch from their existing health insurance platform to that of an HMO platform, which will further erode or destabilize the guaranty association system.
- The existence of "hold-harmless" provisions that HMOs have with contracted providers may protect consumers during an HMO insolvency; however, it also leaves health care providers and hospitals exposed to partial or complete non-payment for their services and the use of their facilities. As a result, the failure of a large HMO could cause significant stress on the provider system, as recently evidenced in New York and New Jersey. It is important to note that in the two states where HMOs are treated as "member insurers" of the life and health insurance guaranty associations (Idaho and Wyoming), unpaid claims of health care providers are covered (up to state-specified limits), as they are considered either the "beneficiaries, assignees or payees" of "persons" covered under the states' guaranty association laws.
- State laws and regulations that require HMOs to maintain certain capital requirements (e.g., risk-based capital, special deposits for "uncovered expenditures" not subject to "hold harmless" provisions) do not eliminate the need for them to be included as "member insurers" of life and health insurance guaranty associations. Life and health insurers have capital requirements as well, however, they are included in the guaranty association system since such requirements do not definitively prevent insurer insolvencies or the subsequent need for the services of a guaranty association. In the event of an HMO failure, guaranty associations with HMOs as "member insurers" would step in to provide and/or transfer coverage of existing plans, as well as pay unpaid claims (up to state-specified limits).
- While a few states have their own separate HMO guaranty associations, we believe it would be more beneficial for the HMOs in those states to be included in a state's life and health insurance guaranty association as it would better ensure sufficient assessment capacity in the case of a large HMO failure. Furthermore, the existence of these HMO guaranty associations should not prevent or deter the NAIC from addressing the broader issue of maintaining an overall robust guaranty association system.
- It is important for all stakeholders to take a long-term view when considering how to handle future LTC insurance guaranty association assessments. While it currently may be easier to simply shift the assessment base for LTC insurance-related insolvencies without broadening it to

include HMOs, such partial action would actually exacerbate the problem that we are all trying to solve. As stated above, excluding HMOs from the guaranty association system would encourage the major medical carriers to leave the system, significantly reducing the assessment capacity in the event another LTC insurance provider or health insurer were to become insolvent.

Thank you for the opportunity to provide comments on this very important matter. Feel free to contact me at 202-624-2385 or [bruceferguson@acli.com](mailto:bruceferguson@acli.com) if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Bruce Ferguson". The signature is written in a cursive, flowing style.

Bruce Ferguson  
Senior Vice President, State Relations

cc: Jane Koenigsman



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July 6, 2017

VIA EMAIL

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

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

Dear Chairman Kennedy:

On behalf of the 36 independent members of the Blue Cross Blue Shield Association (BCBSA) that provide health coverage to over 106 million – one in three – Americans, we would like to take this opportunity to thank you, again, for undertaking this long overdue review of the Life and Health Insurance Guaranty Association Model Act (#520) and how it relates to insolvencies of long-term care insurers.

Currently, the funding of an insolvency of a long-term care insurance company is disproportionately borne by health insurance writers, despite the fact that long-term care is most often a product developed and sold by life insurers or subsidiaries of life insurers and typically not sold by health insurers. The inequity of this burden is unwarranted and could jeopardize the solvency of health insurers already suffering from substantial losses and market instability.

To address these concerns, BCBSA convened a system-wide Workgroup to evaluate potential ways to address this inequity and to develop recommendations to assist your Working Group in its review of Model #520. That Workgroup met over the course of three months and developed the following recommendations, which were recently approved by our Board:

1. Any revision to the Life and Health Insurance Guaranty Association Model Act must include language that explicitly expands the assessment base for Long-Term Care insurer insolvencies among ALL members of the state Life & Health Guaranty Association.

2. In the interest of spreading the burden of insolvency-related assessments as broadly as possible, HMOs should be included in the state Life & Health Guaranty Association assessment base. However, the complexity surrounding actually accomplishing that task, given the abundance of state laws and regulations governing the tax treatment and insolvency protections associated with these entities, will necessitate a great deal of time and effort to work through and realign these various requirements. Therefore, we recommend that the model law be revised, in short order, so that life insurers share in the assessments for Long-Term Care-related insolvencies, and that the NAIC's Receivership Model Law Working Group proceed to identify and address the barriers to incorporating HMOs into the state Guaranty Associations, as a longer term initiative.
3. The Model Law should be revised to include language that ensures a representative level of health insurer participation on state Life & Health Guaranty Association Boards of Directors.
4. The Model Law should be revised to clarify that Long-Term Care policy Inflation Protection Riders are to be treated similarly to a "rate of interest" under the "Moody's Rollback" provision of the model.
5. When dealing with a distressed Long-Term Care insurer, state regulators must ensure that all possible rate increases have been requested and no actuarially sound rate actions have been left unaddressed.

Based upon these recommendations, BCBSA would urge you and the members of the Working Group to proceed as soon as practicable down a "simultaneous" work path, encompassing Options 1 and 3 of your survey, as was discussed during the last Working Group call. (Also as discussed during the call, any reference in Option 3 to "a third account" should be deleted/ignored.)

Option 1 - Aggregate the life / annuity and health insurance accounts for the purpose of making Class B assessments with respect to LTC policies issued by an insolvent member insurer. Accounts remain separate for all other purposes.

Option 3 - Include HMOs as members of the guaranty association. HMOs would be a third account under Section 6 of the Model. However, Class B assessments with respect to LTC policies issued by an insolvent member insurer would be apportioned among all three accounts in accordance with the methodology provided by legislation. This option will require changes to the Model to provide for the payment of claims against HMOs.

Bringing HMOs into the state life and health guaranty associations will not be as simple as flipping a switch. It will take time to review, evaluate and harmonize NAIC models and the myriad of state laws currently regulating HMOs and traditional major medical carriers. That is a task that cannot be understated or underestimated. Plus, it will take time to align the diverse tax treatment of these entities, which directly impacts the entities' ability to recoup assessments paid to guaranty associations. The last thing anyone wants to see is one set of inequities inadvertently replaced by another set of inequities.

If the Working Group undertakes both options at the same time, Option 1 will likely be brought to closure more quickly and those relatively simple revisions to the model law should be made immediately. While that activity is being undertaken, the Working Group should also be exploring the issues associated with bringing HMOs into the guaranty association membership, pursuant to Option 3. By proceeding this way, no time will be lost in either effort, but the simpler of the two tasks may be implemented more expeditiously. To do otherwise would just slow down the entire process and would not bring timely relief to an increasingly untenable situation.

We look forward to working with you and the Receivership Model Law Working Group to accomplish this task and to ensure the equitable treatment of all insurers and the continued effectiveness of the state guaranty association system.

Thank you for your ongoing leadership on this important issue. If you have any questions or need additional information, please do not hesitate to contact me at (202)626-4802, or at [paul.brown@bcbsa.com](mailto:paul.brown@bcbsa.com).

Sincerely,

*Paul S. Brown*

Paul S. Brown  
Managing Director - State Affairs

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July 9, 2017

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RE: MODEL 520 COMMENTS

Dear Mr. Kennedy:

I wrote you regarding the captioned matter on January 26, 2017. In that letter I addressed several issues arising under the Working Group's charge to:

Evaluate the need for amendments to Model 520, *Life and Health Insurance Guaranty Association Model Act*, to address issues arising in connection with the insolvency of long-term care insurers.

Among other things, I recommended that the assessments for LTCI failures should be allocated among all life and health insurer members of the guaranty associations, not just or principally health insurers. To accomplish this, I proposed that the following subsection be added as Section 9.C.(4) of the Model Act:

[For purposes of this Section long term care insurance shall be deemed to be both life and health insurance and the subaccount for life insurance described in Section 6.A.\(1\) shall be aggregated with the account for health insurance described in Section 6.A.\(2\) for purposes of determining each member insurer's share of a Class B assessment necessary to discharge the association's responsibilities with respect to long term care insurance issued by the impaired or insolvent insurer.](#)

You have ably guided the discussion of this assessment issue to present the working group four options. Of these Option 1 most closely resembles my recommendation. The ensuing debate has centered largely on whether Option 3 - inclusion of HMOS - is preferable to Option 1. You have received several articulate letters examining this debate and I will not repeat herein the arguments

presented skillfully in those letters. Suffice it to say that the comments of BCBSA largely reflect my own views.

To be sure, the matter of whether HMOs should be encompassed within some form of guaranty association protection is an important and compelling one. But no number of comments to the contrary will overcome the obvious: the issue is very complex and will require active participation of many constituencies not currently “at the table.” Most notably, they would include doctors, hospitals and health care providers, as well as non-insurance state regulators of HMOs in several states and perhaps CMS.

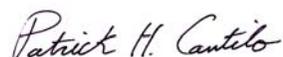
**It is commendable that several interested parties have suggested that we take on these issues now, no matter how complex. It should be observed that if we do so, it is not reasonable to believe that a resulting model will be ready for adoption around the country before the next LTC failure. At that time, Aetna, Cigna, HCSC, United and the many advocates of Option 3 should not be heard to complain about perceived inequities in the allocation of assessments made for the next LTC insolvency.**

I was a very active participant throughout the 1970s and 1980s as the issue of guaranty association protection for health maintenance organizations and managed care organizations was debated very robustly at the NAIC and at the National Association of Managed Care Regulators and its predecessor, the National Association of HMO Regulators. I was also a contributor to what became Model 430, the Health Maintenance Organization Model Act. Currently, my firm serves as Special Deputy Receiver of the Nevada Health COOP and of Universal Health Care of Nevada, two insolvent health maintenance organizations. I will be pleased to assist in a renewed debate of those issues.

The views I express are strictly my own and not offered on behalf of any client or organization. They are informed generally by my experience with troubled insurers and health maintenance organizations, with insurance and managed care regulation during the last four decades, and specifically by my work with troubled long term care insurers during the last five years.

I would be happy to answer any questions about these matters. Thank you for your courtesy in considering my comments.

Very truly yours,



Patrick H. Cantilo

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July 6, 2017

Mr. James Kennedy  
Chair, Receivership Model Law Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106-2197

Dear Chairman Kennedy:

I am writing on behalf of Aetna, Anthem, Cigna, HCSC and United, a coalition of national major medical health insurers who together provide major medical health insurance coverage to more than 227 million members world-wide and who offer a wide range of health insurance plans including major medical coverage and HMO products. We feel it is important to respond to the suggestions that it is too difficult to amend the Life and Health Insurance Guaranty Association Model Act (#520) ("Model Act") to include health maintenance organizations and that therefore the Working Group should avoid the issue and the discussion altogether.

The comments against including HMOs in the Model Act fall into five basic categories:

1. HMOs, and the products they offer, are substantially different from major medical carriers thus it is not appropriate to include them in the Model Act;
2. It would not be fair to HMOs and/or their customers to include HMOs in the guaranty fund assessment;
3. HMO enrollees are already protected through hold harmless provisions and other regulatory provisions;
4. HMO regulation is complicated and thus it would be difficult to include HMO in the Model Act; and
5. We can adopt "quick fixes" now and include HMOs later when the Working Group has more time to discuss and debate the issue.

As set forth below, these arguments are, when examined closely, not persuasive. The only equitable solution that will preserve the stability of the state-based guaranty association system in the U.S. and the competitiveness of the health insurance markets

in the majority of states is for the Working Group to adopt Option 3, which amends the Model Act to include HMOs in the assessment formula.

HMOs, and the Products They Offer, Are Substantially  
Similar to the Coverage Offered by Major Medical Carriers

In its comment letter, the Alliance for Community Health Plans (“ACHP”) states that “HMOs are not health insurance” and that “HMOs have always provided health coverage and care that is different from health insurance.” Although these statements might have been true when the Model Act was first drafted, this proposition simply does not apply to today’s marketplace. As noted by several regulators on the Working Group’s last conference call, the products offered by HMOs and major medical insurers are substantially similar, if not virtually identical, in almost every state. The Working Group must take into account the inherent similarities of products that have different names. At its most basic, health insurance provides financial protection for medical events, whether it is called a PPO, HMO, EPO or POS type of plan.

The ACHP letter cites “in network benefit structures” and “preventive care” as two examples of how HMOs are different from major medical insurance. These examples ignore the fact that in the current marketplace, all plans compete with each other and use networks, financial incentives, capitated arrangements, hold harmless provisions, quality standards, policy limits (i.e. visitation limits), gatekeepers, utilization management and other tools to manage care – regardless of whether or not they are licensed as an HMO. In fact, products called “EPOs” are virtually indistinguishable from HMO products. Additionally, all health plans, especially post-ACA, offer comprehensive preventative coverage so no significant difference exists there as well. If the test for exclusion from a guaranty fund is whether the products offer in-network benefits or preventive care, then all health products should be excluded; conversely, if a product offered by a commercial carrier is included, then an identical product offered by a health maintenance organization should similarly be included.

Excluding HMOs from the guaranty fund assessment system is an outdated concept. The health insurance market has changed dramatically over the decades since the NAIC originally excluded HMOs from the guaranty fund assessment health accounts. There is no significant difference between the products offered by HMOs and major medical health insurers. To the extent that there are minor differences, they do not justify excluding HMOs from Model Act.

It is Not Fair to the Customers of Major Medical  
Insurers to Have HMOs Excluded from Guaranty Funds

The ACHP letter states that it does not believe it would be a “fair approach” for the Working Group to consider Option 3. The letter further states that “HMOs would derive no benefit from participation in state guaranty funds. Consequently, the effect on HMOs would thus be an adverse one, that is, to require payments of assessments, which would most likely be reflected in increased premiums, with no benefits for enrollees.” To the extent that this statement is true, the same is also true for the consumers of major medical insurance products.

They also do not receive any “direct” benefit for helping to absorb the cost of long-term care insurance insolvency. However, all health insurance consumers, including HMO enrollees, benefit from the stability and confidence that a well-funded guaranty system provides to the insurance marketplace.

It is fundamentally unjust that individuals who purchase the exact same product from a major medical health insurance writer are forced to bear the financial burden of guaranty fund assessments, while individuals who purchase the exact same product from an HMO writer are not. The major medical industry writes very little of today’s long-term care insurance yet is being asked to fund the lion’s share of these insolvencies. This is unworkable in today’s marketplace. The American Council of Life Insurers (“ACLI”) recognizes these inequities and working together in Colorado we developed a solution that spreads the cost across the **entire** health and life insurance industry. The ACLI and this coalition of health insurers recognizes the societal benefits of a functioning and fair safety net for customers of long term care insurance. The HMO industry should also participate in providing this safety net.

Hold Harmless Provisions Do Not Provide Adequate  
Protections in the Case on an HMO Insolvency

It is true that HMO plans in almost all states hold consumers harmless from balance billing in the case of insolvency. Many non-HMO contracts have the same provision. However, while this is a good consumer protection, it is insufficient, by itself, to justify disparate treatment of HMO/EPO/PPO products. Current history has proven that HMOs with hold-harmless clauses in their contracts can still leave millions of dollars of unpaid medical bills in their wake. Consumers and providers in New York have learned that lesson in the wake of the Health Republic insolvency; consumers in Utah and Nevada have faced similar issues. Hold-harmless clauses alone do not provide adequate protection from a large insolvency that could leave millions of unpaid providers and hospitals, and certainly does not provide sufficient protection to warrant special treatment for HMOs.

Existing statutory deposit requirements similarly do not provide adequate protection in today’s marketplace. Statutory deposits and other pre-funded insolvency protections are no different for HMOs than other commercial plans. Again, as we learned in the Health Republic insolvency, the existence of statutory deposits makes no appreciable difference to how the insolvency is conducted. If states have increased statutory deposits for HMOs, they could – but are not required to - consider making them equal to the deposits required of commercial carriers.

In the event of insolvency, the consumers of HMOs, like PPOs and other managed care plans, are subject to virtually identical risks of collection by non-contracted providers. In virtually all states, both HMOs and PPOs are obligated to cover non-contracted providers for emergency care, cases of network inadequacy, cases where the consumer is too ill to travel, and for non-contracted hospital-based providers. Option 3 would protect those consumers in the case of an HMO insolvency.

The Changes Needed to the Model Act and Other NAIC  
Models to Adopt Option 3 are not Complicated

Arguments that it is too complex and difficult to include HMOs in state-based guaranty funds are simply overstating the differences between the two types of health writers. There are no significant obstacles to including HMOs in the guaranty fund system. Including HMOs in state-based guaranty funds is not difficult and to the extent there are challenges around their inclusion, they are not insurmountable, as evidenced by the fact that they have been included seamlessly in a number of states, including Wisconsin, Idaho and Wyoming. Recent legislative activity in Colorado and Florida provide a road map as to how the Working Group can readily amend the Model Act and other NAIC model in order to include HMOs in the Model Act.

Integrated delivery systems do not pose a regulatory challenge for guaranty funds. Simply because certain provider networks may be “owned” by an HMO does not grant them a special or more complex status. Many states have carriers writing coverage through “exclusive provider organizations” which operate identically to an integrated delivery system. There is nothing special about paying claims for these plans.

The Model Act can address variations in existing state structures. While it is true that a small number of states, including Florida and Illinois, have free-standing HMO guaranty funds, this should not prevent the NAIC from taking appropriate actions to ensure that both their health insurance markets and guaranty associations are stable and robust. It is possible to craft a solution that would address the Florida and Illinois variations, ranging from creating a single association all the way to ensuring simply that HMOs and health carriers have equal responsibility for long-term care insolvencies. The fact that the solution may require some policy discussions does not mean the Work Group should shy away from finding that solution. To the contrary, the fact that these variations exist among states demands that the NAIC examine the current structure closely to ensure that it creates the best possible organization. To “kick the can” down the road simply avoids the issue and ensures that the NAIC is not in a leadership position with respect to the insurance public’s social safety net.

The fact that some states do not regulate HMOs should not change the outcome. In a small number of states HMOs are not regulated by the Department of Insurance, but instead are regulated and licensed by Departments of Health or Departments of Managed Health Care. Clearly it would be beneficial for those states to adopt legislation placing their HMOs in the guaranty fund, in order to further the social policy of broadly spreading the risk of insolvency among the widest base, particularly for long-term care. However, whether they do so should not in any way prevent the NAIC from taking up the issue of whether it would be beneficial to stabilize health markets and guaranty funds; nor should it prevent the NAIC from making appropriate recommendations to policymakers. While absolute uniformity among guaranty funds is a laudable goal, nevertheless, there already are variations among the states regarding inclusion of HMOs. The Working Group should address the issue in the context of today’s marketplace, rather than simply relying on a decades-old, outdated model that has not kept pace with the changing health and long-term care industries. This is crucial in order to ensure that the guaranty fund system remains stable and viable.

The NAIC Should Not Adopt a Piecemeal Approach to Amending the Model Act

On the Working Group's last call, a significant number of regulators expressed the view that HMOs should be included in the assessment formula. What separated these regulators was the issue of whether HMOs should be included immediately or whether the NAIC should first amend the Model Act to include life insurers (Option 1) and then amend the Model Act at a later date, and after additional discussion, to include HMOs. We have several concerns with this approach.

First, the future solvency and stability of the guaranty fund system is so critical that the NAIC needs to get it right the first time. If regulators believe that HMOs should participate in guaranty funds, then now is time to include them; at the very least, this is the time to begin the dialogue. This issue is too important for regulators to have to go their state legislatures twice with legislative solutions to fix the problem. State legislatures will be rightly confused as to why the NAIC could not address all the issues surrounding guaranty system reform the first time; thus, putting the NAIC's credibility at stake.

Further, the idea that significant changes need to be made to other models is simply a red herring. We note that draft legislation was prepared in Colorado last year; regulators found no major impediment to implementation. It is important that the NAIC build on the discussions that have already taken place, and the agreements that have already been reached. There is no incentive, however, for the HMO industry to work with the life and major medical writers to address the inherent instability in the markets if they are not to be included in the conversations. Option 3 is the only option outlined that will effectively stabilize the guaranty fund system and the health insurance markets. The NAIC should embrace this opportunity to stabilize the entire life and health guaranty association system for the protection policyholders.

Finally, the compromise reached between the health and life insurance industry was contingent upon the HMO industry also becoming part of the long-term care insurance insolvency assessment base. If they are not included, there could be unintended consequences that regulators should consider. First, if HMOs are excluded, the life insurance industry has indicated it would withdraw its support of the compromise. Second, major medical carriers could move their business to the HMO platform removing a vast majority of its assessment liability. This coalition would like to avoid both of these outcomes. We believe that all life and health insurance payers have a societal responsibility to help long term care policyholders when their insurer becomes insolvent. The reality is; however, we cannot uphold this responsibility if our competitors in the market do not have the same obligations. The solution to the long-term care insolvency issue must include all payers regardless of the types of plans they offer or the licenses under which they operate. The health insurance industry, and the guaranty fund system, cannot afford to tackle potential future long-term care insurance solvencies solely through assessments on major medical insurers and life insurers. Excluding HMOs from the Model Act could create a domino effect that results in the Model Act not being amended, or adopted at the state-level, or which leaves long term care policyholders with an unstable guaranty fund system

**Arbor Strategies, LLC**

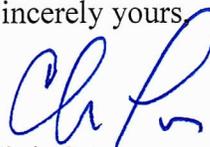
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We urge members of the Working Group to support an amended version of Option 3 that includes HMOs within the health insurance account. We believe Option 3 is the fairest approach, and provides the greatest stability to guaranty funds, to the insurers participating in the guaranty funds and to the consumers protected by the funds. We also strongly support the reference in Option 3 to a more equitable apportionment of assessments among the life and annuity industry and health insurers, including HMOs. Finally, we believe Option 3 recognizes that all participants in the life and health insurance industry should help pay for the future viability of the state-based guarantee fund system.

Please feel free to call me at 703-847-3610 if you have any questions regarding our comments. Thank you.

Sincerely yours,



Chris Petersen

Arbor Strategies, LLC