The Executive (EX) Committee met April 7, 2019. During this meeting the Committee:

1. Adopted the April 6 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which included the following action:
   a. Adopted its 2018 Fall National Meeting minutes.
   b. Adopted the Executive (EX) Committee’s Feb. 1 and Jan. 11 minutes.
   c. Adopted the report of the Internal Administration (EX1) Subcommittee, which met Feb. 14 and took the following action:
      1. Received an update on the defined benefit plan portfolio as of Dec. 31, 2018.
      2. Received an update on the NAIC long-term investment plan portfolio as of Dec. 31, 2018.
      3. Adopted the long-term investment portfolio asset class mix recommendation and fund manager selection.
   d. Adopted the report of the Audit Committee, which met April 5 and took the following action:
      1. Received an overview of the Dec. 31, 2018, financial statements and the Feb. 28, 2019, summary financials.
      2. Received the 2018 audit report from RSM.
   e. Adopted the report of the Information Systems (EX1) Task Force, which met April 5 and took following action:
      1. Adopted its 2018 Fall National Meeting minutes.
      2. Received an operational report on the NAIC’s information technology (IT) activities.
   f. Approved relocating the NAIC 2021 Fall National Meeting from San Francisco, CA, to San Diego, CA.
   g. Approved the NAIC providing technical assistance, including tools and training for state insurance regulators, in the area of predictive modeling.
   h. Approved the NAIC filing an amicus brief in Guardian Flight v. Godfread.
   i. Received the joint chief executive officer (CEO)/chief operating officer (COO) report.
   j. Received a cybersecurity update.

2. Adopted its interim meeting report from Feb. 1 and Jan. 11, which included the following action:
   a. Appointed Alaska, Illinois, Missouri, Nevada, New Mexico and North Carolina to serve on the 2019 System for Electronic Rate and Form Filing (SERFF) Advisory Board. Commissioner Barbara D. Richardson (NV) will serve as chair of the 2019 SERFF Advisory Board.
   b. Appointed Commissioner David Altmaier (FL) and Commissioner Gary Anderson (MA) to serve on the International Association of Insurance Supervisors’ (IAIS) Executive Committee and appointed Director Raymond G. Farmer (SC) as the standing member of the IAIS Executive Committee.
   c. Approved a recommendation to the Property and Casualty Insurance (C) Committee to: a) change the name of the Climate Change and Global Warming (C) Working Group to the Climate Risk and Resilience (C) Working Group; and b) consider adoption of charges that reflect the expanded scope.
   e. The NAIC officers and the Government Relations (EX) Leadership Council recommended Commissioner Jon Godfread (ND) for the U.S. Department of Transportation’s (DOT) advisory committee on air ambulance and patient billing. This advisory committee will provide recommendations to the Secretary of the DOT and the Secretary of the U.S. Department of Health and Human Services (HHS). There is a requirement that the advisory committee include a state insurance regulator, although there was no specific request that the NAIC make a recommendation.
   f. Appointed Florida, Idaho, Kentucky, Massachusetts, Missouri, Ohio, Oklahoma and Wyoming as members of the 2019 Audit Committee.

3. Adopted the reports of its task forces: the Financial Stability (EX) Task Force; the Government Relations (EX) Leadership Council; and the Innovation and Technology (EX) Task Force.

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4. Received a status report on the NAIC State Ahead strategic plan implementation.

5. Received the 2018 Annual Report of the NAIC Designation Program Advisory Board.

6. Received a status report on the actuarial credentialing project.

7. Received a status report of model law development efforts for amendments to the: *Accident and Sickness Insurance Minimum Standards Model Act* (#170) and *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); *Annuity Disclosure Model Regulation* (#245); *Suitability in Annuity Transactions Model Regulation* (#275); *Life Insurance Disclosure Model Regulation* (#580) and *Life Insurance Illustrations Model Regulation* (#582) policy overview document; *Mortgage Guaranty Insurance Model Act* (#630); *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786); and new model: Real Property Lender-Placed Insurance Model Act.

8. Heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).

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Long-Term Care Insurance (EX) Task Force

**Charge:** Recognizing the gravity of the threat posed by the current long-term care insurance environment both to consumers and our state-based system of insurance regulation, the Long-Term Care Insurance (EX) Task Force is charged with developing a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization. Identify options to provide consumers choice regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

Deliver such a proposal to the Executive Committee by the 2020 Fall National Meeting. Provide periodic reporting to the LTCI (B/E) Task Force to help ensure coordination between the two task forces on LTCI issues.

Unless otherwise affirmatively extended or modified by the Executive (EX) Committee, the Task Force and its charges will expire January 31, 2021.
TO: All Medicare Supplement Carriers  
FROM: Commissioner of Insurance  
RE: Filing Requirements for Outlines of Coverage Forms updated to comply with MACRA  
DATE: ___________________________

I. Purpose  
The purpose of this bulletin is to notify insurers offering Medigap policies of the filing requirements for Outlines of Coverage forms revised to comply with state adoptions of the Medicare Access and Chip Reauthorization Act (MACRA).  
Specifically, this Bulletin provides guidance with respect to the one-page Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020.  

Any insurer replacing the chart that is in its currently approved Outline of Coverage form with the chart revised to comply with MACRA, in the format below, may simply use the revised MACRA Outline of Coverage form without refiling the Outline of Coverage form for approval.  

The form number of the previously approved Outline of Coverage form should remain unchanged. If any other changes to the previously approved form are made, the form must then be filed for review and approval.  

II. Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020  
This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
Note: A ✔ means 100% of the benefit is paid.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plans Available to All Applicants</th>
<th>Medicare first eligible before 2020 only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Medicare Part B coinsurance or Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood (first three pints)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A hospice care coinsurance or copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part A deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part B deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part B excess charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign travel emergency (up to plan limits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket limit in [2019]&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Plans F and G also have a high deductible option, which require first paying a plan deductible of $[2,300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.
PROJECT HISTORY

BULLETIN: Filing Requirements for Outlines of Coverage Forms Updated to Comply with MACRA

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

As required by the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), insurers that offer Medicare supplement (Medigap) policies must file outlines of coverage forms. The Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020, is a one-page form that must be filed. For insurers that do not offer a high-deductible Plan G, this benefit chart is all that might need to be filed. The benefit chart was initially developed by the Senior Issues (B) Task Force, and it does not vary by insurer.

The bulletin could be used by a state to indicate that any insurer replacing its currently filed benefit chart with the required chart revised to comply with MACRA would not need to file that revised form.

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

Speed to Market (EX) Working Group

Alabama
Arkansas
Colorado
District of Columbia
Delaware
Illinois
Kansas

Minnesota
North Carolina
North Dakota
New Hampshire
New Mexico
Ohio

Missouri
North Dakota
Utah
Virginia
Washington
West Virginia

Oklahoma
Texas
Utah
Virginia
Washington
West Virginia

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

The Working Group has an ongoing charge to provide a forum to gather information from the states and the industry regarding tools, policies and resolutions to assist with common filing issues.

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

The concept for the bulletin was proposed by Michael A. Colliflower (Aetna) at the 2018 Summer National Meeting. A proposed bulletin was drafted and submitted by Mr. Colliflower Aug. 21, 2018, and it was adopted without change by the Working Group during its Oct. 19, 2018, conference call. The bulletin was adopted without change by the Innovation and Technology (EX) Task Force during its Nov. 17, 2018, meeting at the 2018 Fall National Meeting.

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

The bulletin was distributed prior to the Working Group’s Oct. 19, 2018, conference call and prior to the Innovation and Technology (EX) Task Force’s Nov. 17, 2018, meeting at the 2018 Fall National Meeting.
6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)**

Some states would not be able to issue the bulletin. The bulletin would not apply to carve-out states; i.e., Massachusetts, Minnesota and Wisconsin. Some states (e.g., Oklahoma, Oregon and Washington) would consider the change to the chart to be a substantive change that requires a form number change; thus, filings would be required. Some states would require filings so the regulatory review process would help catch mistakes.

The bulletin would not be adapted for the states that have not yet adopted the new regulation to conform to MACRA, but those states could consider issuing the bulletin ahead of adoption to give carriers advance notice for planning purposes.

Those states that would not adopt the bulletin agreed with the plan to offer a consistent or uniform methodology for those states that would like to adopt the bulletin.

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

None.
The Plenary met via conference call Feb. 3, 2019. The following members participated: Eric A. Cioppa, Chair (ME); Raymond G. Farmer, Vice Chair (SC); Dean L. Cameron, Secretary-Treasurer (ID); Julie Mix McPeak, Most Recent Past President (TN); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Allen W. Kerr (AR); Keith Schraad (AZ); Ricardo Lara (CA); Michael Conway (CO); Paul Lombardo (CT); Stephen C. Taylor (DC); Trinidad Navarro (DE); David Altmaier (FL); Jim Beck (GA); Dafne M. Shimizu represented by Alice Cruz (GU); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron (ID); Kevin Fry (IL); Stephen W. Robertson represented by Amy Beard (IN); Vicki Schmidt (KS); Nancy G. Atkins (KY); James J. Donelon (LA); Gary Anderson (MA); Al Redmer Jr. represented by Nancy Grodin (MD); Anita G. Fox (MI); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mark O. Rabauliman represented by Charlotte Borja (MP); Mike Chaney represented by Mark Haire (MS); Matthew Rosendale (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Bruce R. Ramge (NE); John Elias (NH); Marlene Caride (NJ); John G. Franchini (NM); Barbara D. Richardson (NV); Jillian Froment (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman (PA); Javier Rivera Rios (PR); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); Kent Sullivan represented by Doug Slape (TX); Todd E. Kiser (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak (VT); Mike Kreidler (WA); Mark Afable (WI); Erin K. Hunter (WV); and Tom Glause (WY).

1. **Conducted NAIC Vice President Interim Election**

The Plenary conducted an interim election Feb. 3, in which Commissioner Altmaier was elected NAIC vice president to serve from Feb. 3 to Dec. 31.

Having no further business, the Plenary adjourned.
Meeting Summary Report

The Life Insurance and Annuities (A) Committee met April 7, 2018. During this meeting, the Committee:

1. Adopted its 2018 Fall National Meeting minutes.

2. Adopted the report of the Annuity Disclosure (A) Working Group, including its March 7 minutes and extension of the Request for NAIC Model Law Development. During its March 7 meeting, the Working Group took the following action:
   a. Exposed the Feb. 9 draft revisions to the Annuity Disclosure Model Regulation (#245) to allow for the illustration of indices that have been in existence for at least 20 years, which is a change from previous drafts that allowed the illustration of indices that had been in existence for at least 10 years, for a public comment period ending April 26.

3. Adopted the report of the joint meeting of the Life Insurance and Annuities (A) Committee and the Annuity Suitability (A) Working Group, which met April 6 and took the following action:
   a. Adopted the Working Group’s 2018 Fall National Meeting minutes.
   b. Heard a presentation on the U.S. Securities and Exchange Commission’s (SEC) proposed Best Interest rule and the draft of proposed revisions to the Suitability in Annuity Transactions Model Regulation (#275).
   c. Adopted a motion to have the Working Group continue its work to revise Model #275. As part of its discussions, the Working Group is to consider the presentation; the comments received on the current draft of revisions by the Feb. 15 public comment deadline; and comments from Working Group members, interested state insurance regulators and interested parties received during its discussions. The Working Group is to complete its work as soon as possible, with the Working Group holding an in-person interim meeting sometime in May or June.

5. Adopted the report of the Life Insurance Illustration Issues (A) Working Group, including its Dec. 18, 2018, minutes and extension of the Request for NAIC Model Law Development. During its Dec. 18 meeting, the Working Group took the following action:
   a. Discussed comments received on the Oct. 9, 2018, draft revisions to the Life Insurance Disclosure Model Regulation (#580) that include the requirement of a policy overview document to accompany all life insurance policies along with the Life Insurance Buyer’s Guide.
   b. Agreed to revise the Oct. 9, 2018, draft revisions to Model #580 based on the Dec. 18, 2018, conference call

7. Adopted the report of the Life Insurance Online Guide (A) Working Group, which met March 18 and took the following action:
   a. Discussed its charge to “develop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public.”
   b. Agreed to plan to finish the online guide by November.
   c. Agreed to focus on content and wording before the graphic design of the online guide.
   d. Discussed a list of topics to include in the online guide, and volunteers agreed to draft language on certain topics for the Working Group’s review by April 4.

8. Adopted the report of the Life Actuarial (A) Task Force, which met April 4–5.

9. Discussed the Committee’s charge on retirement security and asked for volunteers for a working group to develop a work plan to promote and engage consumers on the topic of retirement readiness.
The Health Insurance and Managed Care (B) Committee met April 7, 2019. During this meeting, the Committee:

1. Adopted via e-vote ending March 29 revised 2019 charges, which deleted the charges for the Health Care Reform Regulatory Alternatives (B) Working and the CO-OP Solvency and Receivership (B) Subgroup and adopted the charges for the Health Innovations (B) Working Group. The revised charges reflect the Committee’s action taken during its Feb. 14 conference call.

2. Adopted its Feb. 14 minutes, which included the following action:
   b. Adopted revisions to the Health and Welfare Plans Under the Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook). The revisions include updates to case law, as well as new sections related to the federal Affordable Care Act (ACA) and the recently finalized federal regulations on association health plans (AHPs).
   c. Adopted revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170). The revisions remove provisions on the types of health benefit plans subject to the ACA’s requirements and leave remaining those types of plans not subject to the ACA’s requirements.
   e. Adopted the Regulatory Framework (B) Task Force’s recommendation to open the Health Maintenance Organization Model Act (#430) to address identified conflicts and redundancies between the model and the Life and Health Insurance Guaranty Association Model Act (#520).
   f. Disbanded the Health Care Reform Regulatory Alternatives (B) Working Group and appointed the Health Innovations (B) Working Group.
   g. Disbanded the CO-OP Solvency and Receivership (B) Subgroup.

3. Adopted the Regulatory Framework (B) Task Force’s report and its Request for NAIC Model Law Development to develop a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs).

4. Adopted its 2018 Fall National Meeting minutes.

5. Adopted the following subgroup, working group and task force reports: the Consumer Information (B) Subgroup, including its March 29, March 15 and Feb. 11 minutes; the Health Innovations (B) Working Group; the Health Actuarial (B) Task Force; and the Senior Issues (B) Task Force.

6. Heard a panel presentation on health care cost data. Representatives from the Blue Cross and Blue Shield Association (BCBSA), the Health Care Cost Institute (HCCI) and the New Hampshire Insurance Department provided information to the Committee on what the data collected from their respective organizations indicated concerning health care costs, spending trends, major health care cost drivers and potential policy options to help control health care costs.

7. Heard an update on legal actions related to the ACA, including: a case challenging the constitutionality of the individual mandate and its potential impact on other key ACA provisions; a case challenging the legality of the recent federal AHP regulation; and a case challenging the legality of the recent federal short-term, limited-duration plan (STLDP) regulation.

8. Heard a presentation describing the results of consumer testing trying to assess consumer understanding of an STLDP particularly as related to the coverage and limitations of that coverage provided under such a plan.

9. Heard a federal legislative update on congressional legislation and administrative actions of interest to the Committee.

10. Discussed the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Committee’s next steps for future discussions of the MHPAEA that would be of interest to Committee members.
ACCIDENT AND SICKNESS SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose
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Section 8. Administrative Procedures

Section 1. Purpose

The purpose of this Act is to standardize and simplify the terms and coverages of individual accident and sickness insurance policies and group accident and sickness insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage (hereafter referred to as “group supplemental health insurance”). This Act is also intended to facilitate public understanding and comparison, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or unreasonably confusing in connection either with the purchase of these coverages or with the settlement of claims. This Act also provides for full disclosure in the sale of accident and sickness coverages, group supplemental health insurance, and dental and vision plans supplementary and short-term health insurance, as defined in this Act.

Drafting Note: States should determine if the phrase “individual accident and sickness insurance policies” is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g., “subscriber contracts” or “nonprofit hospital, medical and dental associations”) to cover these plans should choose terminology conforming to state statute.

Section 2. Applicability and Scope

A. This Act shall apply to coverages of individual accident and sickness insurance policies and group supplemental health insurance policies and certificates providing hospital indemnity or other fixed indemnity insurance, accident only, specified accident, specified disease, limited benefit health, and disability income protection, referred to collectively in Section 1 of this Act and hereafter, as “supplementary health insurance.” This Act also applies to short-term, limited-duration health insurance coverage, which, unless otherwise specified, is included in the definition of “short-term health insurance” under this Act.

Drafting Note: Subsection A includes short-term, limited-duration health insurance within the scope of this Act. Although, short-term, limited-duration health insurance is not an “excepted benefit,” as the other listed coverages, short-term, limited-duration coverage has been included in this Act because it is not considered individual health insurance under federal law and, as such, is not subject to the individual market reforms under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the federal Affordable Care Act (ACA).

Drafting Note: The term “individual” as used in this Act corresponds to its use in the NAIC Uniform Individual Accident and Sickness Policy Provision Law (#180), thus extending the coverage of the Act to “family” policies. The term “group” as used in this Act corresponds to its use in the NAIC Group Health Insurance Definition and Group Health Insurance-Standards Provisions Model Act (#100).
Drafting Note: States should be aware that generally, Section 1251 of the ACA exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA if the coverage was in force as of March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as “grandfathered health plan coverage.” However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered health plans, while other provisions apply only to grandfathered group health insurance plans. To the extent provisions of the PHS Act, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the final regulations on grandfathered plans (26 CFR 54.9815-1251, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the Federal Register Nov. 18, 2015 (80 FR 72191).

B. This Act shall apply to limited scope dental plan coverage and limited scope vision plan coverage only as specified.

C. This Act shall not apply to:

(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this Act;

(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this Act;

(3) Medicare supplement policies subject to [insert reference to state law equivalent to the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#650)];

(4) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act (#640)]; or

Drafting Note: The NAIC Long-Term Care Insurance Model Act (#640) defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited benefit long-term care insurance plans, and should be subject to the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643).

(5) TRICARE formerly known as the Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10, of the United States Code) (CHAMPUS) supplement insurance policies.

Drafting Note: CHAMPUS TRICARE supplement insurance is not subject to federal regulation. CHAMPUS TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to CHAMPUS TRICARE benefits. In general, states regulate CHAMPUS TRICARE supplement insurance policies under the state group or individual insurance laws.

Section 3. Definitions

A. “Accident and sickness insurance” means insurance written under [insert reference to state law authorizing accident and sickness insurance].

—— Accident and sickness insurance does not include credit accident and sickness insurance.

Drafting Note: The phrase “accident and sickness” should be replaced by “accident and disability,” “accident and health,” or other phrase appropriate under state law.
A. “Certificate” means a statement of the coverage and provisions of a policy of accident and sickness supplementary and short-term health insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

B. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

D. “Dental plan” means insurance written to provide coverage for dental treatment.

C. “Direct response solicitation” means a communication through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.

D. “Form” means policies, certificates, contracts, riders, endorsements and applications as provided in [insert reference to state law regarding the filing and approval of individual accident and sickness supplementary and short-term health insurance policy forms].

Drafting Note: This definition may be unnecessary if the term “form” is appropriately defined elsewhere, but it may be helpful to include it here with an appropriate cross-reference.

G. “Group supplemental health insurance” means group accident and sickness insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage.

E. “Hospital indemnity or other fixed indemnity insurance” refers to coverage that provides benefits on an independent, non-coordinated basis and that pays a fixed amount for specified events without regard to other insurance.

Drafting Note: “Hospital indemnity or other fixed indemnity insurance” does not include any other type or category of insurance that is listed separately as an excepted benefit in Section 2791(c) of the federal Public Health Service Act (PHSA) (e.g., disability income protection coverage, specified disease coverage, etc.) regardless of whether benefits under such coverage are paid as a fixed dollar amount.

F. “Limited scope dental coverage” means insurance that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

G. “Limited scope vision coverage” means insurance that provides coverage substantially all of which is for treatment of the eye, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

H. “Policy” means the entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.

I. “Vision plan” means insurance written to provide coverage for vision care.

J. “Short-term, limited-duration insurance” means health insurance coverage offered or provided within the state pursuant to a contract by a health carrier, regardless of the situs of the delivery of the contract, that has an expiration date specified in the contract that is less than [X days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier’s consent, has a duration no longer than [X days or months] after the original effective date of the contract.
**Drafting Note:** Subsection I does not include a potential maximum length of coverage for short-term, limited duration insurance. States have established different terms and durations of coverage for short-term, limited-duration insurance, if such coverage can be sold. Some states have prohibited the sale of such products, while others have set the maximum duration of coverage at less than 12 months, such as establishing a three-month maximum. In addition, some states provide that such coverage may not be renewed or extended beyond the established term, or have otherwise limited total duration, while other states have no such provisions regarding renewal or extension. The current federal regulations, which were effective Oct. 2, 2018, limit short-term, limited-duration insurance contracts to less than twelve months and, taking into account renewals or extensions, to a maximum duration of no longer than 36 months in total. States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans, including whether renewability or extension of such coverage is appropriate and consistent with federal law. States should also ensure that any other definitions of short-term limited-duration insurance that are used in statutes that provide exemptions from otherwise applicable regulatory requirements are consistent with the definition used above in order to prevent gaps in regulatory authority.

J. (1) “Supplementary and short-term health insurance” means insurance written under [insert reference to state law authorizing supplementary and short-term health insurance].

(2) “Supplementary and short-term health insurance” does not include credit accident and sickness insurance.

**Drafting Note:** The phrase “supplementary and short-term health” should be replaced by “accident and disability,” “accident and health,” or other phrase appropriate under state law.

### Section 4. Standards for Policy Provisions

A. The commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual accident and sickness insurance and group supplemental health insurance supplementary and short-term health insurance subject to this Act. The commissioner may issue additional regulations to establish specific standards for the sale of limited scope dental and limited scope vision plans coverage. This Act and any regulations issued pursuant to this Act shall be in addition to and in accordance with applicable laws of this state, including the [insert reference to state law equivalent to the NAIC Uniform Individual Accident and Sickness Policy Provision Law (#180)], which may cover, but shall not be limited to:

1. Terms of renewability or extension of coverage;
2. Initial and subsequent conditions of eligibility;
3. Nonduplication of coverage provisions;
4. Coverage of dependents;
5. Preexisting conditions and pre-existing condition exclusions;
6. Termination of insurance;
7. Probationary periods;
8. Limitations;
9. Exceptions;
10. Reductions;
11. Elimination periods;
(12) Requirements for replacement;

(13) Recurrent conditions; and

(14) The definition of terms, including but not limited to, the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, guaranteed renewable and noncancelable;

(15) Any maximum duration of coverage.

**Drafting Note:** States may want to consider reviewing issues surrounding post-claims underwriting possibly using their state unfair practices law or regulation, or other appropriate state law or regulation, to address issues, such as policy rescissions in instances of fraud and intentional misrepresentation.

**Drafting Note:** This section authorizes the commissioner to establish specific standards to facilitate public understanding of policy provisions. The section does not alter the requirements of the NAIC Uniform Individual Accident and Sickness Policy Provision Law (UPPL) (#180) or other specifically applicable state laws dealing with individual policy provisions. Regulations adopted under this section should be consistent with the UPPL and other applicable state laws relating to the subject matter. The phrase “including standards of full and fair disclosure” provides the commissioner authority to establish standards that ensure policy provisions are technically accurate, in clear language and make the significance of policy provisions fully understandable.

B. The commissioner may issue regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, a person insured under the policy, or to a beneficiary of the policy.

**Section 5. Minimum Standards for Benefits**

A. The commissioner shall issue regulations to establish minimum standards for benefits under specified categories of coverage of individual accident and sickness insurance and group supplemental health insurance supplementary and short-term health insurance subject to this Act.

B. The regulation shall set minimum standards for benefits for the following categories of supplementary coverage:

1. Basic hospital expense coverage;
2. Basic medical-surgical expense coverage;
3. Basic hospital/medical-surgical expense coverage;
4. Hospital confinement indemnity or other fixed indemnity coverage;
5. Individual major medical expense coverage;
6. Individual basic medical expense coverage;
7. Disability income protection coverage;
8. Accident only coverage;
9. Specified disease coverage;
10. Specified accident coverage; and
**Drafting Note:** “Specified disease coverage” or “specified accident coverage” refers to coverage that contains exclusions, limitations, reductions, or conditions that limit the payments of benefits under the policy or contract to a specified frequency and/or amounts. Examples of a specified disease or specified accident coverage would be a cancer only policy or an automobile accident only policy.

(11)(6) Limited benefit health coverage.

**Drafting Note:** “Specified disease coverage” or “specified accident coverage” refers to coverage that contains exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under the policy or contract are limited in frequency or in amounts. An example of a specified disease or specified accident coverage would be a cancer only hospital indemnity policy or an automobile accident only policy.

C. The regulation shall set minimum standards for benefits for short-term coverage referred to hereafter as “short-term, limited duration health insurance coverage.”

D. This section does not preclude the issuance of a policy or contract that combines two (2) or more of the categories of coverage enumerated in Paragraphs (1) through (11) of Subsection A, B, or C.

**Drafting Note:** This subsection does not restrict reasonable combinations of the coverages in Paragraphs (1) through (11) of Subsection B and C. For example, accident only coverage may be issued in conjunction with other categories. However, the section does not permit the combination of specified disease or specified accident coverages with other categories of coverage unless specifically permitted by a regulation adopted pursuant to this Act. In addition, it should be noted that the combination of coverages might raise Health Insurance Portability and Accountability Act of 1996 (HIPAA) creditable coverage issues, that is, certain combinations of coverages might not qualify as “excepted benefits” under HIPAA, as amended by the ACA, thus making those combination policies subject to HIPAA requirements as amended by the ACA, and ACA requirements, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. States may want to consider developing regulations on combination products and the potential for such products to confuse consumers that the combination coverage is equivalent to comprehensive, major medical coverage.

E. A policy or contract shall not be delivered or issued for delivery in this state that does not meet the prescribed minimum standards for the categories of coverage listed in Paragraphs (1) through (11) of Subsection A, B, or C or does not meet the requirements set forth in [insert reference to state law authorizing the commissioner to disapprove policy forms if the benefits provided in the policy forms are unreasonable in relation to the premium charged].

F. The commissioner shall prescribe the method of identification of policies, certificates and contracts based upon coverages provided.

Section 6. Disclosure Requirements

A. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness supplemental health insurance, group supplemental health insurance, subject to this Act and limited scope dental plan coverage and limited scope vision plan coverage delivered or issued for delivery in this state.

B. If the sale of a policy described in Subsection A occurs through an insurance producer, the outline of coverage shall be delivered to the applicant at the time of application or to the certificateholder at the time of enrollment.

C. If the sale of a policy described in Subsection A occurs through direct response advertising, the outline of coverage shall be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.

D. If the outline of coverage required in Subsections A and H, and any regulations issued by the commissioner pursuant to this Act, is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee shall contain all the information required in Subsection H and in any regulations issued by the commissioner pursuant to this Act.
E. If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the insurer shall collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer shall maintain evidence of the delivery.

F. If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued shall be delivered with the policy or certificate to the applicant or enrollee.

G. An insurer shall not be required to deliver an outline of coverage for group supplementary and short-term health insurance group supplemental health insurance, group limited scope dental plans coverage, and group limited scope vision plans coverage shall not be required to be delivered by the insurer to individual members of the group if the certificate contains a brief description of:

1. Benefits;
2. Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;
3. Renewability provisions Conditions under which the insurance coverage may terminate; and
4. Notice requirements as provided in the regulation promulgated pursuant to this Act.

Drafting Note: Advertisements can fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage under Subsection H and in the regulation promulgated pursuant to this Act.

H. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. “Format” means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage shall include:

1. A statement identifying the applicable category or categories of coverage as prescribed in Section 5 of this Act;
2. A description of the principal benefits and coverage provided;
3. A statement of the exceptions, reductions and limitations;
4. A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and
5. A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing policy provisions.

Drafting Note: Any possible conflict with Section 3A(1) of the NAIC Uniform Individual Accident and Sickness Policy Provision Law (#180) can be avoided by enclosing and not attaching the outline at the time of policy or certificate delivery.

I. An insurer shall deliver to persons eligible for Medicare notice required under [insert reference to state law equivalent to Section 17D of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)].

J. For supplementary health insurance providing hospital indemnity or other fixed indemnity coverage, an insurer shall display prominently in the application materials in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to check the policy to understand what the policy covers and does not cover (including exclusions related to pre-existing conditions and treatment limitations on health benefits outside the scope of coverage.) The notice shall also state that if coverage expires or eligibility for coverage...
under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

**Drafting Note:** States may have to alter the language in Subsection J or consider additional disclosures to reflect hybrid types of supplementary coverage subject to this Act.

K. For short-term, limited-duration coverage, an insurer shall display prominently in the application materials provided in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to review and check the policy to understand what the policy covers and does not cover and the possibility that if coverage expires or eligibility for coverage under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

**Drafting Note:** Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the language in Subsection K to ensure it accurately reflects a state’s specific requirements. States also should be aware that federal regulations effective Oct. 2, 2018 (see Federal Register, Vol. 83, No. 150, p. 38243 for the changes to 45 CFR §144.103), include specific notice requirements for short-term, limited-duration coverage, and recognize that the notice also may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage. States also may have to consider including language to alert consumers to potential issues to consider prior to enrollment when the consumer is purchasing coverage under a policy using funds from a health reimbursement account (HRA).

### Section 7. Preexisting Conditions

A. Notwithstanding the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC Uniform Individual Accident and Sickness Policy Provision Law (#180)], if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured’s health at the time of application or enrollment, but without any questions concerning the prospective insured’s health history or medical treatment history, the policy shall cover any loss occurring after twelve (12) months from any preexisting condition not specifically excluded from coverage by terms of the policy, and except as so provided, the policy or certificate shall not include wording that would permit a defense based upon preexisting conditions.

**Drafting Note:** States that have specific requirements with respect to waivers, exclusionary riders or evidence of insurability for group insurance should modify Subsection A by deleting references to “enrollment” and adding a new subsection addressing the requirements.

B. Notwithstanding the provisions of Subsection A and the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC Uniform Individual Accident and Sickness Policy Provision Law (#180)] an insurer that issues a specified disease policy or certificate, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form, may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least six (6) months, unless the loss results from a preexisting condition that first manifested itself within six (6) months prior to the effective date of the policy or certificate or was diagnosed by a physician at any time prior to that date. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

### Section 8. Administrative Procedures

The adoption of regulations pursuant to this Act shall be subject to the notice and hearing requirements set forth in [insert reference to state law relating to the adoption and promulgation of rules and regulations or state Administrative Procedures Act].
PROJECT HISTORY

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT (#170)

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

In 2013, the Regulatory Framework (B) Task Force was charged with reviewing NAIC existing models related to health insurance to determine whether they needed to be amended in light of all the changes made by the federal Affordable Care Act (ACA). During that review process, the Task Force added the Accident and Sickness Insurance Minimum Standards Model Act (#170) to the list of NAIC models to be considered for revision given the model’s provisions for certain types of health insurance plans that would not be permitted under the ACA.

Beginning at the 2014 Fall National Meeting, the Task Force began discussing revisions to Model #170 and the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). At the 2015 Spring National Meeting, the Task Force decided, given its other priorities for 2015, specifically with respect to revising the formerly titled Managed Care Network Adequacy Model Act (#74), now the Health Benefit Plan Network Access and Adequacy Model Act (#74), to defer discussing additional revisions to the models until it finished its work on Model #74. The Task Force finished its work in late 2015.

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. In March 2016, the Subgroup began meeting every other week to review and discuss the comments received on Model #170 by the Jan. 22, 2016, public comment deadline. The Subgroup met throughout 2016 until November 2016. During its conference calls, the Subgroup discussed a myriad of issues with respect to the revisions to Model #170, including issues concerning the definition of “hospital indemnity or other fixed indemnity insurance;” short-term, limited-duration insurance; and the disclosure of certain information with respect to these coverages as reflected in federal regulations. The Subgroup also discussed initial revisions to Model #171. At the 2017 Spring National Meeting, concerned with the uncertainty of the ACA’s future, given congressional proposals to repeal, replace and/or repair it, the Task Force decided to halt Subgroup meetings until there was more certainty about actions at the congressional level.

At the 2017 Fall National Meeting, the Task Force decided to move forward with discussing revisions to Model #170 and Model #171, and it directed the Subgroup to resume its work in early 2018. During its first meetings in 2018, the Subgroup decided to focus first on revisions to Model #170, and after those revisions were complete, the Subgroup would begin discussion of revisions to Model #171. During its meetings via conference call, the Subgroup continued its discussions of revisions to Model #170 to address issues related to hospital indemnity or other fixed indemnity insurance; and short-term, limited-duration insurance. The Subgroup also discussed what language disclosures and notices carriers must provide to consumers purchasing such coverage to alert consumers that these types of coverages are not required to comply with the requirements of the ACA because they are not considered the types of health insurance coverage subject to the ACA’s requirements. The Subgroup also discussed revisions to Model #170’s scope section for consistency with the types of coverage subject to the model’s provisions.

The Subgroup adopted the revisions July 23, 2018. As part of its adoption, the Subgroup established a 30-day public comment period ending Aug. 27, 2018, for the Task Force to receive comments on the revised model. Following the end of the public comment period, the Task Force met Oct. 17 and Sept. 24, 2018, via conference call to discuss the comments received focusing on comments related received related to Model #170’s title and other clarifying suggested revisions. The Task Force adopted the revised model at the 2018 Fall National Meeting. The Health Insurance and Managed Care (B) Committee adopted the revisions Feb. 14.

The proposed revisions to Model #170 remove provisions in the model concerning the type of health insurance plans subject to the ACA’s requirements, such as its guaranteed issue, guaranteed renewal, and prohibition on preexisting condition exclusion requirements. The revisions add specific provisions concerning short-term, limited-duration insurance; and hospital indemnity or other fixed indemnity insurance, including definitions of the terms and provisions requiring that certain notices and disclosures be provided to consumers purchasing such coverage.
2. Name of Group Responsible for Drafting the Model and States Participating

The Subgroup of the Task Force drafted the proposed revisions to Model #170. The members of the Subgroup were: Wisconsin, Chair; Colorado; Florida; Iowa; Louisiana; Maine; Missouri; Nebraska; Oklahoma; Oregon; Pennsylvania; South Carolina; Utah; Vermont; and Washington. The Task Force adopted additional revisions to Model #170 following the Subgroup’s adoption of the proposed revisions. The members of the Task Force were: Wisconsin, Chair; Colorado, Vice Chair; Alaska; American Samoa; Arkansas; California; District of Columbia; Florida; Idaho; Iowa; Kansas; Kentucky; Maine; Maryland; Massachusetts; Minnesota; Missouri; Nebraska; New Hampshire; North Carolina; North Dakota; Oklahoma; Pennsylvania; South Dakota; Texas; Utah; Virginia; Washington; and West Virginia.

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

The Task Force established the Subgroup in February 2016 to consider revisions to Model #170 and Model #171 based on the Task Force’s continuing charge to “review the model law review recommendations of NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group to revise the NAIC model(s) prioritized for revision in 2016.”

Based on that charge, the Task Force’s charge to the Subgroup is to “review and consider revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170) and its companion regulation, the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).”

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

Beginning in March 2016 and ending in July 2018, the reviewed and discussed all comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, insurers and other stakeholders. Each draft of proposed revisions was posted to the Subgroup’s webpage and as appropriate, the Task Force’s webpage, on the NAIC website. All comment letters received were also posted.

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

Beginning in March 2016 and ending in July 2018, the Subgroup reviewed and discussed all comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, insurers and other stakeholders. Each draft of proposed revisions was posted to the Subgroup’s webpage and as appropriate, the Task Force’s webpage, on the NAIC website. All comment letters received were also posted.

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

A few significant issues were raised and addressed during the drafting process. Those issues focused on: 1) the definition of “short-term, limited-duration insurance;” and 2) what specific information insurers must include in the notices provided to consumers purchasing hospital indemnity or other fixed indemnity insurance or short-term, limited-duration insurance. Specifically, regarding the definition of “short-term, limited-duration insurance,” the Subgroup discussed whether the draft should reflect language in the final federal regulations defining the maximum duration of such coverage or whether to provide flexibility to the states to establish their own such provisions. After extended discussion, given the different requirements the states have with respect to the duration of short-term, limited-duration insurance coverage and the renewal of such coverage, the Subgroup decided to include in the revisions language in the definition of “short-term, limited-duration coverage,” in proposed Section 3I, providing flexibility to the states to establish their own requirements related to such coverage. The Subgroup also added a drafting note for proposed Section 3I explaining its rationale. In its discussions related to the information insurers must include in the notices to be provided to consumers purchasing hospital indemnity or other fixed indemnity insurance or short-term, limited-duration insurance coverage, the Subgroup discussed how detailed the language should be with respect to distinguishing these types of coverage from major, medical insurance coverage and the ACA requirements. The Subgroup decided not to be too detailed in order avoid consumer confusion. The Subgroup decided to require insurers to include in the notices broad language noting these coverages are not required to comply with ACA requirements. In addition, the Subgroup decided to require that insurers include in the notice language advising consumers to check the policy to understand what it covers and does not cover as an additional measure to help ensure that consumers know what they are purchasing.
7. **Any Other Important Information (e.g., amending an accreditation standard)**

None.

**Section-by-Section Summary of Proposed Revisions**

The proposed revisions to Model #170 revise the title to “Supplementary and Short-Term Health Insurance Minimum Standards Model Act.”

**Section 1. Purpose**

The proposed revisions to Model #170 revise this section for consistency with the substantive changes to the model, which remove provisions concerning the types of health insurance coverage subject to the requirements of the ACA.

**Section 2. Applicability and Scope**

The proposed revisions to Model #170 for this section clarify what types of health insurance coverage are subject to and not subject to its requirements.

**Section 3. Definitions**

The proposed revisions to Model #170 for this section add, revise and delete definitions to reflect the substantive changes made in the other sections of the model. The proposed revisions add new definitions for the terms: 1) hospital indemnity or other fixed indemnity insurance; 2) limited scope dental coverage; 3) limited scope vision coverage; 4) short-term, limited-duration insurance; and 5) supplementary and short-term health insurance. The proposed revisions revise and delete several definitions for consistency with the substantive changes to the model’s provisions.

**Section 4. Standards for Policy Provisions**

The proposed revisions to Model #170 for this section make a few revisions for consistency with the substantive revisions to the model. The proposed revisions also clarify a few of the standards for policy provisions related to terms of renewability or extensions of coverage and preexisting condition exclusions.

**Section 5. Minimum Standards for Benefits**

The proposed revisions to Model #170 revise this section for consistency with the substantive revisions to other sections in the model. For example, the proposed revisions delete references to the health insurance coverage subject to the ACA’s requirements removed from the model. The proposed revisions also make a few non-substantive changes.

**Section 6. Disclosure Requirements**

The proposed revisions to Model #170 revise this section for consistency with the substantive revisions to other sections in the model. The proposed revisions to this section also add new consumer notice requirements for hospital indemnity or other fixed indemnity insurance coverage and short-term, limited-duration insurance coverage.

**Section 7. Preexisting Conditions**

The proposed revisions to Model #170 make no changes to this section.

**Section 8. Administrative Procedures**

The proposed revisions to Model #170 make no changes to this section.
Health and Welfare Plans Under the Employee Retirement Income Security Act:

Guidelines for State and Federal Regulation
Health and Welfare Plans Under the
Employee Retirement
Income Security Act:

Guidelines for State and Federal Regulation

ERISA Working Group of the
Health Insurance and Managed Care (B) Committee

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National Association of Insurance Commissioners
Insurance Products & Services Division
816-783-8300
prodserv@naic.org

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Central Office
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
816-842-3600

Capital Markets and
Investment Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212-398-9000

Government Relations
Hall of States Bldg.
444 North Capitol NW, Suite 700
Washington, DC 20001-1509
202-471-3990
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*Health and Welfare Plans Under the Employee Retirement Income Security Act (ERISA): Guidelines for State and Federal Regulation* has been prepared by the National Association of Insurance Commissioners (NAIC) ERISA Working Group of the Health Insurance and Managed Care (B) Committee.

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INTRODUCTION

The Employee Retirement Income Security Act of 1974 (ERISA)\(^1\) is a complex and comprehensive statute that federalizes the law of employee benefits. ERISA establishes a comprehensive regulatory framework for employee pension benefit plans and also preempts most state laws relating to “employee welfare benefit plans,” a broad category that includes nearly all employer-sponsored and union-sponsored health plans.\(^2\)

However, ERISA does not preempt state insurance law. The result is a dual regulatory framework. To the extent that an ERISA plan pays directly out of plan assets (a “self-funded plan”), it is exempt from state regulation. To the extent that the plan purchases insurance to cover some or all of its benefit obligations (an “insured plan”), the state’s regulatory authority over the insurance contract results in indirect state regulation of aspects of the plan.\(^3\)

The precise boundary of state jurisdiction has been the subject of numerous disputes involving complex preemption analysis. In contrast to the detailed and substantive standards that are imposed on employee pension benefit plans, there is no comparable federal regulatory program for employee welfare benefit plans.\(^4\) The minimal federal standards for employee welfare benefit

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\(^1\) Public Law 93-406, codified at 29 U.S.C. §§ 1001 et seq. (2018). Note that federal laws have their own internal numbering system and the numbering of many titles of the United States Code remains “unofficial.” For example, ERISA’s preemption clause is P.L. 93-406, § 514, as amended. It is codified at 29 U.S.C. § 1144, but is often cited as “Section 514.” The Affordable Care Act and the Public Health Service Act, discussed later in this Handbook, follow similar dual citation systems.

\(^2\) The terms “employee welfare benefit plan” and “welfare plan” include any “program ... established or maintained by an employer or employee organization ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise” with any of a broad range of benefits, including “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.” 29 U.S.C. § 1002(1) (2018).

\(^3\) While ERISA governs both the insured and self-funded plan, the term “ERISA plan” is often used colloquially to refer to a self-funded plan. In this handbook, the term “ERISA plan” is used in the correct sense to include a reference to both the “self-funded” plan and the “insured” plan.

\(^4\) ERISA was drafted specifically in response to concerns that working people were losing their pension benefits for a variety of reasons, including pension fraud, mismanagement and employer bankruptcy. With the growth in asset accumulation and the number of pension plans, Congress sought to ensure that appropriate safeguards were in place to protect pension plan funds. Congress also sought to encourage multistate employers who might be reluctant to form employee benefit plans in the face of fifty separate state regulatory schemes to provide employee benefits to their workers.

It is important to note that the impetus for ERISA was the security of pension plans and not concern for health care related benefits. Congress’s central concern for pension plan management is evident in the text of the Act as well as its legislative history. Under ERISA, pension plans are subject to uniform reporting, disclosure, fiduciary, participation, funding, and vesting requirements. Through these requirements, detailed and substantive standards are imposed on employers who furnish pension plans to their employees. On the other hand, only the reporting, disclosure, and fiduciary responsibility requirements were made applicable to welfare benefit plans. Consequently, the law does not require employee welfare benefit plans to meet requirements such as financial solvency standards. However, through the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191, Congress did create standards for employee health plans that limited the use of preexisting condition exclusions and prohibited discrimination based on health status-related factors, and additional substantive benefit standards have now been
plans and the imprecision and complexity of the ERISA preemption analysis result in numerous disputes over the limits of state jurisdiction in areas related to employee welfare benefit plans.

The complexity of ERISA preemption is derived primarily from the multiple stages in the analysis of whether a state law is preempted by ERISA. When determining whether ERISA preemption applies, state regulators must consider the following questions:

1. Is the plan under consideration an ERISA plan and, if so, what type of ERISA plan?
2. Does the state law “relate to” the ERISA plan?5
3. Even if the law does “relate to” an ERISA plan, is it protected by the “saving clause” which saves “any law of any State which regulates insurance” from preemption?6
4. Is the “saving clause” protection limited by ERISA’s “deemer clause,” which prohibits states from “deeming” an employee benefit plan to be an insurer, bank, or investment company in order to assert their authority to regulate one of those entities?7

Determining whether a state law is preempted by ERISA is complex and confusing. Unfortunately, unscrupulous operators capitalize on this confusion and illegitimately claim that state laws do not apply to their health plans because they are preempted under ERISA. State regulators need to be aware of the common scams and understand ERISA in order not to fall victim to these spurious claims. See the Section on “Typical Illegal Operations Claiming ERISA Status” for a description of some of the more common scams claiming exemption from state law under ERISA.

The principal purpose of this handbook is to provide state insurance regulators with a resource guide to help them through the labyrinth of ERISA preemption analysis. While ERISA preemption applies to a broader range of contexts, this handbook focuses exclusively on health-related employee welfare benefit plans. The first section discusses the scope of ERISA preemption. Specifically, it provides historical background information on ERISA preemption of state law and an overview of the statutory elements of the ERISA preemption analysis. The section ends with a summary of cases in which the Supreme Court has interpreted these statutory elements.

The second section of this handbook highlights the general characteristics of an ERISA plan and reviews the specific types of employee welfare benefit plans governed by ERISA: single-employer plans, multiemployer plans, and multiple employer welfare arrangements. The section describes how the preemption analysis applies to each individual plan type. The section also highlights some of the typical theories used by sham plan operators claiming ERISA preemption from state laws. The relationship between ERISA and Taft-Hartley trusts is also highlighted. The second section ends with an analytical checklist and chart regulators may find useful.

5 29 U.S.C. § 1144(a) (2018). It should be noted that ERISA does not apply to employee benefit plans maintained by governmental or church employers or to plans maintained only to comply with applicable state workers’ compensation, unemployment or disability laws. There are additional exemptions from ERISA for unfunded excess benefit plans and plans maintained outside the U.S. primarily for nonresident aliens. ERISA does provide an opt-in provision for church employers. 29 U.S.C. § 1003(b) (2018).
The third section of this handbook explores in a question and answer format a number of timely topics of interest to state insurance regulators. Some of the issues addressed in this section are basic settled questions that are commonly asked. Other questions reflect cutting edge issues that are still the subject of debate.

Finally, the fourth section of this handbook contains appendices that include various regulatory alerts.
ERISA PREEMPTION OF STATE REGULATION

The Scope Of Preemption

The scope of ERISA preemption is sweeping. With the exception of state regulations applied to MEWAs, any state law that attempts to regulate ERISA-covered employee benefit plans is preempted due to federal occupation of the field.8 However, ERISA exempts from federal preemption state laws that regulate the business of insurance. A “saving clause” in the Act empowers states to enforce all state laws that regulate insurance. The broad language of the saving clause is limited by a “deemer clause” in the statute, which has been judicially interpreted to mean that an employee benefit plan covered by ERISA cannot be deemed to be an insurance company or engaged in the business of insurance for the purposes of the application of state laws which regulate insurance.9 Because little legislative history exists with respect to these clauses, the interpretation of their meaning has been developed through the judicial decision making process.

The “saving clause” is also limited by case law holding that some provisions of state insurance codes regulating insurers go beyond regulating “the business of insurance” and therefore are preempted to the extent that they apply to insurance issued to employee benefit plans.10 The Supreme Court’s “interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.”11

This section provides a brief overview of those provisions of ERISA that:

• preempt state laws “relating to” employee welfare benefit plans;
• save state laws “regulating the business of insurance”; and
• prohibit states from “deeming” employee welfare benefit plans to be insurers or engaged in the business of insurance.

Summaries of a number of key Supreme Court cases interpreting these clauses are provided at the end of this section.

The Preemption Clause

The preemption clause states that “Except as provided in subsection (b) of this section [referring to the saving clause] ... the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee

11 FMC, 498 U.S. at 64.
benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.”12

Preemption applies only to a plan that was established or is maintained by an employer and/or an employee organization to provide any of the specified benefits to the employees of the employer or members of the employee organization.13 Congress defined an employer as “... any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”14 An employee organization is defined as “any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning any employee benefit plan, or other matters incidental to employment relationships; or an employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.”15

The scope of ERISA preemption has been altered since the federal law’s original enactment. The vague phrase “any person acting directly... or indirectly in the interest of an employer” in the definition of employer and the extremely broad scope of the language of the preemption clause created a troublesome loophole in ERISA. This loophole allowed unscrupulous promoters to peddle spurious health plans to all comers and to claim protection from state regulation as entities acting directly or indirectly in the interest of employers.

Congress reviewed the effect of preemption under ERISA in the Activity Report of the Committee on Education and Labor of the United States House of Representatives on January 3, 1977.16 Although the Committee thought that the broad preemption provision of ERISA should be retained, it emphasized that entrepreneurial ventures masquerading as ERISA plans were “no more ERISA plans than is any other insurance policy sold to an employee benefit plan.”17 Also, “[w]here a ‘plan’ is, in effect, an entrepreneurial venture, it is outside the policy of section 514 (the preemption clause of ERISA) ... In short, to be properly characterized as an ERISA benefit plan, a plan must satisfy the definition requirement ... in both form and substance.”18 The committee concluded: “We most earnestly encourage private persons, in particular the membership of the National Association of State [sic] Insurance Commissioners, and urge the Department of Labor, to take appropriate action to prevent the continued wrongful avoidance of proper state regulation by the entities.”19 Finally, in 1983, Congress enacted language to facilitate the efforts of the states

14 Id. § 1002(5).
15 Id. § 1002(4).
17 Id. at 10.
18 Id. at 11.
19 Id.
and the DOL to establish a clear and effective regulatory framework for multiple employer plans. These provisions are discussed in more detail in the section on multiple employer welfare arrangements (MEWAs).

Although the 1983 amendment to ERISA reduced the scope of ERISA preemption, for non-MEWA ERISA plans the potential for ERISA preemption of state laws remains significant. ERISA’s preemption provision has been interpreted broadly by the federal courts. When plaintiffs seek state law remedies in state courts for claims related to employee benefit plans, defendants invariably have the cases removed to federal court where cases usually are dismissed on the grounds of preemption.

The Saving Clause

Notwithstanding the preemption clause, ERISA does not substitute for or eliminate state insurance regulation. To preserve state laws regulating insurance and state authority to continue to do so, Congress included a “saving clause” in the Act. This provision reads: “Except as provided in subparagraph (B), [referring to the “deemer clause”], nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”20 In other words, ERISA generally does not prohibit states from applying state insurance laws to entities engaged in the business of insurance.

The “saving clause” is consistent with the McCarran-Ferguson Act,21 which Congress passed in 1945 to reserve for the states the authority to regulate the business of insurance. Furthermore, ERISA explicitly states that “Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States ... or any rule or regulation issued


§ 1011. Declaration of policy
The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948
(a) State regulation. The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
(b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance; Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act [15 U.S.C. §§ 1 et seq.], and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C. §§ 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.
under any such law.” Known as an “equal dignity” clause, this provision protects the McCarran-Ferguson Act from being superseded or modified by ERISA.

The Deemer Clause

While the “saving clause” seeks to protect state authority to regulate the business of insurance, state insurance laws cannot be applied to employee benefit plans. The “deemer clause” states, “Neither an employee benefit plan described in 29 U.S.C. §1003(a) of this title, which is not exempt under §1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer ... or to be engaged in the business of insurance ... for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts ....”

A state law that treats an employee welfare benefit plan as if it were an insurer negates the effect of the saving clause. The deemer clause does not negate the ability of states to apply insurance laws to those entities with which the employee welfare benefit plan has contracted to purchase insurance for its employees.

Key United States Supreme Court Opinions On ERISA’s Preemption Provisions

The interplay between ERISA’s preemption, saving and deemer clauses and the impact of these clauses on state regulatory authority has been the subject of a multitude of cases presented before the judiciary. The Supreme Court established tests to be used when evaluating whether a state law is preempted because it “relates to” an employee benefit plan or because the state law “deems” an employee benefit plan to be an insurer or to be engaged in the business of insurance. The Court also established tests to be used when evaluating if a state law is “saved” because it regulates “the business of insurance.”

The guidance established in the Supreme Court cases is further augmented by lower court opinions. While the Supreme Court has provided the lower courts with direction not readily apparent in the statutory language, the complexity of the statute and the fact-specific nature of the cases that the courts must decide result in an uncertain judicial decision making process. Lower courts often reach conflicting decisions in interpreting similar state laws. As a consequence, legislators, regulators, employers, and insurers sometimes have difficulty predicting what the courts will consider a “preempted” or “saved” regulatory initiative.

The Supreme Court further complicated the issue in the April 2003 decision, *Kentucky Association of Health Plans v. Miller*, when it announced a “clean break” from the tests the Supreme Court relied upon previously in interpreting the saving clause. Some uncertainty remains about the impact of the *Miller* case on future cases and on the precedential value of the Court’s previous ERISA preemption cases. See the summaries of a number of the key Supreme Court cases provided below.

23 Id. § 1144(b)(2)(B).
In *Shaw v. Delta Air Lines*, the Supreme Court decided whether New York’s Human Rights Law and Disability Benefits Law were preempted by ERISA. *Delta Air Lines* is particularly valuable because of its efforts to define what the phrase “relate to” means in the context of the ERISA preemption clause and to clarify the breadth of the states’ reserved authority to regulate state-mandated disability, unemployment, and workers’ compensation benefit plans.

New York’s Human Rights Law contained a number of employment discrimination provisions, including one prohibiting employers from discriminating against their employees on the basis of sex, and defining sex discrimination to include discrimination on the basis of pregnancy. New York’s Disability Benefits Law required employers to provide employees the same benefits for pregnancy as were provided for other disabilities.25

In its analysis, the Court held that both of these state laws “related to” employee benefit plans. The Court’s interpretation of “relate to” was according to “the normal sense of the phrase, if it has a connection with or reference to such a plan.”26 The Human Rights statute prevented employers from structuring their employee benefit plans in a discriminatory fashion on the basis of pregnancy. The Disability Benefits statute required employers to include certain benefits in their employee welfare benefit plan.27

The Court noted that ERISA does not merely preempt state laws that deal with requirements covered by ERISA, such as reporting, disclosure, and fiduciary responsibility. Nor does the Act merely preempt state laws specifically directed to employee benefit plans.28 State laws that indirectly “relate to” employee benefit plans may also be preempted by ERISA. The Court did note that some state laws “may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”29

Following its conclusion that both state laws “related to” employee benefit plans, the Court proceeded to inquire whether either of the laws was nevertheless exempt from ERISA preemption. The state argued that the Human Rights Law was exempt from ERISA preemption because ERISA’s “equal dignity” clause prohibited interpretations that impaired other federal laws and state fair employment laws were integral to the federal enforcement scheme under Title VII. The Court rejected this claim, noting that ERISA preemption of the Human Rights Law as it related to employee benefit plans did not impair Title VII because Title VII did not prohibit the practices under consideration in this case.30

With respect to the Disability Benefits Law, the Court noted that ERISA specifically exempts from coverage those plans which are “maintained solely for the purpose of complying with applicable

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26 *Id.* at 96–97.
27 *Id.* at 97.
28 *Id.* at 98.
29 *Id.* at 100 n.21.
30 *Id.* at 103–04.
... disability insurance laws.” Consequently, the Court held that states cannot apply their laws to multi-benefit ERISA plans which may include disability benefits, but can require the employer to administer a separate disability plan which does comply with state law.

**METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS, 471 U.S. 724 (1985)**

In *Metropolitan Life v. Massachusetts*, the Court reviewed whether a state statute mandating coverage of mental health care was preempted by ERISA as applied to insurance policies purchased by employee welfare benefit plans. All insurance policies within the scope of the statute, including policies purchased by ERISA health plans, were required to include the mandated mental health benefit. Because the statute had the effect of requiring insured employee benefit plans to provide a particular benefit, the Commonwealth of Massachusetts did not dispute that the statute “related to” ERISA plans. The Commonwealth did claim, however, that the law regulated the business of insurance, and thus, was saved from ERISA preemption.

In its analysis, the Court highlighted that ERISA does not distinguish between “traditional and innovative insurance laws.” Further, the Court noted that “[t]he presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.” The Court also noted that Congress did not intend to preempt areas of traditional state regulation.

The opinion adopted a “common-sense view” of the saving clause, observing that it would seem to “state the obvious” that a law which “regulates the terms of certain insurance contracts” is “a law ‘which regulates insurance’” within the meaning of the saving clause. The Court explained further that the case law interpreting the phrase “the business of insurance” under the McCarran-Ferguson Act “also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws ‘which regulate insurance.’” Under the McCarran-Ferguson Act, “Statutes aimed at protecting or regulating [the insurer-policyholder] relationship, directly or indirectly, are laws regulating the ‘business of insurance.’” The Court reviewed the McCarran-Ferguson “reverse preemption” cases as an aid to determine if a practice is the “business of insurance.” Those cases applied an analysis that considered three key factors:

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32 *Id.* at 107–08.
34 *Id.* at 733.
35 *Id.* at 741.
36 *Id.*
37 *Id.* at 740.
38 *Id.*
39 *Id.* at 742–43.
41 *Id.* at 742, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). Although some courts, including on occasion the Supreme Court itself, have cited *Metropolitan Life* and/or *Pireno* as supporting the proposition that courts should evaluate whether the law itself “has the effect of spreading a policyholder’s risk,” that is not how the
(1) Does the practice have the effect of “spreading a policyholder’s risk”?
(2) Is the practice an “integral part of the policy relationship between the insurer and the insured”?
(3) Is the practice “limited to entities within the insurance industry”?

The Supreme Court opinion that established this three-pronged test, Union Labor Life v. Pireno, specifically stated that not all of these prongs are necessary and noted, in particular, that the third prong of the test was not dispositive to a determination whether or not an entity was engaged in the business of insurance.

The Court held that the Massachusetts law met all three of the Pireno criteria derived from the McCarran-Ferguson Act. It found that:

(1) The law regulated the spreading of risk since the state legislature’s intent was that the risk associated with mental health services should be shared;
(2) The law directly regulated an integral part of the relationship between the insurer and the policyholder;
(3) The law met the third prong because it only imposed requirements on insurers.

The Court acknowledged, “we are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction created by Congress in the “deemer clause,” a distinction of which Congress is aware and one it has chosen not to alter.”

It is important for regulators to keep in mind that this distinction between indirectly regulated insured plans and unregulated self-funded plans is the result, not the source, of states’ reserved authority to regulate insurance. Thus, the applicability of state insurance law to an insurance policy purchased by an employee benefit plan is not conditional on some prior determination that the plan is an “insured” plan.

**PILOT LIFE INS. CO. v. DEDEAUX, 481 U.S. 41 (1987)**

Pilot Life Ins. Co. v. Dedeaux involved state common-law tort and contract claims as applied to the processing of claim benefits under an employee welfare benefit plan. In Pilot Life, a unanimous Court held that the plaintiff’s common-law causes of action for the insurer’s alleged bad faith handling of the plaintiff’s disability claim “related to” an employee benefit plan and were preempted by ERISA because they involved the processing of claims under an employee benefit plan.
The Court found that the state law bad-faith common-law tort claims were not protected by the “saving clause.” The Court stated that “in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry.”

Applying the criteria used to determine whether a practice constitutes the business of insurance for purposes of the McCarran-Ferguson Act, the Court determined that: (1) the common-law tort of bad faith did not effect a spreading of the risk; (2) the tort was not integral to the insurer-insured relationship; and (3) because common-law tort claims were not limited to entities within the insurance industry, the McCarran-Ferguson “business of insurance” test did not save the state law claims. Further, the Court stated that “the deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.”

The Court went beyond considering the exclusive remedy as an additional factor in support of its conclusion that the bad faith tort does not “regulate insurance” within the meaning of the saving clause – the Court concluded that even if Mississippi’s law did regulate insurance, it would still be preempted. The Court distinguished *Metropolitan Life* on the ground that it “did not involve a state law that conflicted with a substantive provision of ERISA.” The Court concluded that all state laws that “supplemented or supplanted” the causes of action and remedies available under ERISA were preempted, whether or not they “regulated insurance” within the meaning of the saving clause.

ERISA preemption also controls the forum in which the complaint is to be heard. The Federal Rules of Civil Procedure provide that “any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.” In a companion case to *Pilot Life*, *Metropolitan Life Ins. Co. v. Taylor*, the Supreme Court held that state court cases can be removed to federal court if the common-law cause of action is preempted by ERISA, even though no federal law issues appear in the complaint. The Court held that this doctrine, originally developed in the context of labor law preemption, was equally applicable to ERISA preemption.

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47 *Id.* at 50 (emphasis supplied).
48 *Id.* at 57.
49 *Id.* at 54.
50 *Id.* at 56–57.
51 *Id.* at 56. The Court based its analysis on legislative history, submitted by the Solicitor General as *amicus curiae*, indicating that the preemption provisions in ERISA were based on the broad exclusive remedy provisions in the Taft-Hartley Act (LMRA), 29 U.S.C. § 185. The Taft-Hartley Act does not contain an insurance saving clause, a difference from ERISA that was not addressed by the *Pilot Life* Court. See *UNUM Life Ins. Co. v. Ward*, 526 U.S. at 376 n.7.
54 See *Avco Corp. v. Machinists*, 390 U.S. 557 (1968). In *Avco*, the Court permitted the removal of cases purporting to be based only on state law causes of action in labor cases preempted by Section 301 of the Labor Management Relations Act.
55 *Taylor*, 481 U.S. at 66–67. However, as noted by the U.S. Supreme Court in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), for non-diversity-of-citizenship cases, a defendant may not remove a case to federal court unless the plaintiff’s complaint establishes that the case arises under federal law. Federal law as
The deference that the Court afforded to the civil enforcement scheme of ERISA stressed the need for exclusivity and uniformity of ERISA plan remedies. As a result, it is important to distinguish state insurance regulation and enforcement relating to claims handling, utilization review, grievance handling and coverage or claim appeals from civil remedies. The Pilot Life “conflict” exception to the saving clause should not be invoked by a court reviewing an insurance regulatory provision relating to these topics because they are not a “civil remedy” for the participant, even if they have the effect of providing restitution to consumers.

**FIRESTONE TIRE & RUBBER CO. v. BRUCH,**

*489 U.S. 101 (1989)*

While *Firestone Tire & Rubber Co. v. Bruch* is often cited for the proposition that ERISA plan administrators (including insurers when the plan provides insurance benefits) are entitled to broad discretion, that is not actually what the Court held. To the contrary, the Court rejected the standard that had previously been widely applied in the lower federal courts, under which plan administrators were understood to have inherent discretionary authority, so that courts could only overturn the administrator’s decisions if it was arbitrary and capricious. Instead, the Court held that such decisions are subject to *de novo* review by the courts unless the terms of the plan grant discretionary authority to the administrator.

*Firestone* was neither an insurance case nor a health benefit case. It involved a dispute over the employer’s severance payment plan that arose after the employer sold five of its plants to another employer. The trial court had granted summary judgment to Firestone on the basis that its denial of severance pay was not arbitrary and capricious, but the Third Circuit reversed on the ground “that where an employer is itself the fiduciary and administrator of an unfunded benefit plan, its decision to deny benefits should be subject to *de novo* judicial review. It reasoned that in such situations deference is unwarranted given the lack of assurance of impartiality on the part of the employer.”

The Supreme Court affirmed this standard of review. Although “ERISA abounds with the language and terminology of trust law,” the “arbitrary and capricious” standard of review lower courts had often applied in ERISA cases was not based on general principles of trust law, but on precedent under the Taft-Hartley Act. Under the Taft-Hartley Act, a suit against a trustee is an extraordinary remedy; by contrast, Congress expressly provided for judicial review of decisions by ERISA fiduciaries. Another crucial difference between ERISA and the Taft-Hartley Act is that Congress did not make Taft-Hartley’s exclusive remedy provision subject to a saving clause for insurance laws, a distinction that the Pilot Life Court did not take into account in its analysis. See *supra* note 51.

58 *Id.* at 107–108.
59 *Id.* at 110.
60 *Id.* at 109–110.
under ERISA should be *de novo* review, and noted that this standard is consistent with the standard applied under contract law to employee benefit plans before ERISA was enacted.\(^{61}\)

However, the Court also provided guidance for mitigating the impact of the *de novo* standard. Despite acknowledging that one of the purposes of ERISA was “to protect contractually defined benefits,”\(^{62}\) the Court interpreted ERISA as replacing contract law with trust law as the governing principle for resolving employee benefit disputes, and stated that when the trustee is exercising a discretionary power that has been expressly granted by the terms of the trust instrument, trust principles then “make a deferential standard of review appropriate.”\(^{63}\) In this case, though, there was no discretionary clause, so the *de novo* standard was fully applicable. Finally, the Court cautioned: “Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest,” as when an insurer or employer adjudicates a claim for benefits that would be paid out of its own assets, “that conflict must be weighed as a factor in determining whether there is an abuse of discretion.”\(^{64}\)

**FMC CORP. v. HOLLIDAY,**

*498 U.S. 52 (1990)*

At issue in *FMC Corp. v. Holliday* was a Pennsylvania state statute that prevented employee welfare benefit plans from subrogating a plan beneficiary’s tort recovery involving motor vehicle-related incidents. The plan at issue was a self-funded employee welfare benefit plan.\(^{65}\)

The Court concluded that the statute “related to” the employee benefit plan because it referenced such plans and was connected to such plans by subjecting multi-state self-funded plans to conflicting state regulations.\(^{66}\) The Court also concluded that the statute fell within the “saving” clause as an insurance regulation.\(^{67}\)

Nevertheless, after concluding that the statute “related to” the employee benefit plan and regulated insurance, the Court ultimately held that the statute was not “saved” to the extent that it regulated ERISA-covered self-funded employee welfare benefit plans. Since the “deemer” clause exempts ERISA plans from state laws that regulate insurance, the state could not apply laws directed at the business of insurance to self-funded employee welfare benefit plans or to the terms of the plans.\(^{68}\) The Court reaffirmed that the “saving” clause “retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee welfare benefit plans.”\(^{69}\) Specifically, the Court stated that “if a plan is insured, a State may regulate it indirectly through

\(^{61}\) *Id.* at 112.

\(^{62}\) *Id.* at 113.

\(^{63}\) *Id.* at 111. However, the Court has acknowledged that “trust law does not tell the entire story” and might be “only a starting point.” *Conkright v. Frommert*, 559 U.S. 506, 516 (2010), quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

\(^{64}\) *Id.* at 115. See discussion below of *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).


\(^{66}\) *Id.* at 58–60.

\(^{67}\) *Id.* at 60–61.

\(^{68}\) *Id.* at 65.

\(^{69}\) *Id.* at 64.
regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.”70

**DISTRICT OF COLUMBIA v. GREATER WASHINGTON BOARD OF TRADE,**

*506 U.S. 125 (1992)*

In *District of Columbia v. Greater Washington Board of Trade,* the Supreme Court held that ERISA preempted a statute that required an employer to provide employees who were eligible for workers’ compensation benefits with the same coverage the employer provided through its health insurance program if one was offered.71

The Court noted that the statute clearly “related to” employee welfare benefit plans because it specifically mentioned them.72 The Court rejected the District of Columbia’s reliance on *Delta Air Lines* because *Delta* had specifically held that a `state cannot apply a statute directly to an employee welfare benefit plan. Although *Delta* does allow a state to require an employer to set up a separate plan to comply with laws directed at benefits not covered by ERISA, such as disability, unemployment, and workers’ compensation benefits, the District of Columbia law did not do so.73 The benefit it mandated was tied directly to the terms of the employer’s ERISA plan.74

**NEW YORK STATE CONF. OF BLUE CROSS & BLUE SHIELD PLANS v. TRAVELERS INS. CO.**

*514 U.S. 645 (1995)*

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, the Court upheld a statute which required that hospitals impose one level of surcharge on patients insured by commercial insurers, another level of surcharge on patients insured by HMOs, and no surcharge on patients insured by Blue Cross and Blue Shield plans. Commercial insurers challenged the state law, claiming that the statute was preempted by ERISA because the state law “related to” the bills of patients whose insurance was purchased by employee welfare benefit plans.

The District Court held that the surcharges “related to” ERISA plans and were thus preempted because they had the effect of increasing the costs to commercial insurers and HMOs and therefore, indirectly increasing the costs to employee welfare benefit plans. Consequently, the District Court enjoined the enforcement of the surcharges. The Court of Appeals affirmed the District Court’s decision, reasoning that the “purpose[ful] interfer[ence] with the choices that the ERISA plans make for health care coverage ... is sufficient to constitute [a] “connection with” ERISA plans.”75

In a unanimous decision, the Supreme Court reversed the holding of the Court of Appeals. The Court noted that the statute did not make “reference to” an employee welfare benefit plan because

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70 *Id.*
72 *Id.* at 130.
73 *Id.* at 132.
74 *Id.*
the surcharge was imposed irrespective of whether the insurance was purchased by an ERISA plan, private individual, or other purchaser.\footnote{Id. at 1677.}

After reviewing the purposes and objectives of Congress in enacting the ERISA statute, the Court also concluded that the statute did not have a “connection with” employee welfare benefit plans. The Court held that an indirect economic influence is not a sufficient connection to trigger preemption if it does not bind plan administrators to any particular choice or preclude uniform administrative practices. While a surcharge may increase plan costs and affect its shopping decisions, it does not preclude the plan from seeking the best deal that it can obtain. The Court noted that the state laws which have an indirect economic effect on the relative costs of health insurance packages leaves “plan administrators where they would be in any case, with the responsibility to choose the best overall coverage for the money.”\footnote{Id. at 1680.}

The \textit{Travelers} Court clarified that state statutes that “produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers … might indeed be preempted.”\footnote{Id. at 1683.} Because the hospital surcharge statute only indirectly affects the cost of insurance policies, it does not fall into this category of indirect regulation preempted by ERISA.

\textbf{CALIFORNIA DIVISION OF LABOR STANDARDS ENFORCEMENT v. DILLINGHAM, 519 U.S. 316 (1997)}

At issue in \textit{California Division of Labor Standards Enforcement v. Dillingham} was whether ERISA preempted California’s minimum wage law to the extent that it allowed payment of a lesser wage to workers that participate in a state-approved apprenticeship program. The Supreme Court considered whether the state law “related to” an ERISA plan and was therefore preempted under ERISA § 502(a). The Court utilized a two-part inquiry to determine whether California’s minimum wage law “related to” an ERISA plan. The Court considered whether the state law had either a “reference to” or a “connection with” an ERISA plan.\footnote{California Division of Labor Standards Enforcement v. Dillingham, 519 U.S. 316, 324 (1997), quoting the test used in District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125, 129 (1992) (quoting \textit{Shaw v. Delta Airlines, Inc.} 463 U.S. 85, 96–97 (1983)).}

The Court noted common characteristics among the cases where it had held that certain state laws made “reference to” an ERISA plan. The Supreme Court highlighted cases “[w]here a State’s law acts immediately and exclusively upon ERISA plans, as in Mackey, or where the existence of ERISA plans is essential to the law’s operation, as in Greater Washington Board of Trade and Ingersoll-Rand, that “reference” will result in preemption.”\footnote{Id. at 325.} The Court determined that California’s minimum wage law, as it applied to apprentice wages, applied to more than just ERISA plans and, as a result, did not make “reference to” ERISA plans.
In order to determine whether a state law has a “connection with” an ERISA plan, the Court acknowledged that “an ‘uncritical literalism’ in applying the ‘connection with’ standard offers scant utility in determining Congress’ intent to the extent of the reach of the preemption clause.”

In applying the “connection with” standard, the Court looked to the “objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive [ERISA preemption] as well as to the nature of the effect of state law on ERISA plans.”

With respect to the issue of Congressional intent, the Supreme Court’s analysis starts with a presumption against preemption—Congress did not intend to preempt areas of traditional state regulation absent evidence that it was the clear and manifest purpose of Congress. In Travelers, the Court stated that “the preemption of areas of traditional state regulation where ERISA has nothing to say would be ‘unsettling.”’ California’s minimum wage laws, like the hospital surcharge law at issue in the Travelers case, involved issues traditionally regulated by the states. In addition, the Court observed that the areas covered by the state laws at issue in both cases were “quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like.” Therefore, the Supreme Court was not persuaded that it was the intent of Congress to have ERISA preempt state laws addressing apprentice wages and wages to be paid on public works contracts.

In past ERISA preemption cases decided by the Supreme Court, a “connection with” an ERISA plan was observed when the state law at issue had either “mandated employee benefit structures or their administration.” The Court compared the effect of the New York law on ERISA plans in the Travelers case to the effect of the California law on ERISA plans in the instant case. The indirect economic influence that resulted from the state law at issue in Travelers did not force ERISA plans to make a particular choice, nor did it regulate the ERISA plan itself. Similarly, California’s prevailing wage statute did not bind ERISA plans to any particular decision. The Court stated that “[t]he [California] law only alters the incentives, but does not dictate the choices facing ERISA plans.” The Court reasoned that the California minimum wage law was no different “from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”

The Court concluded that California’s prevailing wage law had neither a “connection with” nor did it make “reference to” an ERISA plan. Therefore, it did not “relate to” an ERISA plan so as to be preempted under Section 514(a) of ERISA.

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81 Id., citing Travelers, 514 U.S. at 656.
82 Id., citing Travelers, 514 U.S. at 658–659.
83 Id., citing Travelers, 514 U.S. at 655 (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)) (citation omitted).
84 Id. at 330, citing Travelers, 514 U.S. at 665 n. 7.
85 Id. at 330, citing Travelers, 514 U.S. at 661 (quoting Delta Air Lines, 463 U.S. at 98).
86 Id. at 328 (citations omitted).
87 Id. at 332.
88 Id. at 334.
89 Id. at 334, citing Travelers, 514 U.S. at 668.
De BUONO v. NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND,
520 U.S. 806 (1997)

At issue in De Buono v. NYSA-ILA Medical and Clinical Services Fund was the application of a New York hospital tax to medical centers operated by an ERISA plan. The Court of Appeals for the Second Circuit held that the New York tax was preempted because it “related to” an ERISA plan within the meaning of ERISA §514(a). The case was appealed to the United States Supreme Court. The Supreme Court remanded the case for reconsideration in light of its opinion in Travelers, discussed above.90

The Second Circuit reconsidered its opinion and, distinguishing the tax at issue in Travelers from the tax at issue in this case, again held the law preempted as it applied to hospitals owned by ERISA plans. The Second Circuit reasoned that in Travelers, the surcharge only impacted ERISA plans indirectly by influencing a plan administrator’s decision. However, in this case, the impact of the tax on ERISA plans was direct, by depleting the fund’s assets.91

On petition before the Supreme Court for the second time, the Court reversed the Second Circuit and held that the New York tax did not “relate to” an ERISA plan, and therefore, was not preempted as it applied to hospitals owned by ERISA plans. The Court explained that the holding in Travelers required re-evaluation of its previous interpretations of the “relates to” phrase. Prior to its decision in Travelers, cases requiring the Court to interpret the “relates to” language in ERISA had obvious connections to or made obvious references to ERISA plans.92 The Court’s decision in Travelers rejected a strict and literal interpretation of “relates to.”93

The Court explained that the “relates to” language in §514(a) does not modify the starting presumption that Congress does not intend to preempt state law.94 In order to overcome this presumption against preemption, one “must go beyond the unhelpful text ... and instead look to the objectives of the ERISA Statute as a guide to the scope of the law that Congress understood would survive.”95

The Court reiterated that the scope of ERISA’s preemptive reach was not intended to extend to the historic police powers of the states, which includes matters of health and safety.96 The Court observed that the tax at issue in this case, while a revenue raising measure and not a hospital regulation per se, clearly occupied a realm that was historically a state concern.97 Consequently,

90 De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806, 812 (1997).
91 Id. at 812, citing the decision below, NYSA-ILA Medical and Clinical Services Fund v. Axelrod, 74 F.3d 28, 30 (1996).
92 Id. at 813, citing Shaw v. Delta Airlines, Inc., 463 U.S. 85.
93 Id. at 812.
94 Id. at 813, citing Travelers, 514 U.S. at 655, citing Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230.
95 Id. at 813, 814, citing Travelers, 514 U.S. at 656.
96 Id. at 814.
97 Id.
the Fund had the “considerable burden” of overcoming the presumption against preemption of state law.\textsuperscript{98}

The Court explained that the New York hospital tax was a law of general applicability. All hospitals were required to pay the tax regardless of their relationship to an ERISA plan. Laws of general applicability may impose burdens on the administration of ERISA plans and still not “relate to” an ERISA plan.\textsuperscript{99} The Court observed that “any state tax or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.”\textsuperscript{100} In a footnote the Court reiterated a statement from \textit{Travelers} conceding that there may be a situation where the economic impact of the state law is so great that an ERISA plan would be forced to buy certain coverage or not use certain insurers, in which case there may be preemption.\textsuperscript{101} However, the tax at issue in this case was not such a law. The tax was held not to “relate to” an ERISA plan and was not preempted by ERISA.\textsuperscript{102}

\textbf{UNUM LIFE INS. CO. v. WARD.} \textit{526 U.S. 358 (1999)}

\textit{UNUM Life Ins. Co. v. Ward} involved John Ward’s claim for disability benefits pursuant to a policy provided by his employer. Mr. Ward filed his claim with UNUM Life Insurance Company after the expiration of the deadline provided for in his insurance policy. Consequently, UNUM denied his claim. Mr. Ward filed suit under ERISA §502(a) for benefits due under the terms of the plan, claiming that under California law, \textit{Elfstrom v. New York Life Ins. Co.}, 432 P.2d 731(1967), UNUM had received timely notice of Ward’s disability. Under \textit{Elfstrom}, an employer that administers a group health plan is the agent of the insurer. Therefore, the notice that Ward provided to his employer, which was within the timeframe set forth in the insurance policy, served as notice to UNUM. The district court, however, disagreed and granted summary judgment in favor of UNUM. The district court reasoned that the \textit{Elfstrom} rule did not apply to Mr. Ward’s situation because the rule “related to” an ERISA plan and was therefore preempted.

Ward appealed to the Court of Appeals for the Ninth Circuit, which reversed the district court’s decision and remanded. First, the Ninth Circuit held that a doctrine of California law, known as the notice-prejudice rule, operated to prevent UNUM from denying Ward’s claim as untimely unless UNUM could show that it had been prejudiced by the delay. Alternatively, the Ninth Circuit held that, if UNUM could show that it was prejudiced by the delay, the \textit{Elfstrom} rule would not prevent UNUM from denying Ward’s claim for benefits. According to the Ninth Circuit, the notice-prejudice rule was saved from preemption because, although it “relates to” an ERISA plan, it was nevertheless “saved” from preemption as a law that “regulates insurance” within the meaning of ERISA § 514(b)(2)(a). The \textit{Elfstrom} rule also was not preempted, according to the Ninth Circuit, because as a law of general application, it did not “relate to” an ERISA plan.

\textsuperscript{98} Id.
\textsuperscript{99} Id. at 815, citing \textit{Travelers}, 514 U.S. at 668.
\textsuperscript{100} Id. at 816.
\textsuperscript{101} Id. at n.16, citing \textit{Travelers}, 514 U.S. at 668.
\textsuperscript{102} Id. at 816–17.
The decision of the Ninth Circuit was affirmed in part and reversed in part by the Supreme Court. The Supreme Court conducted a two-part analysis into whether the notice-prejudice rule was a law that “regulates insurance” within the meaning of ERISA’s saving clause. First, the Court considered whether the law regulates insurance from a “common-sense” perspective. Second, the Court considered three factors used to determine whether a state law is the “business of insurance” within the meaning of the McCarran-Ferguson Act. Under the first factor, the Court considered whether the law “has the effect of transferring or spreading a policyholder’s risk.” Under the second factor, the Court considered “whether the law is an integral part of the policy relationship between the insurer and the insured.” Under the third factor, the Court considered “whether the law is limited to entities within the insurance industry.” The three factors assist the Court in verifying the common sense view of whether a law regulates insurance. The Court clarified that the three McCarran-Ferguson factors are not mandatory requirements. Each factor does not need to be met individually, but instead, they collectively serve as “guideposts” or “considerations to be weighed” when determining whether a law “regulates insurance” within the meaning of ERISA’s saving clause.

The Court applied this two-part analysis to the notice-prejudice rule. The Court first considered whether the law regulated insurance from a common sense perspective. Observing that the notice-prejudice rule “controls the terms of the insurance relationship,” is “directed specifically at the insurance industry” and is “grounded in policy concerns specific to the insurance industry,” the Court found that the notice-prejudice rule clearly regulated insurance.

The Court considered the second part of the “regulates insurance” analysis—the three factors used to determine whether a state law regulates the business of insurance within the meaning of the McCarran-Ferguson Act. The Court declined to decide the first factor, the risk spreading factor, because the remaining two factors were clearly satisfied. However, with respect to the “risk spreading” factor, the Court acknowledged, but did not adopt, the argument forwarded by the United States as amicus curiae. In its brief, the United States noted that the notice-prejudice rule “shifts risk” to the extent that the risk of late notice and stale evidence is shifted from the insured to the insurer and may result in higher premiums and spreading risk among policyholders. The second factor is satisfied because the notice-prejudice rule dictates the terms of the insurance contract by requiring that the insurer prove prejudice before enforcing a timeliness of claim provision in the contract. The third factor is also satisfied because the notice-prejudice rule has more than a passing impact on the insurance industry—it is aimed at it.

The Court specifically rejected UNUM’s arguments that the notice-prejudice rule conflicted with ERISA. UNUM asserted that the notice-prejudice rule conflicted with ERISA’s requirement in § 504(a)(1)(D) that requires fiduciaries to act in accordance with plan documents. The Court

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104 *Id.* at 372.
105 *Id.* at 374.
106 *Id.* at 373.
107 *Id.* at 374.
108 *Id.*, citing Brief of United States as *Amicus Curiae* at 14.
109 *Id.* at 374–75.
110 *Id.* at 375 (citations omitted).
pointed out that, under this argument, ERISA § 504 preempts any state law contrary to a written plan term, an outcome that “makes scant sense”\textsuperscript{111} and would “virtually read the saving clause out of ERISA.”\textsuperscript{112} The Court, citing \textit{Metropolitan Life}\textsuperscript{113} and \textit{FMC Corp.},\textsuperscript{114} pointed out that it had repeatedly held that state laws mandating insurance contract terms are saved from preemption under §514(b)(2)(A).\textsuperscript{115}

UNUM also attempted to convince the Court that ERISA’s civil remedies preempt any action for plan benefits brought under state rules. The Court summarily disposed of this argument by pointing out that the cause of action in this case was brought pursuant to ERISA § 502(a)(1)(B). However, the Court specifically acknowledged in a footnote the United States’ argument as \textit{amicus curiae} that, notwithstanding \textit{Pilot Life}, a state law that “regulates insurance” within the meaning of the saving clause is saved from preemption even if it provides a state law cause of action or remedy.\textsuperscript{116}

However, the Court rejected the Ninth Circuit’s conclusion that the \textit{Elfstrom} rule does not “relate to” an ERISA plan and, therefore, was not preempted. The Court pointed out that the \textit{Elfstrom} rule, by “deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration.”\textsuperscript{117} Therefore, the \textit{Elfstrom} rule “relates to” an ERISA plan and is preempted, though that did not affect the outcome of this case because UNUM was not prejudiced by the late notice..

\textbf{RUSH PRUDENTIAL HMO, INC. v. MORAN, 536 U.S. 355 (2002)}

In \textit{Rush Prudential HMO, Inc. v. Moran}, the Court held that Illinois’s independent review law was not preempted as a law that “relates to” an ERISA plan because it “regulates insurance” within the meaning of ERISA’s saving clause.

The Court explained that there is a presumption against preemption that informs the saving clause analysis. According to the Court, the “unhelpful drafting” of ERISA’s preemption and saving clauses require that the ordinary meaning of these “antiphonal phrases” be qualified by the assumption that “the historic police powers of the states were not meant to be superseded unless it was the clear and manifest purpose of Congress.”\textsuperscript{118}

The Court stated that the Illinois independent review law “related to” an ERISA plan because it “bears indirectly but substantially on all insured benefit plans (citation omitted) by requiring them

\textsuperscript{111} Id.
\textsuperscript{112} Id. at 376.
\textsuperscript{113} 471 U.S. at 758.
\textsuperscript{114} 498 U.S. at 64.
\textsuperscript{115} Id. at 375–376.
\textsuperscript{116} Id. at n.7.
\textsuperscript{117} Id. at 379.
to submit to an extra layer of review for certain benefit denials” and would be preempted unless it “regulates insurance” within the meaning of the saving clause.

The Court held that an HMO is both a health care provider and an insurer. By underwriting and spreading the risk of treatment costs among the HMO participants, the HMO performs a traditional insurance function. The fact that an HMO may also provide medical services or that it may transfer some of its risk to the providers does not take the HMO out of the insurance business. The Court also recognized that Congress intended for state insurance laws to apply to HMOs and that most state insurance departments are primarily responsible for the regulation of HMOs. The Court stated that the application of the law to HMOs acting solely as administrators did not lead to preemption of its application to HMOs acting as insurers.

The Court applied the three McCarran-Ferguson factors, pointing out that all three factors are not required in order for a law to regulate insurance within the meaning of the saving clause. The Court confirmed its “common sense” conclusion by observing that the statute met at least two of the three factors: (i) it regulated an integral part of the policy relationship between the insured and insurer by providing “a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO’s medical obligations” and (ii) the statute was aimed at a practice limited to entities within the insurance industry for the same reasons it satisfied the common sense test.

The Court then addressed the Pilot Life doctrine. While acknowledging the “extraordinary preemptive power” of ERISA’s civil enforcement provisions, the Court also noted that the saving clause was “designed to save state law from being preempted.” The Court explained that the Illinois law does not “supplement or supplant the federal scheme by allowing beneficiaries to obtain remedies under state law that Congress rejected in ERISA” because the Illinois law “provides no new cause of action under state law and authorizes no new form of ultimate relief.”

The Court made clear that even though deferential review is “highly prized by benefit plans,” ERISA does not require that a plan’s benefit determinations be discretionary or receive deferential review. The Court stated that the Illinois law effectively “prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract’s terms” and

119 Id. at 365.
120 Id. at 367.
121 Id.
122 Id. at 367–69.
123 Id. at 371–72.
124 See discussion of Metropolitan Life v. Massachusetts, supra.
125 536 U.S. at 373, citing UNUM, supra, 458 U.S. at 129.
126 Id. at 373–74.
127 Id. at 374.
128 Id. at 376.
129 Id. at 375.
130 Id. at 378 (internal quotations omitted).
131 Id. at 379.
132 Id. at 384–87.
in this way, “is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption.”133 The Court observed further that, in contrast to a traditional arbitration proceeding, the law “does not give the independent reviewer a free-ranging power to construe contract terms.” Instead, the law established a process that relied on a qualified professional’s determination of medical necessity that was not adjudicatory in nature and did not conflict with ERISA’s exclusive remedy.134

The Rush Prudential Court ruled that the Illinois independent review law is not preempted. However, the Court left open the possibility that a state independent review scheme might conflict sufficiently with ERISA to be preempted. Rush Prudential involved a state review process that resolves only disputes concerning application of medical judgment. Also, the Court mentioned that a state law would be preempted if it imposed “procedures so elaborate, and burdens so onerous that they might undermine [ERISA’s civil enforcement provisions].”135 However, this concession is made only after the Court stated its view that state independent review laws, while entailing different procedures, would not impose unacceptable administrative burdens so as to be preempted.136 The Court explained that disuniformities are the inevitable result of the congressional decision to save state insurance laws and that HMOs have to establish procedures for conforming with local laws in any event.137

In the years following the Rush Prudential decision, external review requirements have become a standard health insurance consumer protection, and in the Affordable Care Act, Congress not only mandated that insurers comply with applicable state external review laws, incorporating them by reference into federal law,138 but also established a federal external program for self-funded ERISA plans and for insured health plans in states that did not have external review laws consistent with the NAIC Uniform External Review Model Act.139


In Kentucky Association of Health Plans v. Miller, the Court held that Kentucky’s “any willing provider (AWP)” laws were not preempted under ERISA because they “regulated insurance” within the meaning of ERISA’s saving clause, §514(b)(2)(A). In reaching this conclusion, the Court announced a new test for determining whether a state law regulates insurance, and in so doing, announced a clean break from over 15 years of saving clause precedent.

At issue were two Kentucky AWP laws: one requiring that health insurers include in their networks all providers willing to agree to the terms of the contract; and another requiring that insurers

133 Id. at 386.
134 Id. at 383.
135 Id. at 381 n.11.
136 Id.
137 Id.
138 PHSA § 2719(b)(1).
139 Id. § 2719(b)(2).
offering chiropractic benefits include in their networks all chiropractors willing to accept the terms of the contract.

In determining that Kentucky’s AWP laws regulated insurance, the Court announced a new two-part test for determining whether a state law regulates insurance. The first part of the new test requires that the state law be “specifically directed towards entities engaged in insurance.” To explain this test, the Court referred to its previous opinions in *Pilot Life*, *Rush Prudential* and *FMC Corp.* In order for a state law to be “specifically directed toward” the insurance industry, the state law must be more than a law of general application with some bearing on insurers. But even a law specifically directed at the insurance industry must regulate an insurer with respect to the insurer’s insurance practices.

Further, the Court made clear that a state law’s impact on non-insurers is not inconsistent with the requirement that a law be “specifically directed toward” the insurance industry and does not take the law outside the scope of ERISA’s saving clause. The Kentucky Association of Health Plans argued that Kentucky’s AWP laws were not specifically directed at the insurance industry because of: (1) their impact on providers; and (2) their application to “self-insurer or multiple employer arrangements not exempt from state regulation by ERISA” and HMOs that provide administrative services only to self-insured plans. The Court rejected these arguments.

The Court observed that all laws that regulate insurers will have some impact on entities that have relationships with those insurers, including laws the Court held regulated insurance in *FMC Corp.* and *Rush Prudential*. With respect to the scope of the Kentucky AWP laws, the court pointed out that ERISA’s saving clause requires that a state law “regulate insurance,” not “insurance companies” or the “business of insurance.” Therefore, the fact that Kentucky’s AWP laws apply to self-insurers and multiple employer welfare arrangements, which are entities engaged in the same kind of risk-spreading activities as are insurance companies, does not forfeit the laws’ status as laws regulating insurance within the meaning of the saving clause. ERISA’s deemer clause prevents states from regulating self-funded ERISA plans that they could otherwise regulate.

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141 *Id.* at 342.
142 *Id.* at 334–335.
145 *Id.* at 334–335.
146 *Id.* at 335–336.
147 *Id.* at 336 n.1.
148 *Id.*
149 *Id.* at 335.
150 *Id.* at 336 n.1.
151 *Id.*
152 ERISA § 514(b)(2)(B).
153 538 U.S. at 336 n.1.
The Court employed this same analysis to explain that Kentucky’s AWP laws are “specifically directed towards” the insurance industry, even though they apply to HMOs administering self-insured plans. The Court concluded that the activity of administering a self-insured plan, which the Court already explained engages in risk-spreading functions identical to insurers, is sufficient to bring the HMO within the activity of insurance for the purposes of ERISA’s saving clause, even though the deemer clause would prevent a state from applying the law to a self-funded plan.\textsuperscript{154}

Further, the Court in \textit{Rush Prudential} had previously explained that Congress did not intend for overbreadth in the application of a state law to remove a state law entirely from the category of state regulation saved from preemption.\textsuperscript{155}

The second part of the new saving clause analysis requires that the state law “substantially affect the risk pooling arrangement between the insurer and the insured.” This new test is a “clean break from the McCarran-Ferguson factors”\textsuperscript{156} and does not require that the state law actually “spread risk,”\textsuperscript{157} or “alter or control the actual terms of insurance policies” in order to regulate insurance within the meaning of the saving clause.\textsuperscript{158} The Court explained that Kentucky’s AWP laws meet the second part of the new test by “alter[ing] the scope of permissible bargains between insurers and insureds in a manner similar to the mandated benefit laws we upheld in \textit{Metropolitan Life}, the notice-prejudice rule we sustained in \textit{UNUM}, and the independent review provisions we approved in \textit{Rush Prudential}.”\textsuperscript{159}

The practical effect of the Court’s new two-part test on state laws remains to be seen. Perhaps the fact that the McCarran-Ferguson factors are no longer a part of the preemption analysis will result in more laws being considered laws that regulate insurance within the meaning of the saving clause. On the other hand, the McCarran-Ferguson factors were only guideposts used to reinforce the common-sense understanding of whether a law regulated insurance, and a rigid interpretation of the risk-spreading factor, in particular, had already been set aside by the Court in \textit{UNUM} and \textit{Rush Prudential}. More than a decade later, the full impact of this change to the preemption test remains uncertain, and continues to be disputed in the lower courts.

\textbf{AETNA HEALTH INC. v. DAVILA,} \textit{542 U.S. 200 (2004)}

In \textit{Aetna Health Inc. v. Davila}, the Supreme Court revisited the question first raised in \textit{Pilot Life}, and reaffirmed that ERISA’s exclusive remedy preempts conflicting state laws even if the law is a statute expressly directed toward the insurance industry. Although the Court has still never squarely held that any state law actually falls within the \textit{Pilot Life} exception to the Saving Clause, it made clear that if any law providing an alternative remedy for ERISA plan participants were found someday to regulate the business of insurance, it would nevertheless be preempted.\textsuperscript{160}

\textsuperscript{154} \textit{Id.}

\textsuperscript{155} \textit{Id.}

\textsuperscript{156} \textit{Id.} at 341.

\textsuperscript{157} \textit{Id.} at 339 n.3.

\textsuperscript{158} \textit{Id.} at 338.

\textsuperscript{159} \textit{Id.} at 338–339.

\textsuperscript{160} \textit{Aetna Health Inc. v. Davila, 542 U.S. 200 (2004)}, decided together with \textit{CIGNA HealthCare of Texas, Inc. v.
In 1997, the Texas Legislature enacted a provision in its Civil Practice and Remedies Code establishing that a health insurance carrier, HMO, or other managed care entity has a duty to exercise ordinary care when making health care treatment decisions, and creating a private cause of action for insureds and enrollees who claim to be harmed by a carrier’s negligence. Juan Davila filed suit against Aetna, his employer’s insurer, alleging that he suffered a severe reaction to a pain medication he had taken because Aetna required “step therapy” and refused to cover a safer medication that his doctor had prescribed. Aetna removed the case to federal court, but the Fifth Circuit remanded it to state court, ruling that the claim denial was not an ERISA fiduciary decision and that the tort remedy under Texas law had no counterpart in ERISA and therefore did not conflict with ERISA’s exclusive remedy.

The Supreme Court reversed, holding that by its nature, an ERISA benefit determination is generally a fiduciary act, and the “fact that a benefits determination is infused with medical judgments does not alter this result.” Rejecting the plaintiffs’ argument that “ordinary care” was a separate statutory duty under state law that was independent of the benefit determination, the Court concluded that the Texas law “related to” an ERISA plan and was preempted because it conflicted with “Congress’ intent to make the ERISA civil enforcement mechanism exclusive.” The Court did not decide whether the law “regulated insurance” within the meaning of the saving clause. Instead, after noting that the plaintiffs had not made that argument in the lower courts, the Court held that even if the Texas law could “arguably be characterized as ‘regulating insurance,’” the exclusive remedy clause would still control over the saving clause.

The Court cited Rush Prudential v. Moran for the proposition that “a comprehensive remedial scheme can demonstrate an ‘overpowering federal policy’ that determines the interpretation of a statutory provision designed to save state law from being pre-empted. ERISA’s civil enforcement provision is one such example.” Although the Court was unanimous, Justice Ginsburg issued a concurring opinion, joined by Justice Breyer, urging Congressional action to correct “an unjust and increasingly tangled ERISA regime” leaving “a regulatory vacuum” in which “virtually all state law remedies are preempted but very few federal substitutes are provided.”

_Calad_, involving an action brought under the same Texas statute by a CIGNA enrollee.

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162 _Roark v. Humana, Inc._, 307 F.3d 298 (2002). The _Roark_ companion case did not reach the Supreme Court with _Davila_ and _Calad_ because the Fifth Circuit upheld removal on the ground that the complaint also included a count for breach of contract, which was completely preempted by ERISA, giving rise to federal jurisdiction over the entire case (a warning for practitioners). A fourth companion case involved a governmental plan, so ERISA did not apply.

163 542 U.S. at 219.

164 _Id._ at 215.

165 _Id._ at 216.

166 _Id._ at 217–218.


168 _Id._ at 222 (Ginsburg, J., concurring) (citations and internal punctuation omitted).
**METROPOLITAN LIFE INS. CO. v. GLENN,**

554 U.S. 105 (2008)

In *Metropolitan Life Ins. Co. v. Glenn,* the Supreme Court held that the principles set forth in *Firestone* still apply when the benefit plan is fully insured. If the insurer has been granted valid discretionary authority, it is entitled to deference when its decisions are reviewed in ERISA litigation, notwithstanding the inherent conflict of interest that arises from its status as “a plan administrator [that] both evaluates claims for benefits and pays benefits claims.” However, that deference is more limited than the deference that would be given to an independent decisionmaker, and the court must apply a “combination-of-factors method of review” that gives due consideration to the conflict.

Wanda Glenn filed a claim under her employer’s group long-term disability policy, issued by Metropolitan Life. The insurer found her to be unable to perform her job duties and awarded benefits for two years, but once the policy’s two-year “own-occupation” period had expired, she was required to prove that she was able to perform “the material duties of any gainful occupation for which [she was] reasonably qualified” in order to continue receiving benefits. At the insurer’s request, Glenn had applied for Social Security disability benefits, which are also based on an “any occupation” standard, and the Administrative Law Judge found her eligible, ruling that she was disabled “from performing any jobs [for which she could qualify] existing in significant numbers in the national economy.” Nevertheless, the insurer conducted an independent review, decided that Glenn was insufficiently disabled, and denied benefits. After Glenn’s internal appeals were denied, she filed suit under ERISA.

Pursuant to a discretionary clause, the insurer was designated as Claim Fiduciary and was granted “discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.” The insurer argued that its self-interest in the outcome of claim disputes should not diminish the deference that administrators with discretionary authority are granted under *Firestone,* because the employer had

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169 At this writing, the Supreme Court has not yet addressed whether states retain the power under the saving clause to enact laws preventing insurers from being granted discretionary authority. However, all the Circuit Courts of Appeals that have considered the issue have upheld state prohibitions against discretionary clauses in insurance policies. See p.100 below.

170 *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105, 112 (2008). Similarly, in *Conkright v. Frommert,* 559 U.S. 506, 513, the Court held that after an administrator’s decision is set aside as an unreasonable interpretation of the plan documents, its new decision is still entitled to deference and is not tainted by the prior adverse findings.

171 Id. at 118.

172 Id. at 109.

173 Disability policies contain offset clauses, so that when the beneficiary is eligible for Social Security disability benefits, what the insurance provides is income enhancement from the level provided by Social Security to the level guaranteed by the policy. The policies require beneficiaries to apply for Social Security when it is available.

174 554 U.S. at 109.

175 Id.

176 Brief of Petitioner at 3. The NAIC Prohibition on the Use of Discretionary Clauses Model Act (Model No. 42) was amended in 2004 to include disability policies within its scope, but some states either permit discretionary clauses or prohibit them only for medical insurance policies. Challenges to the validity of laws prohibiting discretionary clauses are discussed below in the FAQ, at Page 100.
approved the terms under which the Plan would be administered by the same company that was paying the benefits.\footnote{554 U.S. at 112.} It argued further that when claim decisions are made by a professional insurance company, paying claims is its business and the market provides strong incentives to make accurate claim decisions.\footnote{Id. at 114.}

The Court agreed that the insurer was entitled to deference under \textit{Firestone}, and that its self-interest in the outcome did not require \textit{de novo} review of its claim denials.\footnote{Id. at 116.} It did not consider the possibility that a \textit{Firestone} “discretionary trust” analysis might not be the best way to decide whether an insurer has complied with its contractual obligations under an insurance policy,\footnote{See Brief of Amicus Curiae NAIC at 20–21. The only time the Justices used any form of the word “contract” was in a string citation in a dissenting opinion, describing one of the cited cases as involving a “pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics.” 554 U.S. at 123 (Roberts, C.J., dissenting in part and concurring in the judgment).} when the insurer is not merely the administrator of the contract but one of the parties. However, the Court held that there is an inherent conflict of interest when “a plan administrator both evaluates claims for benefits and pays benefits claims,” and that conflict “must be weighed as a factor in determining whether there is an abuse of discretion.”\footnote{554 U.S. at 111–12 (internal punctuation and citations omitted).}

Thus, a nuanced, case-specific, multi-factor analysis is required. The Court held that the Sixth Circuit had properly applied this standard, enumerating the various factors that were weighed, including in particular “the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency’s finding.”\footnote{Id. at 118.} Therefore, the Court affirmed the ruling that Glenn was entitled to reinstatement of her benefits.


In \textit{Gobeille v. Liberty Mutual Ins. Co.}, the Court held that states cannot require self-insured ERISA plans or their third-party administrators to participate in all-payer claims databases, which provide a comprehensive resource intended to track substantially all health care expenditures in the state.

Vermont’s law was challenged by two insurance companies, but neither of them was acting in its capacity as an insurer.\footnote{Therefore, the Court did not consider the question of whether the saving clause protects such laws as applied to insured plans.} The plaintiff, Liberty Mutual, provided a self-funded employee health plan for its 80,000 U.S. employees. Fewer than 200 were located in Vermont, so Liberty Mutual was below the mandatory reporting threshold. However, the plan was administered by Blue Cross Blue Shield of Massachusetts (BCBSMA), which had enough TPA activity in Vermont that it was
required to report claims to the database on behalf of all of its Vermont clients.\footnote{Gobeille v. Liberty Mutual Ins. Co., 136 S.Ct. 936, 942 (2016).} Liberty Mutual instructed BCBSMA not to report any information from the Liberty Mutual plan, and sought a declaratory judgment that the statute was preempted by ERISA.

Vermont asserted that the statute was a public health law rather than an employee benefit law, and that it did not impose any material costs on employers, so that its incidental impact on employee benefit plans did not “relate to” ERISA plans as the Court had interpreted that term in \textit{Travelers}.\footnote{Id. at 946. See supra pp. 20-21.} The Court, however, described reporting as a core obligation under ERISA, particularly so because ERISA’s regulatory scheme relies on recordkeeping and disclosure rather than on imposing substantive requirements on benefit plans.\footnote{Id. at 943–945. While this is an accurate description of the traditional ERISA approach, the Affordable Care Act has now included self-insured ERISA plans within the scope of many of its substantive protections, \textit{See} ERISA § 715, enacted by PPACA § 1563(e).} Therefore, the Court held that preemption “is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans,”\footnote{Id. at 945.} and because federal authority occupies the field, preemption does not require any inquiry into whether a particular state requirement is in fact novel, inconsistent or burdensome.\footnote{Id. Id.} Although ERISA reporting concentrates on financial matters, that does not mean reporting of health data is reserved for the states to regulate; the Court held that it is sufficient that USDOL has the authority to require reporting of health data and has chosen not to do so.\footnote{Id. at 945–946.}

Justice Breyer wrote a separate concurrence to note that USDOL’s authority to prescribe reporting requirements included the ability to collect this data for the states or to mandate compliance with state reporting requirements.\footnote{Id. at 949. Justice Thomas also concurred separately, agreeing with the majority’s interpretation of ERISA but questioning whether ERISA was constitutional. \textit{Id.} at 947.}

Justice Ginsburg dissented, joined by Justice Sotomayor. She interpreted \textit{Travelers}, \textit{Dillingham} and \textit{De Buono} as having “reined in” the “relate to” clause “so that it would no longer operate as a ‘super-preemption’ provision.’’\footnote{Id. at 958. See supra pp. 20-24 .} She observed that seventeen states already had similar laws, which “serve compelling interests, including identification of reforms effective to drive down health care costs, evaluation of relative utility of different treatment options, and detection of instances of discrimination in the provision of care.”\footnote{Id. at 951.} She criticized the focus on “the sheer number of data entries that must be reported to Vermont…. Entirely overlooked in that enumeration is the technological capacity for efficient computer-based data storage, formatting, and submission” of this information, which any insurer or plan administrator generates in the ordinary course of business.\footnote{Id. at 956.} She concluded that the law should not be preempted because it is a law that “applies to all health care payers and does not home in on ERISA plans,”\footnote{Id. at 953.} and does not
relate to or interfere with ERISA’s exclusive regulation of the management and solvency of ERISA plans or address relationships between entities that are subject to ERISA.195

Conclusion

ERISA establishes a comprehensive federal regulatory scheme for employee benefit plans. Because it was drafted primarily in response to concerns about pension mismanagement, the statutory language does not provide substantial guidance on how preemption may actually affect various forms of state laws.

Supreme Court jurisprudence has provided guidance on the relationship between the ERISA preemption, saving, and deemer clauses and state regulatory initiatives. The Kentucky Association of Health Plans case is likely to expand the courts’ view of what is encompassed by the saving clause.

Subject to some uncertainty as to how the Kentucky Association of Health Plans precedent will be applied, the following is guidance regarding whether state laws “relate to” ERISA plans and the application of the deemer clause.

- Subject to the saving clause, state laws that “relate to” employee welfare benefit plans are preempted by ERISA.
- “Relate to” means having a reference or a connection to an employee welfare benefit plan.
- A state law of general applicability that has an indirect economic influence on ERISA plans, does not “relate to” an ERISA plan and therefore is not preempted by ERISA. State laws that impose such high indirect costs on ERISA plans that the laws force ERISA plans to adopt a certain scheme of substantive coverage or effectively restrict a plan’s administration may be preempted by ERISA.
- The status of a law otherwise “saved” as a law that regulates insurance is not changed even if the law has the effect of indirectly regulating the substance of ERISA plans that purchase insurance.
- While states can regulate the business of insurance and the terms of insurance contracts purchased by employee welfare benefit plans, they cannot apply those laws directly to employee welfare benefit plans.
- A state law is “saved” to the extent that it regulates insurance even if the law’s application to noninsurers is preempted.

ERISA’s impact on a particular state law requires a case-by-case analysis of the statute in question, the parties involved, and the facts at issue.

195 Id. at 954–55.
ERISA PLAN CHARACTERISTICS AND RELATIONSHIP TO STATE REGULATION

The relevance of the preemption analysis discussed in the preceding section presupposes the existence of an ERISA-covered plan. However, not all entities meet the criteria defining an ERISA-covered plan. In addition, some arrangements that meet the criteria to be a plan are exempted from ERISA coverage generally or specifically from the ERISA preemption provisions. Such entities are generally subject to state law. Problems occur when certain operators seek to take advantage of the complexities in ERISA and illegitimately claim exemption from state laws under ERISA. It is crucial that state regulators understand what constitutes an ERISA-covered plan.

This chapter begins with an overview of the scope of ERISA’s coverage and the criteria that a benefit arrangement must meet to be an ERISA plan. In the health insurance context, ERISA addresses three specific forms of employee welfare benefit plans:

- Single-employer plans (including certain groups of closely affiliated employers);
- Multiemployer plans (plans established pursuant to bona fide collective bargaining agreements); and
- Multiple employer welfare arrangements (MEWAs).

The following pages contain discussions of these three different ways in which employee benefit arrangements can be structured and their relationship to state law. This section also includes a discussion of MEWAs and the ERISA Section 3(40)(A) exception to the definition of MEWA for plans established or maintained under or pursuant to one or more collective bargaining agreements.

Non-Covered Benefit Arrangements

Certain types of benefit arrangements are not covered by ERISA, even though they meet the basic defining criteria for employee welfare benefit plans because of the nature of the plan or the nature of the employer. For example, ERISA exempts plans maintained solely for the purpose of

196 State insurance regulators may seek assistance from the DOL’s Employee Benefits Security Administration Office of Regulations and Interpretations by requesting a formal or informal opinion on the scope of ERISA preemption as it applies to a particular arrangement. However, this should not delay the state regulator’s investigation and enforcement action. A DOL Advisory opinion is helpful, but it is only advisory, based on assumed facts, and is not required as the basis to issue an enforcement action.

197 It should be noted that many MEWAs are not actually employee welfare benefit plans, a fact which is recognized by the statutory definition. ERISA requirements for employee benefit plans do not apply directly to a MEWA which is not a plan, although the DOL has taken the position that each employer participating in a non-plan MEWA sponsors its own plan. See MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation, FR Doc. 2013-04863, www.dol.gov/ebsa/pdf/mwguide.pdf (MEWA Guide). State insurance regulators should not assume that an arrangement that has made filings with the DOL or taken other measures purporting to comply with the requirements for ERISA-covered plans is actually covered by ERISA, even if the arrangement’s managers sincerely believed their arrangement was an ERISA plan.
compliance with state workers’ compensation, unemployment, and disability laws. ERISA also excludes governmental plans and church plans.

Regulators will find that some arrangements obviously fall under the governmental and church plan exceptions to ERISA coverage, such as state employees’ retirement and health plans, plans covering police and firefighters, and plans covering employees of a specific church. However, many more plans fall outside the coverage of ERISA than may be immediately obvious. For example, many hospitals are publicly funded, and their plans may be governmental plans under ERISA. The same is true of public educational institutions. Similarly, many hospitals, schools, and nursing homes are owned by religious organizations. The plans that these organizations offer may be church plans.

Plans excluded from ERISA coverage normally fall within the jurisdiction of the state unless they are specifically excluded under state statutes. Knowledge of the exclusion of certain types of plans from ERISA may be useful when a state wishes to assess the potential impact of legislation on entities within the insurance department’s jurisdiction, or seeks to assist a consumer who may appear at first glance to be covered by an ERISA plan.

**General Characteristics of an ERISA Plan**

The statutory definition of an employee welfare benefit plan outlines four elements. State insurance regulators should look for whether each of the elements are met when analyzing whether an arrangement is a plan, fund, or program:

- established or maintained;
- by an employer or by an employee organization, or by both;
- for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits;
- to participants or their beneficiaries.

Arrangements that do not meet the definition of an ERISA plan and whose activities fall under the state’s definition of the business of insurance must acquire a state certificate of authority as an insurer or cease operations. Such arrangements that do not comply with state law are subject to the unauthorized insurer statutes of the various states.

As with much of the language in ERISA, the definition of employee welfare benefit plan raises more questions than it answers. The administrative and judicial branches have been left with the

199 See Advocate Health Care Network v. Stapleton, 581 U.S. ----, 137 S.Ct. 1652 (2017) (holding that plans established and maintained by church-affiliated hospital systems were church plans).
200 The implications of the “governmental plan” exclusion, for example, are not always taken into consideration in drafting or implementing state legislation, resulting in a lack of clarity as to the nature and scope of regulatory oversight of self-funded state and local governmental plans.
task of providing guidance to state insurance regulators and legislators, insurance industry representatives, and employers on what makes an arrangement an employee welfare benefit plan within the meaning of ERISA.

To provide guidance, the DOL has issued regulations discussing certain payroll practices, including those related to group benefits, and advisory opinion letters. Circuit courts have issued a number of opinions, which have also helped somewhat to clarify the meaning of the term. Below is a review of some of the criteria that DOL and the circuit courts have identified as useful in determining whether an arrangement is an ERISA plan.

**Plan, Fund, or Program Established or Maintained Requirement**

The first element of the definition of an employee welfare benefit plan is whether an arrangement is a “plan, fund, or program” that has been “established or maintained.” The Eleventh Circuit specifically discussed this requirement in the much-cited Donovan v. Dillingham. In its analysis, the court stated that the minimum criteria to use to determine whether there was a plan, fund, or program was whether there were:

- intended benefits,
- intended beneficiaries,
- a source of financing, and
- a procedure to apply for and collect benefits.

The Donovan court noted that a plan, fund, or program has been “established or maintained” if “a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.”

The Court noted that an employer does not “establish” a plan merely by deciding to offer benefits. To prove the existence of an employee benefit plan, the employer must provide evidence that its decision has actually been implemented. Furthermore, although the purchase of health insurance is substantial evidence that a plan has been established, the Court stated that it is not by itself conclusive proof.

In 1978, DOL provided guidance in the matter by issuing a safe harbor regulation for certain group arrangements. An employer or employee organization providing group health insurance has not established an employee benefit program if all four of the following criteria apply:

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203 Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982). At issue in Donovan was whether the District Court had subject matter jurisdiction to decide if a particular multiple employer trust was subject to the fiduciary requirements of ERISA. The Eleventh Circuit held that the District Court did have subject matter jurisdiction. The Court stated that a consensus existed among the courts, congressional committees, and the Secretary of the U.S. Department of Labor that multiple employer trusts are generally not employee welfare benefit plans. Id. at 1372. However, they may be subject to ERISA’s fiduciary responsibilities if they are fiduciaries to employee benefit plans established by others, such as in this case. Id. at 1372 n.10.

204 Id. at 1372.

205 Id. at 1373.

206 Id.
• No contributions are made by an employer or employee organization;
• Participation [in] the program is completely voluntary for employees or members;
• The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
• The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.207

In Johnson v. Watts,208 the First Circuit discussed the “established and maintained” requirement in the context of this regulation. It specifically focused on the meaning of the third criterion of employer neutrality. The court stated that the employer “would be said to have endorsed a program ... if, in light of all the surrounding facts and circumstances, an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but had exercised control over it or made it appear to be part and parcel of the company’s own benefit package.”209

In this case, the court held that the employer had not endorsed the program although it had collected premiums through payroll deductions, remitted insurance premiums to CIGNA, issued certificates, kept track of employee eligibility, distributed sales brochures and other materials necessary for enrollment, and recommended enrollment through a letter to employees in which the letter specifically stated that the decision was exclusively the employees’. The court also noted that the employees paid the entire cost of their own insurance, and that the employer did not participate in designing the plan, working out its structural components, determining eligibility for coverage, interpreting policy language, investigating, allowing, and disallowing claims, handling litigation, or negotiating settlements.210 The court contrasted the facts in this case with the facts of Hansen v. Continental Ins. Co.211 In Hansen, the employer performed many of the same functions as the employer in Johnson. Nevertheless, the court held that the employer had endorsed the plan because the employer had distributed material about the insurance program in a booklet embossed with the corporate logo. In addition, the booklet referred to the plan as the company’s plan.212

Other courts that have considered this question have focused on similar factors in their analysis when determining whether an arrangement has been established or maintained. Specific indications that have been identified as particularly relevant are evidence of whether:

• the employer intended to provide benefits on a regular and long-term basis;
• the employer financially contributed to the plan; and

208 Johnson v. Watts, 63 F.3d 1129 (1st Cir. 1995).
209 Id. at 1135.
210 Id. at 1135–36.
212 Johnson, 63 F.3d at 1137.
• the employer had sufficient involvement with the administration of the plan.\textsuperscript{213}

**Employer or Employee Organization Requirement**

The second element is whether an arrangement is sponsored by an “employer or employee organization.” An arrangement is not an ERISA plan unless the entity that establishes or maintains it is an employer or employee organization of the individuals covered by the plan.

**Direct and Indirect “Employers”:** Although the statute refers to a plan established or maintained by “an employer,” the term “employer” is defined in ERISA as “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”\textsuperscript{214} Thus, the sponsor of an ERISA plan could be an “indirect employer,” such as an employer association. Historically, DOL and the courts construed this term narrowly, requiring that to be a bona fide employer association “acting ... indirectly in the interest of an employer,” the employers that constitute the association must have direct or indirect control over the benefit plan. DOL has identified a variety of factors that are relevant to determining whether a bona fide employer association exists. These factors include:

- how members are solicited;
- who is entitled to participate and who actually participates in the association;
- the process by which the association was formed;
- the purposes for which it was formed;
- what, if any, were the preexisting relationships of its members;
- the powers, rights, and privileges of employer members that exist by reason of their status as employers; and
- who actually controls and direct the activities and operations of the benefit program.\textsuperscript{215}

Associations of otherwise unrelated employers established for the purpose of sponsoring a profit-making plan which is made generally available and which is not controlled by employer members do not meet the definition of bona fide employers, and their plans are not ERISA plans.\textsuperscript{216}

In October of 2017, President Trump issued an Executive Order directing the Secretary of Labor to “consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs [Association Health Plans]” and to “consider ways to promote AHP formation on the basis of common geography or industry.”\textsuperscript{217} In June of 2018, DOL adopted a new Final Rule entitled “Definition of ‘Employer’ Under Section


\textsuperscript{215} Department of Labor Opinion 94-07A re: United Service Association for Health Care (Mar. 14, 1994); see generally MEWA Guide, supra note 197.

\textsuperscript{216} Id.

\textsuperscript{217} Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, EO 13813, October 12, 2017.
3(5) of ERISA—Association Health Plans,“218 which makes “bona fide group or association of employers” a formal legal term, and establishes the following criteria for “bona fide” status:

- It “must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits”; however, offering and providing health coverage as its primary purpose is no longer inconsistent with “bona fide” status;219
- Each participating employer must be the direct employer of at least one participating employee; however, working owners (partners, shareholders, and sole proprietors) are considered employees for this purpose if they work at least 20 hours per week or 80 hours per month, or earn enough from the business to pay for the coverage;220
- It must have “formal organizational structure with a governing body and has by-laws or other similar indications of formality”;221
- Employer control of both the association and the health plan “must be present both in form and in substance”;222
- Member employers must either be in the same trade, industry, line of business, or profession, or be located in the same region within a single state or metropolitan area;223
- Coverage must be limited to current or certain former employees and their beneficiaries;224
- It may not engage in underwriting or rating discrimination on the basis of health status, nor use a facially neutral criterion such as geography as a pretext for prohibited discrimination. This prohibits experience rating at the employer level, but does not prohibit occupation or industry rating based on aggregate claims experience; 225 and
- It may not be a health insurance issuer, nor be owned or controlled by an issuer; this does not prohibit an issuer or its affiliate from being a member employer.226

The Rule is effective September 1, 2018, for fully insured plans, on January 1, 2019, for existing non-fully-insured plans, and on April 1, 2019 for all other plans. The accompanying DOL Fact Sheet describes the Rule as providing “a new pathway” for establishing AHPs, while it also “retains the existing AHP pathway.”227 In other words, the criteria set forth in the Rule are a safe harbor that will entitle the AHP’s sponsor to recognition as a “bona fide” group or association, but arrangements qualifying as employee benefit plans under prior DOL guidance will continue to be recognized as employee benefit plans. The Rule’s Preamble explains that it “provides an additional

219 29 CFR § 2510.3-5(b)(1).
220 Id. §§ 2510.3-5(b)(2) & (e)(2)(iii). Except for purposes of participation in AHPs, working owners and their spouses are not considered “employees” for purposes of ERISA. Id. § 2510.3-3(c). HIPAA permits partners to be covered by group health plans as employees, but sole proprietors may only be covered as non-employee participants; therefore, a sole proprietor is ineligible to buy small group health insurance without at least one other employee who is not his or her spouse. 42 U.S.C. § 300gg-21(d).
221 Id. § 2510.3-5(b)(3).
222 Id. § 2510.3-5(b)(4).
223 Id. §§ 2510.3-5(b)(5) & (c).
224 Id. § 2510.3-5(b)(6).
225 Id. § 2510.3-5(b)(4).
226 Id. § 2510.3-5(b)(4).
mechanism for groups or associations to meet the definition of an ‘employer’ and sponsor a single ERISA-covered group health plan; it is not the sole mechanism.”

Thus, the Rule and accompanying guidance create two different types of AHPs: “Traditional Pathway” AHPs formed under the pre-2018 guidance (sometimes called “Pathway One”) and “New Pathway” AHPs formed under the Rule (sometimes called “Pathway Two”).

The Traditional Pathway does not simply grandfather existing AHPs. DOL “emphasizes” that this alternative continues to be available for newly formed employer associations that seek to establish AHPs, which is important because the two Pathways are subject to different requirements. That is a consequence of DOL’s position that the nondiscrimination provisions in the AHP Rule are not necessary for associations that comply with the pre-2018 DOL guidance, because the “pre-rule sub-regulatory guidance had a stronger employer nexus requirement.” In particular, DOL permits experience rating at the member employer level for “Traditional Pathway” AHPs that follow the pre-2018 guidance – regardless of when the AHP was formed – as long as experience rating is not used as a pretext for discriminating against a particular employer or plan participant.

Employee Organizations: An employee organization may also establish or maintain an employee welfare benefit plan. The statute defines “employee organization” to mean:

any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose, in whole or in part, of establishing such a plan.

The meaning of the term “employee organization” was discussed in Bell v. Employee Security Benefit Ass’n. At issue in Bell was an association that claimed that it offered an employee welfare benefit plan. The Kansas Commissioner of Insurance filed suit to enjoin the association from conducting business in Kansas on the ground that the association was offering insurance, not an employee benefit plan. The court found for the Commissioner of Insurance.

In analyzing whether the association was an employee organization, the court looked at (1) the participation of the employees, (2) the purpose of the organization, and (3) the relationship among the employees. The court found that the employees had no meaningful participation in the activities of the association and the organization did not exist, in whole or in part, for the purpose of dealing with employers since there was no employer interaction at all with the plan. Additionally, in inquiring whether the organization was an employees’ beneficiary association, the court noted that commonality of interest was a dominant factor in the analysis. The court found that there was no commonality of interest among the employees since the association did not limit the benefits to

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228 Preamble to AHP Final Rule, 83 F.R.28916 (emphasis in original).
229 Id.
230 Id. at 28928 n.40.
any particular employer, union, or industry, but made the benefits available to any individual who was employed. Consequently, the entity did not meet the definition of an employee organization.

**Purpose Requirement**

The next element is the “purpose” requirement. The ERISA statute delineates the specific welfare benefits that are covered under ERISA. The plan must be established or maintained for the purpose of providing “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or any benefit described in section 186 (c) [referring to Taft-Hartley trusts] of this subchapter (other than pensions on retirement or death, and insurance to provide such pensions).”

As mentioned previously, however, ERISA specifically exempts plans maintained solely to provide disability, workers’ compensation, and unemployment compensation.

**Participants Requirement**

The last element is the “participants” requirement. This last requirement relates to whether the benefits are provided to plan participants or their beneficiaries. The statute defines a participant as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.”

There is no threshold requirement in the text of ERISA for the number of participants that an employee benefit plan must have. There are DOL opinions and case law that suggest that a plan can have as few as one employee participant and still be governed by ERISA. ERISA defines “employee” to mean a person who works for salary or wages under the control and direction of an employer. Generally, this is determined on the basis of the common-law employment tests the courts have developed. However, DOL has issued regulations establishing that a business is not an “employer” for ERISA purposes unless it has at least one common-law employee who is not a working owner or working owner’s spouse. Confusingly, although it is possible for a

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233 *Id.*
235 29 U.S.C. § 1003(b) (2018). For more information on state regulation of these benefits see discussion in Questions & Answers About Insurance Department Jurisdiction.
237 *See, e.g.*, *Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991).
239 *See infra* p. 69.
240 29 CFR § 2510.3-3. The PHS act allows partners (but not sole proprietors or sole shareholders) to be treated as employees for purposes of access to the small group health insurance market, and the DOL rule was amended in 2018 to allow working owners that meet the AHP Rule’s time or income threshold to be deemed their own employees for the limited purpose of allowing them to buy coverage as AHP member employers. 29 CFR § 2510.3-3(c), referencing *Id.* § 2510.3-5(e).
spouse to meet the common-law employment standard, the term “common-law employee” is often used to mean an employee meeting the more restrictive ERISA standard.

Conclusion

As the discussion above indicates, evaluating whether an arrangement meets each of these elements is an imprecise and complex process. Regulators will want to be familiar with ERISA statutory and regulatory provisions, DOL advisory opinions, and the relevant case law applicable to their state. In this analysis, it is particularly important to determine who is the plan sponsor and whether or not the plan is in fact providing benefits to the sponsor’s employees (if it is an employer) or members (if it is an employee organization). If the arrangement does not meet the requirements of the statutory definition or falls within a statutory exception, then the state must evaluate the appropriate application of state laws. Determining that an arrangement is an ERISA plan, however, does not end the analysis.

The form of the organization that sponsors the plan will also have a significant impact upon the applicability of state law. The remainder of this section will include a description of each of the three types of health-related employee welfare benefit arrangements: single-employer plans, multiemployer plans, and multiple employer welfare arrangements, and will highlight ERISA’s relationship to Taft-Hartley trusts.

Single-Employer Plans

Characteristics of a Single-Employer Plan

A single-employer plan is one that is sponsored by one employer for its employees.²⁴¹ However, a plan operated by two or more employers under common ownership or control may also be considered a single-employer plan for purposes of ERISA. The statute refers to “businesses within the same control group” and defines control group to mean a “group of trades or businesses under common control.”²⁴²

The term “common control” must be defined by DOL in a manner consistent with section 414(c) of the Internal Revenue Code.²⁴³ Factors that DOL considers in determining whether two or more employers are under common control include whether the employers are affiliated service groups or “share ownership interests in such a way as to be within the same control group.”²⁴⁴ Those trades or businesses with less than 25 percent ownership interest do not meet the standards for common control.²⁴⁵

²⁴¹ Technically, the term “single-employer plan” is defined in ERISA to mean any plan that is not a multiemployer plan. Paradoxically, this definition would include MEWAs, if they are employee benefit plans. 29 U.S.C. § 3(41) (2018) However, this Handbook will follow ordinary usage and use “single-employer plan” to mean an employee benefit plan that covers only one employer and its affiliates.


²⁴⁵ See MEWA Guide, supra note 197.
**Single-Employer Plans and State Regulation**

State insurance regulators faced with a suspected unauthorized health insurance operation should look to determine the true status of a purported “single-employer plan.” In the first instance, it is the obligation of the insurance licensee to ensure that the health benefit arrangement into which he or she is placing an employer and its employees is either insured with an authorized insurer, or that is a single-employer, self-funded plan.

Conceptually, a “single-employer plan” seems intuitive: it is a plan in which the employees (and their eligible dependents) of an individual employer are afforded certain [health] benefits pursuant to contract. The employer can be a sole proprietor, a partnership, a corporation, or some other entity. For the limited purpose of this definition, it does not matter whether the benefits are provided via an authorized insurer (fully insured) or are paid from the funds of the employer (self-funded). However, that distinction is important for other analyses, such as determining state insurance regulatory jurisdiction. As might be expected, a plan marketed to the general public by an insurance agent is highly unlikely to be a “single-employer” plan.

ERISA preempts state insurance regulation to the extent that the state law or regulatory measure would directly regulate a self-funded single-employer plan. The convergence of a true single-employer plan with true self-insurance results, in the context of health coverage, in an ERISA-qualified plan over which state insurance regulators do not have direct regulatory authority.

Persons, including licensed insurance agents, who promote unauthorized insurance under the guise of “ERISA covered plans” have come to recognize that if they are to sound plausible at all, they must at least use the term “single-employer plan.” Unfortunately, many times the only real relation to a single-employer plan is that terminology. Health arrangements that do not meet the requirements for being a single-employer ERISA plan are subject to the unauthorized insurer statutes of the various states.\(^{246}\)

As noted in the discussion of MEWAs below, some employee leasing companies and professional employer organizations claim to offer “single-employer plans” under ERISA to their clients, but such an arrangement will almost certainly be a MEWA for ERISA purposes.\(^{247}\) Other types of operations have claimed to “employ” each enrollee, usually to promote the plan or ostensibly some product or service. In those situations, it is usually quite apparent that the “employment” is pro forma.

True single-employer plans are not required to comply with state benefit mandates or solvency standards, nor may they be required to pay premium taxes and assessments, or adopt complaint resolution procedures which might otherwise be required by the state, except to the extent that the ERISA plan uses insurance arrangements to provide its benefits. The states may regulate the insurer and the insurer’s contracts used by a single-employer ERISA plan (in accordance with the


\(^{247}\) Some states have chosen to treat such plans as single-employer plans, but that is a matter of state law and is not mandated by ERISA. Those states usually require a license or registration.
“saving” provision in the statute), but may not regulate the ERISA plan directly (in accordance with the “deemer” provision in the statute).

Conclusion

ERISA plans sponsored by one employer or employers under common ownership or control are exempted from state laws as a result of ERISA preemption. Since the critical analysis of whether a single-employer plan exists usually arises when analyzing a suspected unauthorized insurer claiming ERISA exemption from state insurance regulation, these statutory definitions serve as a starting point for any analysis. Two other forms of arrangements—multiemployer plans and MEWAs—are also governed by ERISA. They each have their own unique characteristics and relationship to state law.

Collectively Bargained Multiemployer Plans

Characteristics of a Multiemployer Plan

As used in ERISA, the term “multiemployer plan” does not simply mean a plan maintained by more than one employer. ERISA draws a fundamental distinction between multiemployer plans, discussed in this section, and multiple employer welfare arrangements (MEWAs) discussed in the next section. The terminology is confusingly similar, but the difference is important because “multiemployer plans” are exempt from state regulation, while MEWAs are not. To qualify for ERISA’s multiemployer plan exemption, an employee benefit plan must be maintained pursuant to a collective bargaining agreement between one or more employee organizations and must have more than one contributing employer.248

As a practical matter, multiemployer plans are plans jointly established by employers and labor organizations. These are commonly referred to as “union plans.” In order for a plan to be exempt from regulation as a MEWA, regulations adopted by the U.S. Department of Labor require at least 85% of the plan participants to have an employment nexus through a bona fide collective bargaining agreement. In addition to active employees who are represented by the union, this employment nexus may include several ancillary categories of permitted plan participants such as retirees, management employees, and employees of the union.249 Whether the agreement is a bona fide collective bargaining agreement is a fact-specific inquiry based on such factors as the terms of the agreement, the status of the parties, and the nature of the bargaining process.250 As discussed above, plans operated by businesses under common control are considered single-employer plans, not multiemployer plans, even if contributions are made pursuant to a collective bargaining agreement. Multiemployer plans receive contributions from unrelated employers who make the contributions for participants. Those plans are usually administered by a board that consists of employer and union trustees.

249 See “Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,” 29 CFR § 2510.3-40(b)(2)(i) through (x). The history and purpose of this regulation is discussed more fully in the next section of the Handbook, on Multiple Employer Welfare Arrangements.
250 See discussion of plans maintained pursuant to collective bargaining agreements, MEWA Guide, supra note 197.
Multiemployer Plans and State Regulation

As with single-employer plans, the ability of states to regulate multiemployer plans is very limited. Generally, states do not have the authority to regulate a multiemployer plan directly, although they retain the authority to regulate organizations that contract with multiemployer plans to provide benefits, including the authority to regulate the underlying insurance contracts if a multiemployer plan is fully insured or protected by stop-loss insurance. As will be discussed below in the section on multiple employer welfare arrangements, not all arrangements that ostensibly involve collective bargaining agreements are covered by ERISA or are exempted from the application of state law. They may, in fact, be multiple employer welfare arrangements and consequently, subject to state insurance law.

Conclusion

Multiemployer plans are exempted from state laws as a result of ERISA preemption. However, not all arrangements that involve collective bargaining arrangements are subject to ERISA coverage or ERISA preemption. Arrangements that do not involve bona fide collective bargaining agreements are MEWAs and are subject to state law.

Multiple Employer Welfare Arrangements

Characteristics of MEWAs

The previous sections explained that benefit plans operated by a group of affiliated employers under common ownership are deemed to be single-employer plans, and that certain collectively bargained plans qualify as “multiemployer plans.” With two extremely narrow exceptions, all other benefit plans involving more than one employer fall into a third category. They are classified by ERISA as “multiple employer welfare arrangements” (MEWAs). ERISA defines a MEWA as: “[A]n employee welfare benefit plan, or any other arrangement…which is established or maintained for the purpose of offering or providing any benefit described in paragraph 1254 to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries,” unless a specific statutory exception applies.

251 The exception is a plan that qualifies as a “multiemployer plan” under 29 U.S.C. § 1002(37) and 29 CFR § 2910.3-37, but is nevertheless subject to state regulation as a MEWA because it fails to meet the more stringent standards required to qualify as a plan established or maintained “under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements” under 29 U.S.C. § 1002(40)(A)(i) and 29 CFR § 2910.3-40.
252 See discussion below of the DOL Final Rules Regarding Section 3(40) of ERISA.
253 Regulators are encouraged to read the DOL MEWA Guide, supra note 197, for a more detailed discussion of MEWAs and state regulation.
254 The benefits may include, inter alia, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.
255 29 U.S.C. § 1002(40)(A) (2018). The only exceptions, other than the exceptions discussed earlier for collectively bargained plans and for plans that are deemed to be single-employer plans based on common ownership and control, are plans established or maintained by a rural electric cooperative or by a rural telephone cooperative association. Id. §§ 1002(40)(A)(ii) & (iii).
MEWAs have had a troubled history since the enactment of ERISA. Originally, with the exception of the collectively bargained “multiemployer” plans discussed earlier, ERISA did not draw any distinctions between single-employer and multiple employer benefit plans. While Congress had intended that multiple employer plans be set up at the grassroots level by small business owners and local unions, Congress had not anticipated the involvement of third party promoters using multiple employer plans as profit making vehicles. The 1977 Activity Report of the House Committee on Education and Labor indicates that abuses started almost as soon as ERISA became law in 1974.256 The lack of adequate consumer protection standards at the federal level and misunderstanding the scope of ERISA preemption of state laws facilitated abusive and fraudulent practices by MEWAs that resulted in significant sums of unpaid claims and the loss of health insurance for participants.

Congress enacted the Erlenborn-Burton Amendment in 1983 because of a concern regarding the financial insolvency of multiple employer welfare arrangements and a desire to remove impediments to action by state regulators to prevent those abuses. The amendment saved state regulation of MEWAs from ERISA’s preemption and deemer provisions,257 permitting state insurance regulators to regulate risk-bearing MEWAs as insurance companies. The extent to which state law applies to a MEWA depends on whether the MEWA is an ERISA covered plan and on whether it is “fully insured” or not.

The definition of MEWA is broad. It includes both ERISA plans and “any other arrangement.” An “arrangement” might involve a specific legal entity that has undertaken to provide coverage, which might be issued a “MEWA” license by a state. In other cases, the essence of “the MEWA” might be a contractual agreement between two legal entities - an insurance company and an association – each of which has its own independent existence and many other activities outside the MEWA. But there is also an infinite variety of other ways that an “arrangement” can be created without such a clearly defined formal structure.

This broad definition of MEWA encompasses both fully insured MEWAs (such as association group insurance and multiple employer trust group insurance) and non-fully insured MEWAs. It should be noted that MEWAs that are not fully insured are typically funded by their participating employers. If the premiums collected from employers are insufficient, the entity responsible for payment varies according to the structure of the MEWA. It might be a third party such as a PEO, but often, the employers themselves are jointly and severally responsible for any shortfall. And in the worst-case scenario, participating employers and employees, and their health care providers, discover only after a MEWA collapses that nobody has assumed responsibility for the unpaid claims, or that the responsible entity named in the contract has had its assets stripped, is out of reach of U.S. creditors, or never actually existed.

One common source of confusion is ERISA’s inconsistent use of the term “employer.” There is a statutory definition, but it is circular: an “employer” is an entity that acts directly as an “employer” or indirectly in the interest of an “employer.” This definition, which clarifies that a “group or association of employers” may sponsor a benefit plan, recognizes both “direct” and “indirect”

256 COMMITTEE REPORT, supra note 16.
employers, and it subjects indirect employers to the same regulatory requirements as direct employers when they sponsor benefit plans. However, ERISA occasionally uses the term “employer” more narrowly, as it is used in ordinary English, to mean a direct employer. This is most obvious in the definition itself, which would not make sense if the phrase “common-law employer or bona fide employer group or association” were substituted for “employer” throughout. DOL has issued two separate rules construing the definition of “employer”: one, issued in 1975, provides criteria for qualifying as a direct employer, while the other, issued in 2018, provides criteria for qualifying as an indirect employer.258

The distinction between direct and indirect employers is most important as it applies to the concept of a “multiple employer” welfare arrangement. The fundamental purpose of ERISA’s MEWA clause was to create a distinction between plans with a single direct employer (including a single group under common ownership and control) and plans covering multiple direct employers. Congress would not have gone to the trouble of creating a specific regulatory framework for MEWAs that are employee benefit plans if recognition of the sponsoring association as an “indirect employer,” qualifying the arrangement for “Plan” status, would mean the arrangement was not a MEWA. In the preamble to its 2018 AHP Rule, DOL has reaffirmed at length that all AHPs are MEWAs, even though a “bona fide” association is deemed to be “an employer” for purposes of employee benefit plan sponsorship, and as such, are subject to state regulation, as discussed more fully below.259

In practice, MEWAs are commonly formed by several types of entities. Associations of employers in a common trade, industry or profession (e.g., bankers, retail grocers) often make health plans available to employer members and their employees, as do associations that have no employment related commonality. Professional employer organizations describe their business as co-employing a client workforce. Employee leasing firms describe their business as leasing employees to a variety of unrelated business.260 PEOs or employee leasing firms may also sponsor health plans for these employees. An employee leasing or PEO arrangement can relieve smaller employers from the administrative costs of personnel and payroll record keeping, and the PEO’s or leasing organization’s benefit plans can make pricing economies of scale available to an employer that would otherwise be only a very small group purchaser.261 In the few specific PEO or employee leasing arrangements that the DOL has reviewed, the focus of the review was whether the PEO was acting as a plan sponsor. The DOL has consistently determined those plans to be MEWAs, regardless of whether they are also ERISA plans. The 2018 AHP Rule is unlikely to have a material impact on PEO health plans, because a PEO cannot qualify under the Rule as a “bona fide” AHP unless it is controlled “both in form and in substance” by its client employers.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a filing requirement for MEWAs, and the Affordable Care Act (ACA) added a requirement that MEWAs

258 29 CFR §§ 2510.3-3 & 2510.3-5.
259 See, e.g., Preamble to AHP Final Rule, 83 F.R. 28917, 28919 & n.18, 28936–37, 28942, 28959.
260 However, some state laws use the single term “PEO” or “employee leasing” to encompass both business models. These laws may deem the client to be a co-employer or to be the sole employer notwithstanding any language to the contrary in the contract between the client and the PEO or employee leasing company.
261 See discussion below regarding self-funded PEO plans’ status as MEWAs notwithstanding the claim made by some PEOs to be sponsoring single-employer plans.
which are not group health plans in their own right must register before they may do business. The Form M-1 filing requirement is designed to keep the DOL informed about MEWAs’ compliance with the requirements of Part 7 of ERISA (including the provisions of HIPAA, the Mental Health Parity Act, the Newborns’ and Mothers’ Health Protection Act, and the Women’s Health and Cancer Rights Act). The one-page Form M-1 is filed with DOL once a year online, usually on March 1. The MEWA M-1 forms that have been filed with DOL are accessible online at http://www.askebsa.dol.gov/mewa. The ACA also strengthened federal enforcement authority over MEWAs by giving DOL the power to issue cease and desist orders, summary seizure orders, and orders restoring state regulatory authority that would otherwise be preempted by ERISA or by the Risk Retention Act.

**MEWAs and State Regulation**

**MEWAs that are not Employee Benefit Plans:** Whether a MEWA is itself an ERISA covered plan or not, the states have authority to regulate MEWAs. If the MEWA is not an ERISA covered plan, ERISA places no limits on state regulatory authority over the MEWA. A MEWA does not qualify as an ERISA-covered plan unless it is “established or maintained by an employer or employee organization.” For this purpose, the term “employer” includes “any person acting ... indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.” As discussed above, DOL has issued a safe harbor rule establishing criteria that qualify the sponsor of a MEWA to be recognized as “an employer,” and has also issued guidance for determining whether or not it qualifies if it does not meet the safe harbor requirements. A MEWA that is a single employee benefit plan at the association level is often called a “Plan MEWA” for short. The term “Association Health Plan” (AHP) is often used as a synonym for Plan MEWA, but is sometimes used more generically to refer to all MEWAs operated by or on behalf of associations.

**Fully Insured MEWAs that are Employee Benefit Plans:** The extent of state regulatory authority over a Plan MEWA depends on whether it is “fully insured.” A MEWA is “fully insured” when all of the benefits of the arrangement are guaranteed under an insurance contract. If a MEWA is a “fully insured” ERISA covered plan, state regulatory authority is primarily directed at the insurance policy; however, states may also enforce such requirements on the “fully insured” MEWA as minimum reserving and contribution standards. Operators of MEWAs have claimed that they and the coverage they sell are exempt from state insurance law because they are “fully insured” through arrangements such as surety bonds or reinsurance contracts. These do not meet the statutory definition because the insurer is not making any contractual promise to the beneficiaries. Furthermore, even if the arrangement is genuinely fully insured (which also means

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262 29 U.S.C. § 1021(g) (2018), as amended by PPACA § 6606. The significance of this requirement is that it provides federal jurisdiction (concurrent with the states where the MEWA does business) even if the MEWA is not a group health plan.

263 ERISA §§ 520–521, added by PPACA §§ 6604–6605.

264 29 U.S.C. § 1144(b)(6)(D) (2018) states that “a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.”

the coverage must be issued by an authorized insurer, not a surplus lines company, risk retention group, or offshore insurer), the state has full authority to regulate the terms of the insurance contract, the rates the insurer charges, and the sales practices and personnel used by the insurer. See the discussion on this specific type of scam in the section titled “Typical Illegal Operations Claiming ERISA Status.”

Non-Fully-Insured MEWAs that are Employee Benefit Plans: If a MEWA is not fully insured, even if it is an ERISA covered plan, states may generally enforce all insurance regulations, including requiring the MEWA to qualify for and obtain a certificate of authority as an insurer. Purchasing reinsurance or stop-loss coverage does not make a MEWA “fully insured.” The deemer clause does not protect Plan MEWAs from state regulation. The reason Congress has preserved state regulation of non-fully-insured MEWAs is that to the extent that the MEWA is not buying insurance, the MEWA itself is providing the insurance. Although non-fully-insured MEWAs are commonly referred to as “self-insured,” they do not truly self-insure – they insure their member employers, collecting premiums in return for a promise to pay claims.266

ERISA places only four limits on states’ authority to regulate Plan MEWAs that are not fully insured:

- A group of businesses under common ownership and control is treated as a single employer, so a plan maintained by a single control group is not a MEWA.267
- The definition of MEWAs expressly excludes three categories of plans maintained by multiple employers: rural electric cooperative plans, rural telephone cooperative plans, and plans established or maintained under bona fide collective bargaining agreements.268 The regulations governing the collective bargaining exception are discussed more fully below.
- The law may not be inconsistent with the subchapter of ERISA regulating employee welfare benefit plans. The scope of this prohibition is narrow: states may not prohibit a Plan MEWA from doing what ERISA requires, nor require a Plan MEWA to do what ERISA prohibits. The fact that a state law is more restrictive than ERISA is not enough to make the law “inconsistent.” Congress has, after all, expressly phrased this as an exception to the broad authority it has granted to apply “any law of any State which regulates insurance” to Plan MEWAs that are not fully insured.269
- Finally, as discussed more fully below, DOL has been granted the authority to issue regulations designating certain Plan MEWAs, individually or by class, as exempt from most state regulation.270 As of the writing, DOL has never exercised this authority, although the AHP rulemaking proposal requested comment on whether such exemptions would be appropriate, and the preamble to the final AHP Rule indicated that DOL views

266 Legitimate MEWAs are typically nonprofit arrangements with no assets of their own, and as such, they do not really have any “self” to insure. The participating employers do, however, take on a form of self-insurance risk. If the premiums collected are insufficient to pay all claims when due, member employers are generally responsible for the shortfall – even if the shortfall was the result of some other participating employer’s adverse claims experience.
this exemption authority as “a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule.”

No state is required to take specific legislative action in order to regulate MEWAs. States may regulate MEWAs under their general insurance statutes. However, some states have chosen to adopt MEWA-specific laws, making alternative licensing or registration frameworks available to MEWAs meeting certain statutory qualifications. Unless the state has adopted such a law, a non-fully-insured MEWA is simply a type of insurer. In either case, it is illegal for the non-fully-insured MEWA to do business without meeting the qualifications set forth in the applicable state laws and obtaining the necessary authorization in each state where the MEWA has participating employers, unless DOL issues regulations exempting certain MEWAs from state licensing requirements.

Federal Authority to Exempt Plan MEWAs from Certain State Insurance Laws: Although non-fully-insured MEWAs are currently subject to state insurance regulation even if they are employee benefit plans, Congress did grant DOL the power to issue regulations that would limit state jurisdiction in this area. Such an exemption may be granted either individually – i.e., qualifying MEWAs would be able to obtain a federal license, or its equivalent, rather than being required to obtain state licenses – or through a “class exemption” for all MEWAs meeting the criteria set forth in the regulation. As explained earlier, DOL announced in 2018 that it might consider exercising this authority for the first time, but at this writing has not yet issued or proposed any regulations. Even if DOL does decide to exercise this preemptive power in the future, states should be aware that ERISA places two significant limitations on this power:

- First, DOL’s rulemaking authority applies only to those MEWAs that meet all the qualifications for recognition as “employee benefit plans,” including but not limited to a sponsoring organization that qualifies as an “indirect employer.” States’ authority over Non-Plan MEWAs would not be restricted.
- Second, DOL may only exempt MEWAs “from subparagraph (A)(ii)” of 29 U.S.C. § 1144(b)(6), and state solvency laws are described in Subparagraph(A)(i). The consequence, as described by DOL, is that ERISA “does not allow the Department to exempt self-insured AHPs from state insurance laws that can be applied to fully-insured AHPs, i.e., laws related to reserve and contribution requirements that must be met in order for the fully-insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards.” Thus, such regulations might exempt certain MEWAs from state licensing requirements, but not from state solvency regulation.

In summary, ERISA is clear that a MEWA is subject to state insurance regulation. States may apply certain standards to “fully-insured” MEWAs, may regulate the insurer of a “fully-insured” MEWA, and continues, at this writing, to have full regulatory discretion with regard to all MEWAs that are not fully insured. Some states have enacted specific MEWA licensing statutes, but ERISA does not require the states to have done so in order to exercise their authority. The NAIC Reporting

271 Preamble to AHP Final Rule, 83 F.R. 28937.
273 Preamble to AHP Final Rule, 83 F.R. 28937.
Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation\textsuperscript{274} is designed to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs. In addition, several states have enacted specific statutory structures that govern PEOs.\textsuperscript{275}

\textit{Exception to the MEWA Definition for Collectively Bargained Plans:} As discussed above, the definition of MEWA excludes multiemployer plans that are “established or maintained under or pursuant to one or more agreements which the Secretary of Labor finds to be collective bargaining agreements.”\textsuperscript{276} Unscrupulous operators have claimed to meet this exception to the definition of MEWA to avoid complying with state laws. States should be aware that plans purportedly established through collective bargaining may in fact be MEWAs subject to state insurance laws. DOL has adopted two rules that establish criteria for determining whether a plan qualifies for the collective bargaining exceptions and establish procedures for resolving questions or disputes regarding the status of a plan.\textsuperscript{277}

\textit{History of the Collective Bargaining Exception:} Unscrupulous MEWA operators have tried to avoid state regulation by establishing sham unions as a vehicle for marketing health coverage, and claiming to be protected by ERISA’s exclusion of collectively bargained plans from the definition of “MEWA.” In other cases, they have made arrangements with legitimate unions to sell coverage under multiemployer plans to other employers and individuals who have no collective bargaining relationship with the union. During the years before the current rules were promulgated, because the statutory exemption applies only if “the Secretary find” the agreement in question to be a collective bargaining agreement, both regulators and representatives would make requests to the DOL when the status of a plan was in dispute.\textsuperscript{278}

The DOL determined that it would not make individualized findings with respect to whether specific plans met the exception for collectively bargained plans.\textsuperscript{279} In 1995, the Fourth Circuit held that the DOL did not have any statutory obligation to make individualized findings about whether a particular entity met the exception to the definition of a MEWA for collectively bargained plans.\textsuperscript{280} The DOL’s refusal to make an individualized finding in the \textit{Virginia Beach} case had the same effect as a refusal to grant the exception. The lower court found that “only if the Secretary chooses to make a finding, would a MEWA receive exemption from state regulation.”\textsuperscript{281}

\textsuperscript{274} In 1982, the NAIC adopted the Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Model Act (Model #95), to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs. However, this Model was determined to be obsolete and has been withdrawn. In 1992, the NAIC adopted the Reporting Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation (Model # 220).
\textsuperscript{277} 29 CFR §§ 2510.3-40 & 2570.150 through 2570.159. For an index of rules implementing ERISA, see https://www.dol.gov/dol/cfr/Title_29/Chapter_XXV.htm.
\textsuperscript{279} 60 F.R. 39209, August 1, 1995, Note 3.
\textsuperscript{280} \textit{See Virginia Beach,} 881 F. Supp. 1059, 1069–70.
\textsuperscript{281} \textit{Id.} at 1070.
On August 1, 1995, the DOL published a Notice of Proposed Rulemaking setting forth criteria that must be met in order for the Secretary of Labor to find that an agreement is a collective bargaining agreement for purposes of the exception to the MEWA definition.282 The proposed rule also set forth criteria for determining when an employee benefit plan is established or maintained under or pursuant to such an agreement. The DOL received many critical comments. Due to the numerous concerns raised in those comments, rather than publish a final rule, the DOL decided in 1998 to terminate the pending rulemaking and initiate a new proceeding to promulgate a rule by negotiated rulemaking. The ERISA Section 3(40) Negotiated Rulemaking Advisory Committee completed its report to the Secretary with attached draft notices of proposed rulemaking on November 16, 1999. The final rules were published in the Federal Register on April 9, 2003.283

**Final Rules Regarding Section 3(40) of ERISA:** The first rule, Employee Retirement Income Security Act of 1974; Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,284 sets forth criteria for determining whether an agreement is a bona fide collective bargaining agreement within the meaning of the exception to the definition of “MEWA”, and for determining whether a plan is established or maintained under such an agreement. The second rule, Procedures for Administrative Hearings Regarding Plans Established or Maintained Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,285 establishes a procedure whereby an entity may petition the DOL for an individualized finding when a state’s jurisdiction has been asserted against the entity through any state enforcement action.

Successful cooperation and coordination between the states and the DOL is critical to the successful implementation of these rules, and the administrative procedures rule in particular. These rules should assist state regulators in determining whether an entity legitimately meets the exception to the definition of MEWA for collectively bargained plans, or whether it is actually a MEWA that is subject to state regulation. Copies of the rules are available on the DOL website: www.dol.gov/ebsa.

**Conclusion**

ERISA has established a unique regulatory framework for MEWAs, which recognizes the states’ experience and expertise in consumer protection in the insurance context. State regulation of MEWAs has diminished the extent to which abusive practices are taking place in the MEWA market. However, because of the complex nature of ERISA, abusive practices by MEWAs have not been entirely eliminated.

Presently, some MEWAs fraudulently claim that they meet the exemption requirements for singleemployer plans or collective bargaining arrangements. MEWAs that operate fraudulently and that do not comply with state regulatory requirements harm both employers and employees, often in a relatively short period of time. Employers contributing to these fraudulent MEWAs have

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282 60 F.R. 39209.
283 68 F.R. 17472–17491.
284 29 CFR § 2510.3-40.
285 29 CFR §§ 2570.150 through 2570.159.
lost their investment in the employee benefit they sought to offer and employees are left with unpaid claims and no health insurance.

Because employee welfare benefit plans offered through single-employer plans and collective bargaining arrangements are exempted from state regulation under ERISA, effective regulation of MEWAs requires an ongoing cooperative relationship with the DOL. The states and the DOL have worked together to make great strides to curtail this fraudulent activity and maximize the effective regulation of MEWAs. In its 2018 AHP Rule, DOL acknowledged the history of abusive practices, and reaffirmed its commitment to work cooperatively with the states as more Plan MEWAs commence operation under the rule, subject to concurrent state and federal enforcement authority.
TYPICAL ILLEGAL OPERATIONS CLAIMING ERISA STATUS

Concern with unauthorized insurance activity is driven by a number of factors. Some of the factors include:

1. The ongoing, and not isolated, nature of the activity;
2. The potential for dishonest or criminal activity within the business of insurance – both with respect to the creators of the illicit plans, and those recruited to sell the plans, enroll consumers and service claims;
3. The adverse consequences to authorized insurers and other insurance licensees;
4. The potential for large quantities of unpaid claims due to dishonesty in the operation, actuarial unsoundness, or both;
5. The absence of any state or federal guaranty fund to cover the unpaid claims of an unauthorized insurer;
6. Potential issues arising out of participants’ lack of creditable coverage;
7. The public perception that it is the duty of state insurance regulators to protect them from illicit insurance schemes, and to ensure that benefits are paid as contracted.

State insurance regulators will be better able to protect the public from illicit insurance schemes if insurance departments are aware of the characteristics of some of the more common health plan scams. The following are some descriptions of typical entities that falsely claim exemption from state laws under ERISA.

Purported “Single-Employer” Plan Enrolling Consumers as “Agents”

ERISA’s preemption provision does not apply to a plan covering “agents” who are not employees of an entity. ERISA’s preemption provision, 29 U.S.C. § 1144, applies only to laws that “relate to” an “employee welfare benefit plan.”

An employee welfare benefit plan is “any plan, fund, or program established or maintained by an employer or by an employee organization for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, etc.”

“Participant” under ERISA means “any employee ... of an employer ... who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer.” Employee is defined as “any individual employed by an

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286 For example, participants might be subject to penalties in states that require enrollment in a health plan.
288 Id. § 1002(7).
employer.” The term “beneficiary” is defined as “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.”

An arrangement that purportedly provides coverage of an entity’s “agents” is an insurer under state insurance law. ERISA does not preempt state insurance regulation because:

A. The plan is not established for the purpose of providing benefits for participants (employees and former employees) and their beneficiaries. Such a plan is not an “employee welfare benefit plan” governed by ERISA. The ERISA definition of “employee welfare benefit plan” explicitly requires that the plan cover “participants” (defined as employees or former employees) and their beneficiaries. A “beneficiary” must attain his or her interest through an employee or retired employee. A plan that covers “agents” as independent beneficiaries is not an employee welfare benefit plan.

A few courts have construed the ERISA definition of “beneficiary” as permitting an employee welfare benefit plan to include anyone by its terms. However, these cases are not consistent with Nationwide v. Darden. In that case the U.S. Supreme Court rejected applying ERISA to an agent’s claim for benefits, holding that the agent was not an “employee.” The Court did not consider a contention that the agent was nevertheless a “beneficiary” because the Fourth Circuit had already disposed of that argument at a much earlier stage of the case:

“‘[B]eneficiary,’ for the purposes of ERISA, is a person other than one whose service resulted in the accrual of the benefits, but who is designated as the recipient of benefits accrued through the service of another. 29 U.S.C. § 1002(8).”

B. Such a plan is a “multiple employer welfare arrangement” and subject to state insurance regulation as provided by 29 U.S.C. § 1044 (6). A “multiple employer welfare arrangement” is defined as “an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, …” Since the consumer enrollees are not employees of the entity offering the coverage (regardless of whether they are in fact “agents”) they are either employees of multiple employers, or self-employed, and the plan is a multiple employer welfare arrangement subject to state insurance jurisdiction.

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289 Id. § 1002(6).
290 Id. § 1002(8).
C. The “agency” relationship with the enrollee consumers is usually fictitious. The enrollees in fact enroll to obtain the offered coverage, not to act as agents for the entity. The entity is an entrepreneurial operation, and therefore not an employee welfare benefit plan.\textsuperscript{295}

\textbf{Purported “Single-Employer” Plans—Out Of State Trusts and Stop-Loss Arrangements}

These plans can be described as synthetic group health insurance. By bundling together a purportedly “self-funded” employer-sponsored benefit plan, stop-loss coverage, prepackaged plan design, and third-party administrative services and setting the stop-loss attachment point so low that the “self-insured retention” can simply be treated as a routine cost of the plan the employer can pay a fixed monthly amount and obtain a defined health benefit package for its employees, just like traditional group health insurance. Indeed, these plans are designed to look just like traditional group health insurance from the perspective of the employer and employee as long as things are going well. However, once problems arise, each component of the plan is likely to point the finger at someone else, and all of them will claim immunity from state regulation.

This type of MEWA differs from the others in that the entity operating the MEWA is not necessarily acting as an insurer. Indeed, in many of these arrangements, the insurance coverage is issued by a licensed insurance company, and the MEWA’s role is focused on sales and third-party administrative services. In order to conduct effective enforcement, it is essential for states to understand how these plans work, and to make sure that their laws do not have loopholes through which these plans can escape meaningful regulation.

What this type of plan has in common with other MEWAs is that insurance coverage is packaged as something else, and then marketed under false claims of ERISA immunity from state regulation. As one marketing brochure describes it:

\begin{quote}
As the cost of health insurance sky rockets, our clients are turning to self-funding as an alternative to fully-insured health plans. Through the guidelines of ERISA, employers can take advantage of demographic discounts and good health risks. Also, through ERISA, employer can modify coverage such as mental health and chiropractor.... Once the employer has created their ERISA plan then the risk of the self-funded plan is reinsured through various markets. This allows the employer to know the maximum costs in a plan year.
\end{quote}

The most important thing for regulators to remember is that these plans are not truly self-funded, and ERISA does not preempt meaningful state regulation of these plans. Self-insurance is not something employers can buy—self-insurance simply means the employer has not bought insurance! There is no philosopher’s stone that can take the risk out of self-insurance. If someone is paying a fixed amount for a defined package of benefits they are buying insurance and ERISA reserves the right to regulate insurance to the states, even when that insurance is connected with an employee benefit plan. Some plans of this type are out-and-out frauds.

The stop-loss coverage might be placed with an unlicensed company, or might not exist at all. The employer’s “trust contributions” might be commingled with other employers’ payments, or might

go straight into the pockets of the promoters. When this level of fraudulent behavior is involved
the arrangement is not materially different from other unlicensed entity scams and should be
pursued in the same manner, although it may be necessary to address some of the jurisdictional
issues discussed below, depending on how the promoters respond.

On the other hand, as noted above, the insurance coverage is often provided by a licensed insurer.
This makes damage control easier, since there may be ways to hold the insurer responsible for
unpaid claims even though there is no direct contractual relationship between the insurer and the
covered individuals. However, the participation of a licensed insurer also lends an aura of
legitimacy to the scheme, which makes it easier for participants to argue that they didn’t know any
illegal transactions were involved.

That aura of legitimacy is misplaced. The regulatory arbitrage carried out by substituting stop-loss
coverage for traditional health insurance harms consumers, employers, and the overall health
insurance market in a number of ways, including but not limited to the following:

1. The coverage is medically underwritten. This is what makes it “affordable” – allowing a
licensed company to undercut the market price because it is not playing by the same rules.
This in turn adds to the stresses on the legitimate guaranteed-issue small employer market.
Similarly, stop-loss coverage is also exempt from small group rating laws.

2. The patient has no contractual relationship with the insurer. At worst, the shell game could
leave the claimant holding the bag with a claim against an uncapitalized shell entity. In any
event, there is no regulatory authority to resolve a claim dispute, unless the state orders the
insurer to assume direct responsibility for claims as part of its remedial action. Even if the
insurance department is prepared to do this, the consumer complaint may never be
processed correctly because the intake person takes at face value the representation that the
plan in question is a “self-insured ERISA plan.”

3. The benefit contract does not contain the dispute resolution mechanisms, minimum
benefits, or other consumer protection provisions required by state law. In fact, strictly
speaking it’s not a “contract” at all.

4. The employer may be surprised by gaps in coverage or onerous contract conditions such
as “pay when paid” clauses, and the employer remains responsible for paying the claimants
whether or not the stop-loss carrier pays the employer.

Although these plans are designed to “hide the ball” by stacking multiple layers of contracts, it is
usually fairly easy to identify who is acting as an insurer and who is acting as a producer. The hard
work, when pursuing enforcement actions, is being able to respond effectively to their defenses
and excuses:

• “It’s only reinsurance.” Recall the marketing blurb quoted at the beginning of this section:
“Once the employer has created their ERISA plan then the risk of the self-funded plan is
reinsured through various markets.” However, a contract is not legally considered
reinsurance unless the ceding company is regulated as an insurer. The point at which an
unregulated entity first cedes risk to a regulated entity is a regulated insurance transaction.  

- “This is a self-insured plan.” It is a complex web of transactions (which should already be a red flag) that, if it is “done right,” includes both a self-insured component and an insurance policy. The self-insured component of the plan will likely be of interest to federal investigators, but our concern is the state-regulated insurance policy. Our lack of authority to regulate the self-insured component of these plans is no great loss, since the self-insured component typically represents 5% or less of the dollar value and essentially none of the risk.

- “ERISA preempts state regulation of stop-loss insurance.” Although nothing in the text of ERISA or the relevant Supreme Court jurisprudence would remotely suggest such a result, the Fourth Circuit has ruled that ERISA places some limitations on how states can regulate stop-loss insurance.  
  
  American Medical Security v. Bartlett, 111 F.3d 358 (4th Cir. 1997). The NAIC has taken the position that this decision is at odds with the plain language of the ERISA saving clause, which gives the states free rein to regulate “insurance,” not just “health insurance,” and with the Supreme Court’s ERISA jurisprudence, which acknowledges that the saving clause creates “a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” Metropolitan Life v. Massachusetts, 471 U.S. 724, 747 (1985). The Fourth Circuit elaborated on this doctrine by drawing the line between insured and uninsured plans on the basis of the kind of insurance they purchase, an approach that has become even more questionable now that the Supreme Court has further clarified the broad scope of state regulatory authority in Kentucky Ass’n of Health Plans v. Miller, 123 S. Ct. 1471 (2003).

- “Your state has no regulatory interest in the insurance coverage.” This argument is based on the notion that neither the employer nor the employees are parties to the stop-loss contract, which is typically issued to an out-of-state benefit trust. However, even if a valid out-of-state trust exists (it often does not!), the employer is the real party in interest, since it is the employer’s risk that is covered by the policy.

- “Your state has no jurisdiction because the policy is issued out of state.” This is a variation on the same theme, and has no more merit than saying that the policy is governed exclusively by Delaware law if the employer establishes a Delaware corporation. These “extraterritorial” jurisdictional issues have been dealt with extensively in the traditional

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296 In some states, state statutes expressly clarify this point. In Maine, for example, “The transaction of employee benefit excess insurance does not constitute the conduct of the business of reinsurance.” 24-A Me. Rev. Stat. § 707(1)(C-1) (2018).

297 American Medical Security v. Bartlett, 111 F.3d 358 (4th Cir. 1997). The NAIC has taken the position that this decision is at odds with the plain language of the ERISA saving clause, which gives the states free rein to regulate “insurance,” not just “health insurance,” and with the Supreme Court’s ERISA jurisprudence, which acknowledges that the saving clause creates “a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” Metropolitan Life v. Massachusetts, 471 U.S. 724, 747 (1985). The Fourth Circuit elaborated on this doctrine by drawing the line between insured and uninsured plans on the basis of the kind of insurance they purchase, an approach that has become even more questionable now that the Supreme Court has further clarified the broad scope of state regulatory authority in Kentucky Ass’n of Health Plans v. Miller, 123 S. Ct. 1471 (2003).

298 American Medical Security, 111 F.3d at 365.

299 If state law regulates the policy as health insurance, the employees may also have a legal interest in the coverage.

300 If the benefit plan purports to create no liability for benefits on the part of the employer, then the trust is acting as an unlicensed, undercapitalized insurer. Perhaps because of the fiduciary liability exposure that is created, these plans tend not to be structured in this manner.
group insurance market in context of association group policies and multiemployer trust policies, and states can and should exercise the same regulatory authority here.

- “What we were selling wasn’t insurance.” The producers, licensed or unlicensed, who sell this product to the employer will try to distance themselves by claiming that they only market the ERISA plan, not the insurance. However, the employer would not buy the product if it weren’t made clear somehow that the plan is not truly self-funded. Sometimes the producer slips up and actually offers an “insurance quote” in so many words. However, even if the producer avoids that pitfall, somewhere in the marketing or application of materials there will have to be some discussion of the stop-loss coverage.

- “Any sales, solicitation, or negotiation of insurance took place out of state.” Despite the out-of-state trust documentation, the product was bought and paid for by the employer, who was almost certainly solicited at the employer’s place of business. Almost invariably, all subsequent transactions involving the employer also took place within the state.

All this being said, there is nothing inherently illegal about prepackaged partially-insured plans in which plan design, administrative services, and stop-loss insurance are marketed as an integrated product. However, both the stop-loss insurer and the producer must be properly licensed and appointed, and the insurance must be issued in compliance with all applicable state laws regulating rates, forms, and adequate disclosure to the purchaser of what the product does and does not provide. The state in which the trust is domiciled and the stop-loss policy is issued will need to be particularly diligent, since the promoters of the plan will be relying on that state’s regulatory approval, acquiescence, or lack of knowledge when dealing with regulators in the other states where the covered employers are doing business.

Which laws apply to these plans will vary from state to state. The lack of any direct contractual relationship between the insurer and the plan participants takes it outside most states’ definitions of “health insurance,” even though the self-insured retention is a nominal amount which from the employer’s perspective is simply part of the premium. Under the NAIC Stop-Loss Insurance Model Act, a stop-loss policy cannot be issued unless, among other requirements, its aggregate attachment point for small groups is at least 120% of expected claims and its specific attachment point (if there is specific coverage) is at least $20,000. In states that have adopted this model act, or a similar regulation, an insurer is prohibited from issuing a stop-loss policy with the minimal retention these schemes purport applies to their arrangements.

**Purported “Fully Insured” Plans**

This type of MEWA is in some sense the mirror image of synthetic group health insurance. In each case, there is often a reverse-fronting arrangement in which an unlicensed entity cedes risk to a licensed entity. The difference between these plans and the plans discussed in the previous section is which layer is actually acting as an insurer. In synthetic group health insurance arrangements, the fronting “single-employer” plan holds itself out as self-funded, concealing the fact that the

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301 As discussed above, *American Medical Security* prohibits states in the Fourth Circuit from classifying indirect-payment coverage as health insurance.
insurance risk is actually passed on to the stop-loss insurer. Here, by contrast, an unlicensed insurer, usually structured as a multiple employer trust, holds itself out as “fully insured” by virtue of its reinsurance arrangements.

Unlike many MEWAs, these entities will often admit to being MEWAs, because the provision of ERISA they seek to exploit applies by its terms to MEWAs. The ultimate goal is to try to have it both ways – to argue that the MEWA is exempt from regulation because it is fully insured, but then to turn around and argue that the insurer standing behind the MEWA is somehow also exempt from state regulation, even though this is the same insurer that purportedly “fully insures” the MEWA!

To see why these arguments lack merit it is necessary to analyze the relevant provision in ERISA, which does create a limited exception to states’ authority to regulate MEWAs as insurers. ERISA §514(b)(6)(A)(i) [(29 U.S.C. § 1144(b)(6)(A)(i)] provides that:

[I]n the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured ... any law of any State which regulates insurance may apply to such arrangement to the extent such law provides—

(i) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(ii) provisions to enforce such standards.

And ERISA § 514(b)(6)(D) [(29 U.S.C. § 1144(b)(6)(D)] clarifies when this clause applies by clarifying that:

[A] multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

This means that in order to be exempt from the full range of state insurance regulation, a MEWA must:

• Be an employee welfare benefit plan;
• Have a state-authorized insurer which is fully responsible for the payment of all benefits; and
• Remain subject to applicable state solvency laws ensuring the payment of benefits when due.

Most entities falsely claiming to be “fully insured MEWAs,” like most other entities making abusive preemption claims, fail the threshold test because they are not ERISA plans in the first place. While the 2018 AHP Rule significantly expands the ability of a MEWA to qualify for ERISA plan status, outright scams will still fail to meet the rule’s requirements. Nevertheless, this will not stop promoters from taking advantage of the uncertainty surrounding any significant law
change and making false claims that they qualify as “bona fide AHPs.” Regulators must never take for granted a MEWA’s claim to be an employee benefit plan. Remember that a MEWA can provide ERISA benefits without being an ERISA plan. In that case, the state can regulate the MEWA as an insurer (or if it chooses, as a state-licensed MEWA) without ERISA entering the picture at all.

Often, however, it is easier to refute the claim that the MEWA is “fully insured,” because compliance with the entire framework of state and federal regulatory requirements for fully insured plans is precisely what the promoters are trying to avoid. In particular, many such plans have claimed to be fully insured by virtue of a purported “reinsurance” contract, surety bond, or other contract between a state-licensed or surplus-lines-eligible insurer and the MEWA. However, when ERISA defines “fully insured” in terms of the insurer’s contractual guarantee that benefits will be paid, the insurer must make this guarantee to the individual plan participants, not merely to the MEWA or even to the covered employers. Furthermore, ERISA provides that a MEWA is “fully insured” only if “the Secretary determines” that the amount of all plan benefits “are guaranteed under a contract, or policy of insurance.” The Secretary has issued no such findings.

More important, even if the MEWA does qualify as a fully insured employee benefit plan, only state regulation of the MEWA is subject to preemption, not regulation of the insurer and the insurance policy that “fully insures” the MEWA and participating employers. ERISA is designed to dovetail with state insurance regulation, not to preempt it. States might not be able to regulate the MEWA as an insurer, but that is because they can regulate the insurer as an insurer. The prototypical fully insured MEWA, after all, is the traditional multi-employer group health policy. A state may, and many do, require that the insurer be licensed, the policy filed and approved, and the group policyholder meet the qualifications for permissible groups established by state law.

Although the promoters of “reverse fronting” MEWAs are eager to point out that the federal definition of fully insured MEWA is not limited to traditional group health policies, that point is not nearly as significant as the MEWA promoters make it out to be, for two reasons. First, insurers have shown no interest in offering an alternative product with the kind of endorsements that would truly guarantee the payment of all benefits to all plan participants—if they wanted to bear that risk, they would have written a traditional group health policy rather than inventing something different. And second, the kinds of guarantees that qualify a product as “full insurance” for a MEWA are the same ones that bring it within state law definitions of “health insurance.”

As noted earlier, this is no accident. MEWA promoters try to distract regulators by seizing on ERISA’s phrase “qualified to conduct business in a State,” arguing that “qualified” could mean surplus lines authority, and “a state” does not mean “every state where covered employers do business.” Let the analogy of traditional multiemployer group health policies be your guide here. As a threshold matter, the coverage must be issued in compliance with the laws of the state where the master group policy is issued. That is enough to satisfy the requirements of ERISA. Beyond that point, it is entirely up to the other states to decide whether and how their laws will apply when

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302 See USDOL Advisory Opinion 92-21A regarding MEWAs that are not “established or maintained” by an employer: MEWAs that allow participation by one-family group or other groups that are not considered employee groups under ERISA.

303 See USDOL Advisory Opinion 94-07A, United Service Association for Healthcare (Mar. 14, 1994) for further discussion of this requirement from the Department of Labor’s perspective.
their employers are covered under the policy—ERISA neither requires such regulation nor does ERISA restrict it in any way.

Finally, regulators must also keep in mind that ERISA does not preempt state solvency regulation of fully insured MEWAs. As the DOL explains in its MEWA Guide, 304 “it is the view of the Department of Labor that 514(b)(6)(A)(i) clearly enables states to subject [fully insured] MEWAs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding requirements.”

Non-Fully-Insured Multiple Employer Arrangements Claiming “Single-Employer” Plan Status—Issues Related to Professional Employer Organizations (PEOs) and Employee Leasing Companies

Whether a self-funded benefit arrangement sponsored by an employee leasing company (or professional employer organization (PEO)) is exempt from state regulation because of ERISA preemption depends upon whether the arrangement is an ERISA-covered single-employer plan or a MEWA. Under ERISA, the first inquiry of the state regarding an employee leasing company or PEO arrangement should be whether the arrangement is fully-insured or whether it is self-funded. It is important for regulators and insurers to understand that there are some fundamental differences between self-insured PEOs and self-insured traditional employers. Unlike a traditional employer, the PEO is being paid by its clients to provide this coverage, either as a separate line item or part of a global PEO service fee. Like an insurer, the PEO makes a profit or loss depending on whether the fees are sufficient to pay for the costs of the health plan, and the employer is dependent on the PEO’s ability to pay all claims when due.

Many PEOs across the country do not take on that risk, and provide fully insured health benefit arrangements with authorized carriers. These are less likely to raise regulatory concerns, but the PEO’s carrier must be licensed in every state where it does business. It is not sufficient to be licensed in the state where the PEO is based if licensure is required by the laws of one or more states where the PEO has clients. Marketing on behalf of the PEO might also require licensure as a producer if it includes the solicitation of insurance coverage.305 Rating is another issue regulators need to consider. Before the ACA, rating was controlled by state law, and states took different approaches.306 Now, community rating is required in the small group market on a uniform nationwide basis, and if federal and state definitions of “small employer” conflict, the federal definition controls for purposes of federal law.

DOL has examined a limited number of PEO or employee leasing benefit plans to date, and based on the facts and circumstances of those arrangements, has determined them to be MEWAs. If the benefit arrangement is fully-insured, the state has authority to regulate the carrier and to establish

304 See supra note 197.
305 However, the National Association of Professional Employer Organizations (NAPEO) has identified at least 14 states that have laws expressly providing that the sale of PEO services is not considered the sale of insurance.
306 For example, New York law recognizes a PEO as a single employer for purposes of offering fully-insured health coverage on a large group basis, 31 N.Y. Labor Code § 922(5), while Maine law requires each client with 50 or fewer employees to be separately rated as a small employer. 24-A Me. Rev. Stat. § 2808-B(1)(H).
certain standards for the MEWA itself. The state has far greater authority in the situation where
the MEWA is not fully-insured. Regardless of the employer status of the PEO or the employee
leasing company, the DOL has indicated in these decisions that if one or more of the client
companies is also deemed to be an employer under common-law standards, the arrangement is a
MEWA and the self-funded plan is subject to state regulation.

States may allow PEOs to self-fund, but they may not dictate how ERISA treats such plans. This
is true despite a contract purporting to designate the PEO as the sole employer, even if the PEO is
designated as the sole employer. Both state and federal law look to commonlaw factors, including
day to day control of the employees, in determining whether the clients’ businesses are in fact
acting as employers.

Some operators of PEOs occasionally cite the ERISA provision treating employers “under
common control” as single employers. However, that provision does not apply even if the PEO
can be said to manage its clients’ businesses, because client businesses are not all under common
ownership, which is the basis of the statutory test for single-employer status.307

DOL reviews plans based on the particular facts and circumstances involved. DOL has consistently
said that a PEO or employee leasing company plan cannot qualify as a single-employer plan under
ERISA unless the PEO is actually the sole common-law employer of all of the individuals under
the arrangement. The question of whether or not a common-law employer-employee relationship
exists depends upon the specific circumstances of the case. In Nationwide Mutual Ins. Co. v.
Darden,308 the Supreme Court held that federal common-law principles of employment govern the
definition of employee contained in ERISA. Whether the PEO is a “co-employer”309 is irrelevant.
If the client businesses employ the participating employees, the PEO self-funded plan arrangement
is a MEWA. In Darden, the Court held that the following factors should be considered to determine
the existence of an employer-employee relationship. Each factor must be separately weighed and
none is decisive. Moreover, the actual practices, rather than the contractual terms, are
determinative.

1. the hiring party’s right to control the manner and means by which the product is
accomplished;
2. the skill required;
3. the source of the instrumentalities and tools;
4. the duration of the relationship between the parties;

307 See 29 U.S.C. § 1002(40)(B)(2018). This assumes that the plan is sponsored by a commercial PEO, not a captive
staffing entity that is genuinely under common ownership and control with all its “clients.” Such an entity could serve
as the vehicle for a bona fide single-employer plan for a group of affiliated employers, and is outside the scope of this
discussion.
309 The DOL opinions finding PEO benefit plans to be MEWAs do not adopt the dual employment doctrine, but they
do not reject it either. The key to the analysis is that the client is an employer. Depending on the circumstances of the
particular PEO-client relationship, the PEO might also be entitled to claim an employer-employee relationship with
its leased employees, and even if the PEO does not qualify as a common-law employer, it could still be an indirect
“employer” for purposes of benefit plan sponsorship if it is acting in the interests of its clients. However, that does not
alter the plan’s status as a MEWA, because an employee may have more than one employer. See Vizcaino v. US
District Court, 173 F.3d 713, 723 (9th Cir. 1999).
The few DOL opinions on this topic have generally concluded, based on the facts of the arrangements under review, that the client businesses in these arrangements were common-law employers of the employees. Therefore, these arrangements included multiple employers and as such were MEWAs. In an opinion letter to the Virginia Department of Insurance, the DOL evaluated whether the health benefit program offered by the employee leasing company, Employers Resource Management Company, Inc. (ERM), constituted a single-employer plan or a MEWA. The DOL concluded that the arrangement was a MEWA under the facts as presented. The Department noted several non-exclusive factors which it considers when making a determination of whether the participants are employees of the client business, including who has the right to control and direct the individual who performs the services, the result to be accomplished, the means by which it is accomplished, and the right to discharge the individual performing the services. The Department also stated that the payment of wages, taxes, and provision of benefits do not, in and of themselves, establish an employer-employee relationship. It should also be noted that the enactment of the ACA means that it is not necessarily in the PEO’s interest to be treated as the “employer” for health benefit purposes, since that could make the PEO an “applicable large employer” subject to the “shared responsibility” requirement.

A PEO-operated or employee leasing company “self-funded” health benefit plan covering co-employees or “leased” employees is highly likely, under the criteria outlined above, to constitute a MEWA under ERISA. In those cases, state insurance law is not preempted and the PEO or employee leasing self-funded arrangement would be an unauthorized insurer unless it is operating solely in states that have a specific PEO regulatory scheme and it is in compliance with those regulations. Although DOL’s 2018 AHP Rule has made substantial changes in the test for

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310 Darden, 503 U.S. at 323–24. The IRS, on the other hand, applies a conceptually similar but differently phrased test for common-law employee status. Its 20-factor test is published in Revenue Ruling 87-41.

311 Similarly, in its October 2018 Notice of Proposed Rulemaking entitled Definition of ‘Employer’ Under Section 3(5) of ERISA—Association Retirement Plans and Other Multiple-Employer Plans, DOL described a PEO plan as a type of multiple-employer plan. While acknowledging that a bona fide PEO “performs substantial employment functions,” DOL advised in the PEO section of the preamble that generally, “whether a PEO is an ‘employer’ under section 3(5) depends on the ‘indirectly in the interest of an employer’ provision.” See 83 F.R. 53534, 53538–39, 53560, October 23, 2018.


313 In Maine, for example, a plan that is not fully insured may not be offered unless it is licensed as a MEWA. 32 Me. Rev. Stat. § 14055(1)(A); 24-A Me. Rev. Stat. Ann. § 6603-A. Other states, such as New York, recognize a PEO as a single employer “for purposes of sponsoring welfare benefit plans for its worksite employees.” 31 N.Y. Labor Code § 922(5). Some states, such as Oklahoma, exempt PEO welfare benefit plans from licensing requirements. 40 Okla. Stat. § 600.7.F.2. Texas requires that PEOs be licensed, and if they wish to self-insure, they must submit to an extensive
determining which entities qualify as “indirect employers” under ERISA, there have been no changes in the common-law test for the existence of a direct employment relationship. Thus, as discussed earlier, the AHP Rule is unlikely to have any material impact on the status of PEO health plans.

While the states have the authority to define employer status for the purposes of state law, it is strictly a matter of federal law whether a PEO is a MEWA under ERISA. Thus, contrary state laws are preempted. In Payroll Solutions Group Ltd. v. Nevada, a federal trial court struck down a Nevada law providing that an employee leasing company “[s]hall be deemed to be the employer of its leased employees for the purposes of sponsoring and maintaining any benefit plans, [i]ncluding, without limitation, for the purposes the Employee Retirement Income Security Act of 1974.” The court held that the Nevada law “impermissibly declares that benefit plans offered by employee leasing companies, such as defendants’, that are in all respects Multiple Employer Welfare Arrangements (‘MEWAS’) under state and federal law shall nevertheless be legally deemed single employer plans (‘SEPs’) for purposes of ERISA,” because “[o]nly federal law may determine what is a SEP or a MEWA under ERISA.”

314 See, e.g., 31 N.Y. Labor Code § 922(5), supra, which provides that “[a] fully insured welfare benefit plan or plans offered by a registered professional employer organization to its employees and/or worksite employees shall not be considered for purposes of state law a multiple employer welfare arrangement.” (Emphasis added.)
318 Id. at 5.
PREVENTION

As the saying goes, an ounce of prevention is worth a pound of cure; so it is with unauthorized insurers. Getting the word out to the public about common health insurance scams and enlisting the assistance of agents and authorized insurers in identifying potential scams are the keys to stopping these criminals before they start.

Consumer Education

One of the biggest problems regulators encounter with illegal unauthorized entities is educating the public about the problem and how they can assist in prevention. Consumer alerts, bulletins, pamphlets and public service announcements (both television and radio) are all ways to alert the public to the presence and dangers of sham health plans. Some states have undertaken entire media campaigns to educate the public, complete with billboards, and radio and television spots. For example, Florida has conducted a statewide media campaign urging Floridians to “Verify Before You Buy.” They have incorporated a cartoon figure in a gaping hospital gown with the slogan “Unlicensed Insurance –Think You’re Covered? Check to see if your company is licensed.” This cartoon is on the Florida Department of Insurance website as well as on billboards and television spots. The Nevada Department of Insurance has also implemented a media campaign designed to alert consumers to the presence of unlicensed insurers in the state. Using the image of a dark forest with red eyes peering out, the Nevada slogan cautions “Don’t fall prey to phony insurance.” There is a Nevada Insurance Alert Website that is dedicated to providing additional information about avoiding unauthorized health insurance and how to choose a licensed insurer. These media campaigns utilize simple slogans and memorable images to help alert consumers to the existence of a potential problem—a crucial first step in preventing the proliferation of unlicensed entities. Unfortunately, most consumers have never heard of unlicensed insurers until tragedy strikes.

Consumer alerts are also effective tools for educating insurance consumers. All consumer alerts should be simply worded and provide concrete examples of questions to ask when purchasing insurance as well as a list of “red flags.” All attempts to educate the public should include a name and phone number of someone to contact in the state insurance department who is able to answer any questions about unauthorized insurers. The easier it is for a consumer to alert authorities to a potential unlicensed insurer, the more likely it becomes that a consumer will make the effort. The insurance department can only stop the unauthorized entities it knows about—stop them from stealing money from their state’s consumers and taking the scam into other states to do the same thing to another state’s consumers. A sample Consumer Alert is contained in Appendix A.

Agent Education

Many unauthorized entities utilize conventional marketing channels that involve producers (e.g., agents, brokers, administrators, solicitors and others). To initiate marketing, unauthorized entities solicit producers to enter into various commission contracts. Producer information packets or bulletins developed by the unauthorized entities are often the first activities one can detect in the insurance marketplace.
It is critical that the law-abiding producer community be made aware of unauthorized insurance issues, how to recognize a potential problem or fraudulent scheme, and where to refer it. Producers are the crucial first line of defense in finding out about unlicensed entities before they start to enroll the public. Producers should obtain as much information as possible about a suspicious entity and immediately provide that information to their department of insurance.

The producer community should also be made aware of the negative civil and criminal consequences of selling an unlicensed insurance product. Once a plan has been shown to be unauthorized, most states have the ability to take disciplinary action against the insurance agents who participated in selling the plan. Such action can take the form of license revocation, a fine, or an order to make restitution. In some states, the sale of illegal insurance is a felony, so the attorney general or a district attorney may prosecute criminal charges.

A bulletin is one way to inform the producer community of the problem of unauthorized insurance, the responsibilities of the agent community to assist the insurance department in combating the problem, and who to contact in the insurance department with any information. A sample agent alert is contained in Appendix 2.

**Licensed Insurer Education**

Insurance departments should look to enlisting the assistance of licensed insurers in identifying unauthorized entities. Because of the adverse consequences suffered by authorized insurers as a result of sham plans, most are eager to aid insurance departments in this endeavor. Moreover, insurers that provide coverage to unauthorized entities may be liable under state law for claims they incur, as well as for penalties. In addition, unauthorized entities may expose insurers to liability by falsely representing that the insurer is providing coverage. Insurers should be encouraged to try to maintain procedures and controls to ensure that they do not assist unauthorized entities and to report as much information as possible about a suspected unauthorized entity. The more details that an insurer can provide the insurance department, the faster the insurance department will be able to take action against an entity and inform other states and the federal government to prevent the entity from extending its illegal activities into other states.

**Education of Other Industries**

Insurance departments should make efforts to educate other industries that may be affected by unauthorized entities. Employee leasing/PEOs and preferred provider networks should be encouraged to learn the characteristics of illegal programs, and to maintain controls and procedures to avoid assisting, or being victimized by, such an operation. Educational efforts are also particularly appropriate for small businesses and their trade associations.

**Conclusion**

The public, insurance producers and licensed companies all need to work together to bring suspicious entities to the attention of the departments of insurance. In order to make sure that the insurance department is made aware of any suspicious entities, insurance departments should make sure that the department website address is widely publicized. Insurance department websites can be a critical resource for consumers, producers, and licensed insurers. Department websites should include tools to verify whether an entity is licensed. Insurance departments should designate one
individual to answer all MEWA and unlicensed insurer related inquiries and have that individual’s contact information prominently displayed on the website. In addition, the entire department should know to refer all related inquiries to that individual. The NAIC website contains links to the individual state insurance department websites as well as a list of 50 state MEWA contacts.
ANALYTICAL CHECKLIST FOR DETERMINING STATE JURISDICTION OVER ENTITIES OFFERING HEALTH CARE BENEFITS

A state’s jurisdiction to regulate health plans depends upon whether the arrangement is a plan covered under ERISA and if so, whether it is a:

- single-employer plan;
- multiemployer plan; or
- “fully insured” or not “fully insured” MEWA plan.

Each state should adopt a procedure for identifying and classifying arrangements. States should consider requiring all arrangements providing health care and all persons (such as agents) selling such products to:

- notify the state insurance department of such arrangement’s existence;
- classify the arrangement as an arrangement not covered by ERISA, a single-employer plan, a multiemployer plan, a “fully insured” MEWA, or a not “fully insured” MEWA plan; and
- provide appropriate documentation so that the insurance department can determine whether the arrangement was properly labeled.

ERISA Analysis

The analysis of a state’s jurisdiction over an arrangement involves several key stages. These stages are outlined briefly below. Regulators may want to refer to the applicable sections of this handbook and other relevant sources when undertaking this analysis.

Step 1: Upon learning that an unlicensed entity is selling health care in your state, the first step is to determine whether the entity is offering an arrangement covered by ERISA. If the arrangement is not an ERISA plan, ERISA does not preempt state insurance regulation at all. If the plan is an ERISA plan, ERISA might preempt state insurance regulation to some degree and regulators should proceed to step 2 of the analysis.

Step 2: If the arrangement is an ERISA-covered plan, the next step of the analysis is to classify the arrangement. Determine whether the arrangement is a single-employer plan, multiemployer plan, “fully insured” MEWA plan, or not “fully insured” MEWA plan. (If the plan has come to your attention as an unlicensed entity, it is unlikely to be a single-employer plan.) After accurately classifying the plan, regulators should proceed to step 3 of the analysis.

Step 3: Once the type of plan under consideration is determined, consider the degree of state jurisdiction:

- If the arrangement is either a bona fide single-employer plan OR found by the Secretary of Labor to be established or maintained pursuant to a bona fide collective bargaining
agreement, the department may not regulate the plan. (Rural electric cooperatives and rural telephone cooperative associations are also excluded from the definition of MEWA and thus exempt from state regulation.)

- If the arrangement is a MEWA, even if it is covered by ERISA, it is also subject to state insurance regulation.
- If the arrangement is a “fully insured” MEWA, the state insurance department may regulate the insurer, the sales personnel, and the insurance contract. The state may also enforce standards such as those related to reserves and contributions.
- If the arrangement is a “not fully insured” MEWA, then the state can regulate the MEWA in the same manner that it regulates any other insurer.
- If the arrangement is subject to state insurance laws and an insurance license has not been obtained, then there is probably a violation of the state’s Unauthorized Insurers Act. Go to step (4) below.

Step 4: If the entity is in violation of the state’s Unauthorized Insurers Act (i.e., it is not a bona fide single-employer plan or bona fide collectively bargained multiemployer plan), the next step is to take the enforcement action your department would take against any other kind of unauthorized insurer offering insurance in your state. You might also check the NAIC’s database to see if the organization or its principals are in the Special Activities Database (SAD).³¹⁹

³¹⁹ For further discussion on state regulation and unauthorized entities, see NAIC’s Unauthorized Entities Manual for State Departments of Insurance.
Table: Regulatory Jurisdiction over Employee Benefit Plans

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<thead>
<tr>
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<th>SUBJECT TO FEDERAL REGULATION</th>
<th>SUBJECT TO FEDERAL AND STATE REGULATION</th>
<th>SUBJECT TO STATE REGULATION ONLY</th>
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<tr>
<td>Single-Employer Plans</td>
<td>• Sponsored by Single Employer&lt;br&gt;• Meets ERISA Coverage Test&lt;br&gt;• Not Excepted from ERISA Coverage</td>
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<tr>
<td>Multiemployer Plans</td>
<td>• Meets ERISA Coverage Test&lt;br&gt;• Is Sponsored by More Than One Employer&lt;br&gt;• Established Pursuant to a Bona Fide Collective Bargaining Agreement</td>
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<tr>
<td>Multiple Employer Welfare Arrangements*</td>
<td>• Meets ERISA Coverage Test&lt;br&gt;• Provide Benefits to Employees of More Than One Employer</td>
<td>• Does Not Meet ERISA Coverage Test&lt;br&gt;• Provides Benefits to Employees of More Than One Employer And Does Not Meet Exceptions to MEWA Definition</td>
<td>• Fully Insured: State Regulates the Insurance&lt;br&gt;• Not Fully Insured: MEWA Itself Subject to State Insurance Laws</td>
</tr>
</tbody>
</table>

*Note: Under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, Congress has granted the Secretary of the Department of Labor authority to subject multiple employer welfare arrangements that are not ERISA plans to reporting requirements.
QUESTIONS AND ANSWERS
ABOUT INSURANCE DEPARTMENT JURISDICTION

State insurance departments frequently are confronted with questions about ERISA and its relationship to state insurance regulation. Below is a quick reference guide to some of the most commonly asked questions and accompanying answers. This guide includes questions about both long-standing issues with respect to ERISA as well as questions related to contemporary concerns. Because the interpretation of the law in this area is evolving, state insurance regulators should be mindful of any recent, relevant court and administrative decisions related to these questions, which may not be reflected in this handbook.

What is a Taft-Hartley Trust?

An arrangement established pursuant to a collective bargaining agreement may be a single-employer or multiemployer plan. A Taft-Hartley trust is a multiemployer plan that, in addition to being established or maintained under or pursuant to one or more collective bargaining agreements, also meets criteria outlined in the Labor-Management Relations Act of 1947 (referred to as the Taft-Hartley Act). Regulators should be aware that plans established or maintained under or pursuant to collective bargaining agreements may be governed by both the Taft-Hartley Act and ERISA.

The Taft-Hartley Act described, among other things, the manner in which collectively bargained fringe benefits could be paid by employers to unions. The Taft-Hartley Act required the establishment of a trust administered by an equal number of management and union representatives for the purpose of paying “medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance” for employees and their dependents. \(^{320}\)

The drafters of ERISA recognized the existence of Taft-Hartley trusts and included them within the definition of employee welfare benefit plan. Taft-Hartley plans that provide accident and health benefits are, with few exceptions, employee welfare benefit plans as defined in 29 U.S.C. § 1002(1) of ERISA. As a result, Taft-Hartley plans normally must meet the requirements of both the Taft-Hartley Act and ERISA. This general rule has certain exceptions, as noted in the discussion of state regulation below.

The requirements for a bona fide Taft-Hartley trust are very specific. Familiarity with these requirements will be useful to an insurance department in determining its jurisdiction over a plan.

Characteristics of a Taft-Hartley Trust

The characteristics of a Taft-Hartley trust can be found in 29 U.S.C. § 186(c)(5). These provisions include requirements that:

- The payments contributed to the trust be used exclusively for funding benefits for employees and their dependents.\(^2\)
- The benefits provided be for medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance.\(^3\)
- The written agreement between the employer and the labor organization specify the detailed basis upon which payments are to be made.\(^4\)
- The trust be jointly administered by an equal number of persons representing the employees and employers, as well as by any neutral persons that have been agreed upon by the employee and employer representatives.\(^5\)
- The written agreement provide for an annual audit of the trust fund that is open to inspection by interested persons.\(^6\)
- Pension and annuity trusts be kept separate from health and welfare trusts.\(^7\)

Taft-Hartley trusts are required to file certain information with DOL that states may find useful to obtain as they research a particular entity. All of the reports are available to the public at the Office of Labor-Management Standards (OLMS) National Office in Washington, D.C., and the field office in the geographical district where a particular labor organization reports. These reports and documents may be given to state agencies without charge upon request of the governor of the state.\(^8\)

Labor organizations that are engaged in an industry affecting commerce, except public employee organizations, are required to adopt a constitution and bylaws and file two copies with the OLMS and an initial report (Form LM-1) giving details about the organization’s procedures, including membership qualifications, participation in benefit plans and authorization for disbursement of funds.\(^9\) These reports are required to be filed within 90 days after the labor organization first becomes subject to the Labor-Management Reporting and Disclosure Act of 1959 (LMRDA).\(^10\) Any changes to the information initially reported on the LM-1 must be filed on Form LM-1-A along with the annual financial report.\(^11\)

\(^5\) Id.
\(^6\) Id.
\(^7\) Id.
\(^9\) Id. § 435(c) (2018).
\(^10\) Id. §§ 402(i) & 431 (2018); 29 C.F.R. § 402.2 (2018).
\(^11\) 29 C.F.R. § 402.3(a) (2018).
When the initial report is filed, the OLMS assigns a six-digit file number to the organization that is shown on the annual financial reports. These reports are due 90 days after the end of the organization’s fiscal year using Form LM-2. If an organization has gross receipts of less than $200,000, the organization may file form LM-3, and with gross receipts of less than $10,000, the organization may file form LM-4.331

Persons who handle the funds of a labor organization or a trust in which a labor organization is interested must be bonded.332 Every surety company having such bonds in force must file an annual report with OLMS within 150 days after the end of the company’s fiscal year.333

The administrator or sponsor of an employee benefit plan subject to ERISA is required to file an annual return/report with the Internal Revenue Service (IRS) by the last day of the seventh month after the plan year ends.334 The IRS sends a copy of this report to the DOL Employee Benefits Security Administration (EBSA). If any benefits under the plan are provided by an insurance company, insurance service, or similar organization, a Schedule A must be attached to these forms. Schedule C details service provider and trustee information. An independent auditor’s report (IPA) must also be attached unless the plan is exempt from this requirement.335 These forms are also open to public inspection at EBSA’s Public Disclosure Room in Washington, D.C.

Valid Taft-Hartley trusts should have a discernible paper trail. When attempting to determine the validity of a claimed Taft-Hartley trust, a state may want to obtain the collective bargaining agreement, the plan document, the summary plan description which must be given to employees, IRS annual report Form 5500 with the schedules attached, the LM-1, and the LM-2, LM-3, or LM-4. The reporting labor organization must keep supporting records for five years after the OLMS reports are filed,336 and plans must retain supporting documentation for six years after reports are filed with EBSA.337 A review of these records may be useful during any investigation. While a valid Taft-Hartley trust may have failed to comply with these reporting requirements, the absence of such filings is a warning that further investigation may be warranted.

**Taft-Hartley Trusts and State Regulation**

A Taft-Hartley trust is a type of plan that usually falls under the exception to the definition of a MEWA in Section 3(40) of ERISA as a plan established or maintained pursuant to one or more collective bargaining agreements. However, a purported Taft-Hartley trust may be a MEWA, and as such be subject to state regulation, if it fails to meet the criteria established in DOL regulations to identify bona fide collectively-bargained plans. State insurance regulators should also be aware that certain legitimate Taft-Hartley trusts may be MEWAs because they fail to meet the definition of an employee benefit plan under ERISA.

The courts have permitted Taft-Hartley trusts to cover a broad range of employee classes, including employees who are not in a collective bargaining unit or whose employer does not have a collective bargaining agreement. The courts have held that a Taft-Hartley trust may include retired employees, employees and officers of a union, employees of the trust fund, and employees who are not union members in addition to the employees governed by the collective bargaining arrangement. For example, in *Doyle v. Shortman*, the court refused to bar Taft-Hartley trust coverage of employees of employer members of employer associations which did not have collective bargaining agreements with the unions and of employees who were members of other unions or who were not represented by a union. The Taft-Hartley trust may provide benefits to persons between whom the employee/employer relationship or the bargaining relationship is sufficiently tenuous as to cause the arrangement to lose its character as an employee benefit plan within the meaning of ERISA.

If a Taft-Hartley trust covers employees of more than one unrelated employer other than pursuant to a collective bargaining agreement, a state insurance department should examine the state insurance code and past interpretive opinions to determine whether the trust is subject to the department’s jurisdiction. If state law applies by its own terms, the state must determine whether the provision is consistent with, and not contrary to, the purpose of the Taft-Hartley Act.

States should be aware, however, that even if ERISA does not preempt state insurance regulation of a Taft-Hartley trust, a state may be nevertheless limited in, or prevented from, applying insurance regulation to a Taft-Hartley trust. The complex provisions of ERISA are superimposed over other laws that apply to Taft-Hartley trusts. These provisions may also prevent or impede application of state insurance regulation to Taft-Hartley trusts. Prior to the enactment of ERISA, many states included provisions in their insurance codes that explicitly exempted Taft-Hartley trusts from regulation or which have been interpreted to exempt Taft-Hartley trusts from insurance regulation. A state may have addressed this issue by administrative interpretation. While there is very little case law on this subject, state insurance departments should be aware of any statutory or administrative provisions particular to their state.

It has been argued that state insurance regulation is preempted by the Taft-Hartley Act. Unlike ERISA, the Taft-Hartley Act does not include a provision that comprehensively preempts state law. Accordingly, preemption under the Taft-Hartley Act is limited to those state provisions that actually conflict with the federal law or prevent the accomplishment of its purpose.

**Conclusion**

Genuine Taft-Hartley trusts that qualify as ERISA plans are generally exempted from essentially all state laws under ERISA. However, state regulators should be aware of two factors that may annul or limit federal preemption: an arrangement that is not ERISA-covered and an arrangement that fails to meet the ERISA 3(40) exception to the definition of a MEWA for collectively bargained plans. In those circumstances the plan may be subject to state insurance laws, absent a state law restriction.

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Can employers avoid state laws requiring workers’ compensation coverage by providing workers’ compensation through ERISA plans that also provide other benefits?

No, an employer cannot use an ERISA plan to avoid complying with a state law requiring the purchase of workers’ compensation insurance. States have the option of allowing an employer to provide mandated benefits through an ERISA plan, or requiring an employer to provide mandated workers’ compensation through a separately administered plan.

ERISA expressly excludes workers’ compensation, unemployment compensation, and state-mandated disability insurance from its purview, leaving those areas to state regulation. The literal language of this carveout only allows state regulation of a “plan [which] is maintained solely for the purpose of complying with applicable workmen’s compensation laws or unemployment compensation or disability laws.” 339 The Supreme Court recognized that those laws would be impossible to enforce if the employer could avoid the state mandate by using an ERISA plan that provides other benefits. In Shaw v. Delta Air Lines, 340 a case involving a disability plan, the Court made clear that states’ authority to regulate separate state-mandated benefit plans entails the authority to require employers to maintain such plans. The Supreme Court held that while the state cannot compel the employer to alter its ERISA plan, the state may require that an employer choose between setting up a disability plan that complies with state law and is separate from the ERISA plan or providing the state-mandated benefits through the ERISA plan. If the ERISA plan does not comply with the state’s requirements, the state may compel the employer to maintain a separate plan. 341 The ability of states to prevent employers from evading compliance with state workers’ compensation laws was reiterated by the Ninth Circuit when it stated: “The premise of the complaint in this case is that ERISA opened a loophole so that employers could avoid buying workers’ compensation insurance. It does not.” 342

Most states require employers to secure coverage of their workers’ compensation exposure either by purchasing a commercial workers’ compensation policy, participating in a state fund, establishing a state-regulated self-insurance plan, or participating in a state-regulated self-insurance group. These laws have been upheld by a number of federal courts. 343 These decisions have rejected claims that Delta Air Lines does not apply to these state laws; that it only applies to state minimum benefit requirements and not state solvency requirements; or that it has been overruled or drastically modified by subsequent Supreme Court cases, most notably District of Columbia v. Greater Washington Board of Trade. 344 The circuit courts observed that cases such as Greater Washington Board of Trade can easily be distinguished on the ground that the laws that were held to be preempted, unlike laws requiring coverage or other state-regulated security

341 Id. at 108.
342 Employee Staffing Services v. Aubry, (“Stafcor”), 20 F.3d 1038, 1039 (9th Cir. 1994).
344 District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992) (invalidating a law that required employers — even those with self-funded plans — to keep workers on the plan while they were out on workers’ compensation.)
mechanisms for state law benefits, directly infringe on such core ERISA concerns as self-funded health and pension plans.

The *Delta Air Lines* analysis applies to state laws that permit employers to use ERISA plans to provide workers’ compensation benefits, as well as to more typical laws which require that the workers’ compensation benefits be provided through a separate plan not covered by ERISA. For example, the Maine law upheld by the First Circuit in *Combined Management* allows an employer participating in state-approved 24-hour coverage pilot projects to provide comprehensive medical or disability benefits through an ERISA plan, but only upon conditions which include the employer’s consent to ongoing state financial and actuarial review of the plan to verify compliance. If at any time the plan is not found to be in compliance with state requirements, pilot project approval is withdrawn and the employer must either qualify for state approval as a self-insurer or purchase a separate insurance policy for the workers’ compensation benefits.

In states where participation in the workers’ compensation system is voluntary, employers that opt out can provide similar coverage through employee benefit plans, which (to the extent that they are bona fide employer-maintained plans) are governed by ERISA rather than state law, because they are not set up to comply with a state workers’ compensation law. Texas has developed a long line of unique cases dealing with various ramifications of this situation. South Carolina and New Jersey also have a unique approach to this issue. Cases from states such as New Jersey, South Carolina, and Texas, which have distinct approaches to this issue, must be read very carefully before assuming that their holdings have relevance to any other state’s laws.

Finally, it should be kept in mind that all of the issues involved in the determination of the status and the applicability of state regulation to a MEWA, entrepreneurial plan, labor union plan, or employee leasing arrangement apply in the workers’ compensation context as well. An unlicensed insurer’s spurious claim to be an ERISA plan may be uncritically accepted if the inquiry focuses too narrowly on questions such as “Can an ERISA plan satisfy the state’s workers’ compensation coverage requirement?” In fact, states with compulsory workers’ compensation coverage laws may find that the employers that do not seek to qualify as authorized self-insurers may be less likely than other employers to incur the expense of establishing and maintaining a genuine ERISA plan.

**Association Coverage: Is it Individual, Small Group or Large Group Coverage?**

Most people have health coverage either through their employer (ERISA-covered group health plans), or by purchasing a plan directly from an insurer (individual plans). An alternative is to obtain coverage through a membership-based organization, like an association. This coverage is often issued through a group policy, with the organization or a trustee as the master policyholder, and may be subject to state laws regulating group health insurance. This can be a source of confusion, because the phrase “group health insurance coverage” has an entirely different meaning under HIPAA and the ACA. For purposes of federal law, the distinction between “individual” and “group” coverage is not based on whether the contract is a group policy, but rather whether the
coverage is issued in connection with a group health plan. Group health plan,” in turn, means an employee benefit plan, as defined in ERISA, to the extent that the plan provides medical care.

Group coverage, in turn, is divided into small group coverage and large group coverage, based on the size of the employer. A “large” employer is usually defined to mean one with more than 50 employees, but states have the option to raise the threshold to 100 employees. Thus, all health insurance coverage is classified under federal law as either individual, small group, or large group coverage. There is no separate category for association coverage. Generally, coverage issued to an employer through an association is classified based on the size of the employer, not the aggregate number of employees covered through the association. However, as discussed below, there is an exception for AHP coverage when the AHP qualifies as an ERISA plan at the association level.

How Association Coverage is Classified

Federal law establishes a “look-through” methodology for regulating group policies issued to associations, or to any other group comprising more than one employer or more than one household; i.e., the individual, small group and large group markets are defined by the nature of the customer that buys the coverage, not by the form of the contract. In particular, the Public Health Service (PHS) Act defines the “small group market” as “the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.”

In exactly the same manner, all health insurance provided through a large employer’s group health plan, “directly or through any arrangement,” is defined to constitute the large group market.

And the individual market is defined to encompass everything else falling within the federal definition of “health insurance coverage,” whether it is written as an individual policy, a family policy, or as some type of non-employment-based group policy. The PHS Act also includes some specific “rules for determining employer size,” including an aggregation rule spelling out limited circumstances in which some (but not all) “persons treated as a single employer” for tax purposes – notably, affiliated businesses under common ownership and control – are combined for purposes of determining “small” or “large” employer status. The look-through principle reflects concerns that granting small employers the right to choose between buying community-rated small group coverage and non-community-rated large group coverage might result in adverse selection.

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345 42 U.S.C. §§ 300gg-91(b) (4). Some states make similar distinctions under state law. For example, in Maine, “individual health plans” include both individual policies and certificates under association, credit union, and discretionary group policies, except for coverage issued through an employer that is a member of an association or discretionary group. 24-A Me. Rev. Stat. §§ 2701(2)(C) & 2736-C(1)(C) (2018).
347 42 U.S.C. § 300gg-91(e)(4), as amended by PACE Act, Pub. Law 114-60. As of this writing, four states define employers with 100 or fewer employees to be “small” employers. See http://www.ncsl.org/research/health/small-business-health-insurance.aspx#small_group=50.
348 42 U.S.C. § 300gg-91(e)(5). See also ACA § 1304(a)(3) (42 U.S.C. § 18024(a)(3)).
350 Id. § 300gg-91(e)(1).
351 Id. § 300gg-91(e)(6)(A) (2018), referencing I.R.C. §§ 414(b), (c), (m) & (o). See also ACA § 1304(b)(4). (The list of referenced Tax Code provisions also expressly excludes I.R.C. § 414(n), relating to employee leasing companies.)
against the small group market. Some actuaries believe the destabilizing impact could be significant.

This framework entitles individuals to the same consumer protections whether they buy their coverage directly or through some other “arrangement” such as an association, and does the same for small employers that maintain group health plans. It reduces the opportunity for regulatory arbitrage by providing a level playing field where carriers competing for the same customers are subject to the same rules. The only way in which HIPAA recognized any difference between association coverage and coverage sold directly to individuals or employers was through limited exceptions to guaranteed issue and guaranteed renewal for coverage that “is made available ... only through one or more bona fide associations.” These exceptions allowed the insurer to deny coverage under such plans to employers that were not association members and to terminate such coverage if association membership ceased. However, the ACA repealed the bona fide association exception to guaranteed issue. The guaranteed renewal exception remains in force, but applies only to the remaining “association-only” plans that are still in force, largely grandfathered plans.

**Individual Market Coverage**

If health insurance coverage offered to an individual through an association is not offered in connection with a group health plan, it is defined in PHS Act §§ 2791(b)(5) and (e)(1)(A) as individual health insurance coverage being sold in the individual market. The ACA’s “Health Insurance Market Rules; Rate Review” final rule (Market Rule final rule) provides: “Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage.”352 This includes “mixed” associations whose membership comprises both employers and individuals; the individual members of the association are part of the individual market risk pool in the state and the carrier providing the association coverage must comply with individual market rating rules.

Until 2018, DOL regulations provided that working owners of small businesses and their spouses were not considered “employees” for purposes of ERISA.353 This meant that coverage issued to sole proprietors and sole shareholders was considered individual coverage under federal law unless the business also employed at least one person who was not the owner or the owner’s spouse.354 However, the AHP Rule amends that definition to allow a working owner to be treated as his or her own employee, for the limited purpose of participation in an AHP, as long as the owner either works in the business for at least 20 hours per week or 80 hours per month, or earns enough from the business to pay for the coverage.355

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352 45 CFR § 144.102(c).
353 29 CFR § 2510.3-3(c). See supra note 220.
354 HIPAA made group insurance available to some working owners through statutory exceptions treating partners as “employees” of the partnership for the limited purpose of buying group health insurance, and allowing those sole proprietors who qualify as “employers” to be covered as “participants” under their group policies. 42 U.S.C. § 300gg-21(d). Some state laws permit self-employed individuals to obtain coverage as “groups of 1” even if they have no other employees. The ACA also lowered the minimum small group size from 2 to 1, but the impact was more limited because a “group of 1” under federal law means one “employee” within the ERISA definition.
355 29 C.F.R. §§ 2510.3-5(b)(2) & (e)(2)(iii).
**Group Market Coverage**

Employment-related coverage, on the other hand, is classified as either small group coverage or large group coverage, depending on the size of the employer. Under the ACA, the “small group market” consists of coverage obtained “through a group health plan maintained by a small employer,” regardless of whether the employer has purchased that coverage directly or through some other arrangement, such as an association. However, because the ACA has imposed more stringent requirements on small group coverage, some association plans have sought treatment as large group plans so that they can continue offering health coverage to small employers without being subject to requirements such as modified community rating, restrictions on actuarial value (the metal tiers) and the essential health benefit package. The October 2017 Executive Order asserted that the high cost of small group insurance placed small employers at a disadvantage and that “Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance.”

The AHP Rule was adopted to implement that goal.

**Federal Guidance on Association Coverage**

The status of association plans was addressed in a CMS Insurance Standards Bulletin (CMS Bulletin) published September 1, 2011. That bulletin stated that there is no distinct category of “association coverage” under the ACA. The CMS Bulletin explains: “Although the Affordable Care Act revised and added to Title XXVII of the PHS Act, it did not modify the underlying PHS Act framework for determining whether health insurance issued through associations was individual or group health insurance coverage.” The Bulletin acknowledged that there are limited exceptions to certain provisions of the guaranteed issue and guaranteed renewal laws for coverage offered through “bona fide associations,” but emphasized that “[t]he bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market.”

The CMS bulletin also discussed “mixed” associations. A “mixed” association exists where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member’s circumstances. In this situation, the members of the association cannot be treated as if all of them belonged to same market. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members. Accordingly, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.

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356 42 U.S.C. § § 300gg-91(e)(5). Similarly, laws in some states expressly base eligibility for “small group” coverage on employer size rather than group size. See, e.g., 24-A Me. Rev. Stat. § § 2808-B(1)(D) & (H) (defining “eligible group” to include a “subgroup,” defined as “an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract.”)

357 EO 13813, supra note 217, § 1(b)(i).
The CMS Bulletin discussed how the look-through principle applies to “health insurance coverage offered to collections of individuals or employers through entities that may be called associations, trusts, multiple employer welfare arrangements (MEWAs), or purchasing alliances.” As discussed above, the statute classifies all such coverage, regardless of how it is structured, as either individual coverage, small group coverage or large group coverage, depending on whether it is sold to individuals and families, sold to small employers providing group health plans, or sold to large employers providing group health plans. But what, precisely, does the statute mean when it says that all coverage obtained “through a group health plan maintained by a small employer” is considered small group coverage, whether the employer purchases that coverage “directly or through any arrangement”? If a small employer purchases coverage through an association or other MEWA, is that the type of “arrangement” that must always be looked through?

The answer, according to the Bulletin, is “not always.” Look-through treatment is only required when there is a group health plan “maintained by a small employer,” so the key to the analysis is whether the plan is maintained at the employer level or the MEWA level. The guidance states: “CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level.” In those cases, the size of each employer determines whether the employer’s coverage belongs to the individual, small group or large group market. However, the guidance states further: “In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the ‘employer,’ the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.”

Before the 2018 AHP Rule, this exception to the “look-through” principle was not particularly significant. As the CMS Bulletin phrased it, it applied only in “rare instances.” As a result, association coverage became less prevalent under the ACA because there was little advantage to be gained from buying and selling it through associations rather than directly. However, the AHP Rule has changed the landscape significantly. DOL has reaffirmed the interpretation that health insurance offered through a Plan MEWA is considered large group coverage under the ACA, and revised the criteria for Plan MEWA status to allow a wide range of associations to qualify. Thus, all small employers in a trade or geographic area where an AHP is operating now have the option of buying “large group” coverage, and so will self-employed individuals who devote sufficient time or earn sufficient income from their business to qualify as “working owners” under the AHP Rule.

359 That is not the only possible interpretation of the statute. ERISA does not say that an association establishing an ERISA benefit plan is “the employer”; it says it is “an employer.” The ERISA definition encompasses both direct and indirect “employers,” but the existence of an “indirect employer” depends on the existence of direct employers in whose interest it is acting. The direct employer continues to be the party employing the plan participants, paying for their health coverage, and deciding which coverage to buy every year after working with its broker to review all the different AHPs and non-AHP coverage options that are available in the market, so it is not clear why employee benefit plans cannot simultaneously exist at both the employer level and the AHP level.
If the AHP Rule fulfills its goal of making the ACA market optional for most small employers and self-employed individuals, the effect is to make the states once again the primary regulators of the group insurance market, as they were before the ACA. DOL has emphasized that the AHP Rule does not have preemptive effect. For fully-insured AHPs, states can continue to apply their group insurance laws, such as benefit mandates, rating rules, and prohibitions against fictitious groups. However, state insurance laws may not prevent the application of controlling provisions of the ACA or PHS Act. Non-fully-insured MEWAs were already primarily regulated by the states, as they have always been generally exempt from all ACA requirements except the limited number that apply to self-insured plans, and DOL has reaffirmed states’ broad authority to regulate these arrangements, either as insurers or as alternative risk-bearing-entities under some specialized licensing regime. States may choose to amend their group insurance laws or MEWA laws to take advantage of the increased flexibility the AHP Rule provides in their markets, to close perceived regulatory gaps left by the diminished scope of the ACA standards, or to combine both approaches. However, these choices have been left to the states.

### Rating Requirements for Association Health Plans

If an association group policy is determined to be a “large group” policy, it is exempt from the ACA’s community rating requirements. This means the insurer is free to use claims experience and other underwriting factors when pricing the policy, except as prohibited by state law; and states do not generally regulate large group premium rates. The question then arises whether the exemption from community rating applies at the member employer level or at the association level. If the association as a whole can obtain favorable rates based on its purchasing power, but cannot deny membership or charge member employers higher rates based on health-related factors, the risk of a destabilizing impact on the community-rated market is reduced.

Large group status, as discussed above, means that all participating employees have been deemed to be employed by the “same employer” for health benefit purposes. If the association sponsors a single “group health” plan, that plan is subject to the PHS Act’s prohibitions against discrimination based on health status. In particular, “Health status,” “Claims experience,” or “Any other health status-related factor determined appropriate [sic] by the Secretary” may be used in calculating an employer’s aggregate premium, not to charge different premiums for similarly situated individuals covered through the same employer. The implementing regulation permits premiums or employee contribution rates to vary on the basis of “bona fide employment-based classifications,” such as “full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former

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360 See, e.g., Preamble to AHP Final Rule, 83 F.R. 28936, 28959.
361 See id. at 28934.
362 PHS Act § 2762; ACA §1321(d). For example, CMS issued a letter in 2013 advising the State of Washington that a state law deeming association plans to be large group coverage, and thus purporting to exempt them from community rating, was preempted to the extent that the plans in question were small group coverage under the ACA.
363 With the exception of any entities that were treated as “health insurance issuers” by CMS before the adoption of the AHP Rule but will qualify as Plan MEWAs as of 2019. It is not clear whether any such entities are in operation.
364 See Preamble to AHP Final Rule, 83 F.R. 28936, 28959.
employee status, and different occupations,” but the regulation expressly provides that “a classification based on any health factor is not a bona fide employment-based classification,” with an exception allowing favorable treatment for people with adverse health factors. Many regulators interpret these provisions as permitting the use of claim experience and other health factors only in the aggregate, at the policyholder level; and take the position that permitting association policies to be experience rated at the member employer level would contradict the premise that the association should be treated as if it were a single large employer. Insurers that seek to apply experience rating have responded that the prohibition against using claims experience applies only to “similarly situated” individuals and that treating each a member employer as a separate rating unit is permitted when it is a bona fide employment-based classification within the AHP.

In the 2018 AHP Rule, DOL established nondiscrimination requirements that prohibit experience rating at the member employer level for all “New Pathway” AHPs formed under the Rule. However, DOL indicated that it did not interpret the prohibition on experience rating as being required in all cases by the underlying statute, and that DOL would permit “Traditional Pathway” AHPs, qualifying under the pre-2018 regulatory guidance, to experience-rate at the member level, as long as it was not a pretext for discriminating against a particular employer or plan participant. DOL’s rationale is that the pre-2018 guidance “had a stronger employer nexus requirement.” Likewise, the AHP Rule does permit rating at the occupation or industry level, even if it is based on the claims experience of the different subclassifications within the AHP.

Comparing the Options for Association Coverage

The result is that DOL recognizes two different options for forming AHPs that qualify for federal recognition as large group ERISA plans. Each option is available regardless of whether the plan was formed before or after the effective date of the 2018 AHP Rule. The Traditional Pathway (“Pathway One”) has more stringent requirements for qualifying, while the New Pathway (Pathway Two”) has more stringent operational requirements. In either case, because both types of AHPs are MEWAs, they must also comply with applicable state laws; DOL has made clear that the AHP Rule does not have preemptive effect. Associations may also choose to operate outside either Pathway, either intentionally or because they fail to meet the applicable requirements. The three options are compared in the table below (for simplicity, it will be assumed that the association covers more than 50 employees in the aggregate, and that the members are all small employers or self-employed individuals):

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366 29 CFR § 2590.702(d).
367 Id.
368 Preamble to AHP Final Rule, 83 F.R.28928 n.40.
369 29 CFR § 2510.3-5(d)(5), Examples 7–9.
<table>
<thead>
<tr>
<th><strong>Status under ERISA</strong></th>
<th><strong>Traditional Pathway (“Pathway One”) AHPs</strong></th>
<th><strong>New Pathway (“Pathway Two”) AHPs</strong></th>
<th><strong>Non-Plan MEWAs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group health plan at MEWA level. Eligibility for AHP status determined under pre-2018 DOL and case law standards.</td>
<td>Group health plan at MEWA level. Eligibility for AHP status determined under 2018 AHP Rule</td>
<td>MEWA not directly regulated under ERISA, but must file Form M-1 and may be subject to indirect regulation based on role in participating employers’ ERISA plans</td>
</tr>
<tr>
<td><strong>Status under state law</strong></td>
<td><strong>Status under state law – fully insured</strong></td>
<td><strong>Status under state law – not fully insured</strong></td>
<td><strong>Coverage of self-employed individuals with no employees</strong></td>
</tr>
<tr>
<td></td>
<td>State may regulate insurer and insurance policy; AHP itself may only be regulated with regard to reserves and contributions</td>
<td>State may regulate the plan as an insurer or may adopt a MEWA-specific law</td>
<td>May not participate in the group health plan.</td>
</tr>
<tr>
<td></td>
<td>State may regulate insurer and insurance policy; AHP itself may only be regulated with regard to reserves and contributions</td>
<td>State may regulate the plan as an insurer or may adopt a MEWA-specific law</td>
<td>If they meet the “working owner” time or earnings test</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No restrictions other than HIPAA/ACA “federal floor”</td>
</tr>
<tr>
<td><strong>ACA market sector</strong></td>
<td>Large group or self-insured plan</td>
<td>Large group or self-insured plan</td>
<td>“Look through” to member’s status as small group or individual</td>
</tr>
<tr>
<td><strong>Control by members</strong></td>
<td>Employer control of both the sponsor and the AHP must be present in form and substance</td>
<td>Employer control of both the sponsor and the AHP must be present in form and substance</td>
<td>Depends on state law</td>
</tr>
<tr>
<td><strong>Commonality of interest</strong></td>
<td>Must be based on common industry and meet “bona fide group or association of employers” analysis; underwriting for health risk prohibited</td>
<td>May be based on common industry or common geography (state or metro area); underwriting for health risk prohibited</td>
<td>Depends on state law</td>
</tr>
<tr>
<td><strong>Can health coverage be the sponsoring entity’s primary purpose?</strong></td>
<td>No</td>
<td>Yes, but must have some other substantial business purpose; this can be demonstrated if association would still operate if it didn’t offer the AHP.</td>
<td>Depends on state law.</td>
</tr>
</tbody>
</table>
Experience rating at member level

Subject to state law, permitted unless a pretext for discriminating against a particular employer or individual

No

No

Other rating factors at member or participant level

Subject to state law, may use any non-health-status rating factor (including gender, occupation, and industry) unless a facially neutral criterion is used as a pretext for health status discrimination; ACA restrictions on age and geography do not apply.

Subject to state law, may use any non-health-status rating factor (including gender, occupation, and industry), unless a facially neutral criterion is used as a pretext for health status discrimination; ACA restrictions on age and geography do not apply.

Modified community rating as required under ACA individual and small group rules

Mandated benefits

Only as required by federal law for large employers and self-insured plans, or by applicable state law; EHB requirement does not apply

Only as required by federal law for large employers and self-insured plans, or by applicable state law; EHB requirement does not apply

EHB and applicable state law mandates

What is a voluntary employees’ beneficiary association (VEBA)?

A voluntary employees’ beneficiary association (VEBA) is a tax-advantaged welfare benefits funding vehicle defined under the Internal Revenue Code (IRC). Its operations are substantially devoted to providing for the payment of life, sickness, accident, or other benefits to the VEBA’s members and their dependents and beneficiaries. Membership in the VEBA is voluntary. Further, the net earnings of the association cannot inure to any private shareholder or individual other than from the payment of the benefits.

The VEBA can be established in a number of forms, such as a trust or a corporation, organized under state law. The trust or corporation must exist independent of the member employees or their employer. The employees are entitled to participate in the VEBA because of their employee status and because they have a common employment-related bond (such as covered by common employer or under one or more collective bargaining agreements or are members in a labor union). The organization must be controlled by its membership, independent trustees, or trustees designated by, or on behalf of, the members.

A VEBA may be, but is not always, associated with an employee welfare benefit plan under Title I of ERISA. To be an employee welfare benefit plan, a plan must be established or maintained by an employer or employee organization. A VEBA is not an employer association because its members are the employees, not their employers. A VEBA does not necessarily meet ERISA’s definition of an employee organization either. The fact that a VEBA has been recognized under the Internal Revenue Code does not mean that it will be recognized as an employee organization under ERISA. IRC regulations clearly state that VEBAs are not coterminous with employee beneficiary associations within the meaning of ERISA.\(^{376}\)

Further, a VEBA that is associated with an ERISA plan is likely to meet the definition of a MEWA plan, and hence be subject to state regulation, unless the plan is offered by a single employer or offered pursuant to an agreement that is found to be a bona fide collectively bargained agreement.

**What is the difference between a Multiple Employer Trust (MET) and a Multiple Employer Welfare Arrangement (MEWA)?**

The phrase “Multiple Employer Trust (MET)” has no legal meaning under ERISA. An organization that calls itself an MET is usually a MEWA (unless it qualifies as a bona fide collectively bargained plan), and is subject to state regulation to the same extent as any other MEWA.

**Is a state law that is used to regulate a MEWA preempted by ERISA?**

If the MEWA bears any risk (i.e., is a “not fully insured” MEWA), ERISA does not preempt state laws that regulate MEWAs. State laws that regulate MEWAs are applicable even if the MEWA is an ERISA-covered plan. If an ERISA-covered MEWA bears no risk (i.e., is a “fully insured” MEWA), states may regulate the company holding the risk and the state may enforce certain requirements on the MEWA, such as those relating to reserves and contributions.

Following DOL’s issuance of the AHP Rule in 2018, there have been many questions about whether the Rule has somehow changed this relationship between state and federal law, preempting state laws such as community rating or mandated benefit requirements, and laws limiting which types of association groups were eligible to purchase insurance coverage on a master-policy basis or to qualify under a MEWA-specific licensing law for exemption from the state’s traditional insurance licensing laws.

In the Preamble to the AHP Rule, DOL discussed at length the provisions of ERISA saving state regulation of MEWAs from preemption, and clarified that the Rule has no new preemptive effect.\(^{377}\) Shortly thereafter, DOL issued a compliance pamphlet that includes the following FAQ:

**Do the States have any authority over AHPs?**

Yes. ERISA expressly provides both the Department and State insurance regulators joint authority over AHPs. In addition, States can regulate health insurance issuers and the health

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\(^{376}\) 26 C.F.R. § 1.501(c)(9)-7 (2018).

\(^{377}\) Preamble to AHP Final Rule, 83 F.R. 28936–37.
insurance policies they may sell to AHPs, and they can regulate self-insured AHPs to the extent the regulation is not inconsistent with ERISA. The new rule does not diminish state oversight. Employers and plan administrators should check with the applicable state insurance department for more information on that state’s insurance laws.\(^{378}\)

**What arrangements involving multiple employers that provide health benefits on a “self-funded” basis ease the administrative burden of providing those benefits?**

Employers that provide health benefits on a “self-funded” basis often ease the administrative burden of providing those benefits by contracting for third party administrative services. This is permitted if the money for each employer is kept completely separate from those of all other employers. If the money and/or claims are transferred and commingled, the arrangements are no longer “self-funded” and the entity holding the commingled funds must be licensed as an insurer, or as a MEWA (or comparable state-specific terminology) if state law makes an alternative licensing scheme available. A pooling of risk of loss or commingling of assets to pay such losses is the essence of insurance. Unrelated employers (employers not under common control or operating pursuant to a bona fide collective bargaining agreement) that “pool” their resources have formed a MEWA and are subject to state insurance law.

**If a MEWA that is not “fully insured” covers some employees in a state, but the employers are located in another state, does the state in which the MEWA covers some employees still have the authority to regulate the MEWA?**

Whether a state has authority to regulate a MEWA that covers employees in a state when the employers are located in another state depends upon the laws of the state seeking to apply its laws. ERISA does not preempt a state’s insurance laws, including those that require an insurance company to be licensed in your state irrespective of the location of the employers and employees.\(^{379}\)

**Is the term “fully insured” defined in ERISA?**

Yes. 29 U.S.C. §1144(b)(6)(D) states: “For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a state.”\(^{380}\)

The term “benefit” when used in ERISA “uniformly refers only to payments due the plan participants or beneficiaries.”\(^{381}\) Accordingly, 29 U.S.C. §1144(b)(6)(D) requires that to be “fully

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\(^{379}\) The NAIC’s 2009 white paper *States’ Treatment of Regulatory Jurisdiction Over Single-Employer Group Health Insurance* provides a useful discussion of the issues involved in regulating employment-based coverage when the employers and employees are located in different states.

\(^{380}\) See Department of Labor Opinion 93-11A re: *Associated Builders and Contractors* (April 15, 1993).

A MEWA must have a contract or policy of insurance, which guarantees payment of benefits to the plan participants. A MEWA or trust is not “fully insured” if it has an insurance contract or policy which obligates the insurer only to make payments to the MEWA or trust.

The literal language of the statute and the legislative history strongly suggest that only an insurance contract or policy that directly obligates the insurer to the plan participants constitutes “fully insured.” This protects the participant from the consequences of defenses that arise between the insurer and the MEWA; avoids lengthy delays in claims payments while a receiver for a MEWA attempts to collect on the insurance contract or policy; marshals assets; and ensures claims of participants will be 100-percent paid.

Both judicial decisions and DOL opinions support this literal interpretation of the language and the legislative history of the statute. In Bone v. Ass’n Mgt. Services, Inc., the court pointed out that an insurer which has issued a stop-loss policy was obligated only to make payments to the employee benefit plan itself, and not to plan participants. The court concluded the plan was not an insured plan under the “deemer” clause. Similarly, the DOL has issued an advisory opinion that states a MEWA is not fully insured solely because it has a stop-loss policy. In an opinion issued to the Connecticut Commissioner of Insurance on an arrangement involving United Service Association for Health Care, the Department of Labor considered, and rejected, the contention that an insurance contract directed solely to a trust or arrangement renders the trust or MEWA “fully insured.” The Department concluded that an insurance contract creating only an obligation to the trust fails to “guarantee” directly the benefits of the participants. Also, the Department reiterated that “the question whether a MEWA is fully insured arises only if the arrangement constitutes an “employee welfare benefit plan” covered by ERISA.” Finally, note the literal language of 29 U.S.C. §1144(b)(6)(D), which states that a MEWA is “fully insured” only if the Secretary of Labor so determines.

May a state insurance department subpoena an ERISA plan’s books and records or conduct and charge for a financial examination?

A state insurance agency can subpoena an organization’s records or conduct and charge for a financial examination in accordance with its express and implied legislative authority. Because states do not have regulatory authority over single-employer plans and collectively bargained multiemployer plans, a state insurance agency does not have authority to subpoena those plan’s records or conduct and charge for a financial examination.

However, states do have authority to regulate plans that are MEWAs. State insurance departments, consequently, are authorized to subpoena MEWA plans consistent with the scope of the express and implied powers for insurance regulation granted by the legislature and subject to constitutional requirements.

384 DOL Advisory Opinion 94-07A re: United Service Association for Health Care (March 14, 1994).
Can managed care organizations that are sponsored by providers and accept insurance risk from ERISA plans be required to obtain an insurance license and be regulated under state insurance laws?

To the extent that such an organization assumes insurance risk through the receipt of a prepayment from a purchaser for the delivery or the arrangement of the delivery of health care benefit services, it is subject to state insurance laws.

The nature of the business of insurance has changed dramatically over the past several decades. The market dominance of traditional commercial indemnity insurers and Blue Cross and Blue Shield plans has been eclipsed by the dramatically increased market share of managed care plans. Managed care plans contract with the policyholder — individuals, employers, or other groups — to deliver or facilitate the delivery of health care services. In the contract, the managed care organization may also assume the insurance risk associated with the cost of providing health care benefits, or may arrange for some other entity to assume that risk.

Health maintenance organizations (HMOs) are the most prominent form of managed care organization, which assumes an individual’s, employer’s, or other group’s insurance risk. Recently, employers have begun to focus more on relationships with managed care organizations that are sponsored by providers. The organization may assume insurance risk in the process of delivering or facilitating the delivery of health care services.

Not all contractual transactions between employers and managed care organizations involve insurance risk. The distribution of risk must be an essential characteristic of the transaction in order to invoke the issues that insurance regulation is designed to address. Premium payment mechanisms through which employers transfer and distribute their risk to managed care organizations include arrangements, such as capitation, whereby the managed care organization is paid a fixed payment per member per month to cover the cost of all or some of the employee’s health care.385

Whether a state law that is applied to managed care organizations is preempted by ERISA depends upon whether that state law “relates to” an ERISA plan, and if so, if the law is “saved” as an insurance regulation. Laws that explicitly reference ERISA plans or that involve substantive ERISA requirements may “relate to” ERISA plans. Some laws that indirectly affect ERISA plans may “relate to” ERISA plans as well. However, in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,386 the Court held that a statute which has an indirect economic influence that does not bind plan administrators to any particular choice, or preclude administrative practices or the provision of uniform interstate benefit packages, is not connected with employee welfare benefit plans and does not “relate to” such plans. A state law that imposes such high costs on plans that the law restricts an ERISA plan’s choice of available insurers, or

385 For a broader discussion on other possible risk-sharing arrangements see NAIC’s white paper, The Regulation of Health Risk-Bearing Entities, developed by the Risk-Bearing Entities Working Group of the State and Federal Health Insurance Legislative (B) Policy Task Force in 1996.

forces an ERISA plan to adopt a certain scheme of coverage, may be held to “relate to” the ERISA plan.\textsuperscript{387}

While ERISA prohibits states from regulating employee welfare benefit plans, it does not prohibit states from regulating the business of insurance or insurance contracts. In \textit{Metropolitan Life v. Massachusetts},\textsuperscript{388} the Supreme Court held that a state law that mandated that insurers cover certain mental health benefits was saved from ERISA preemption.\textsuperscript{389} The Court based its analysis on the test developed under the McCarran-Ferguson Act to determine whether an entity was engaged in the business of insurance:

\begin{enumerate}
  \item Whether the practice has the effect of transferring or spreading a policyholder’s risk;
  \item Whether the practice is an integral part of the policy relationship between the insurer and the insured; and
  \item Whether the practice is limited to entities within the insurance industry.
\end{enumerate}

The Court held that the state statute was saved because the law regulated the spreading of risk; regulated an integral part of the policy relationship between the insurer and the insured; and applied only to entities within the insurance industry.\textsuperscript{390}

When a managed care organization has assumed insurance risk on behalf of an employer to deliver health care benefit services, it is involved in the business of insurance, whether the organization is sponsored by providers or not. Under an arrangement such as capitation, the employer has transferred its risk associated with the cost of providing health care benefits to the organization. In turn, the organization distributes the employer’s risk. Even if the employer states that it continues to retain the enrollee participant’s risk, under a capitated (or similar risk-sharing) arrangement the organization still accepts the employer’s risk. And, the employee receives benefits directly from the organization pursuant to the insurance risk arrangement. The capitated payment is an integral part of the relationship between the insurer and the insured. Further, the practice of assuming a policyholder’s health insurance risk is limited to entities within the insurance industry. Under \textit{Metropolitan}, a state statute that regulates the spreading of risk, governs some integral part of the relationship between the insurer and the insured, and is applied only to entities within the insurance industry is saved from ERISA preemption.

A wide variety of health care reimbursement arrangements can be devised, so there is not always a clear line between receiving compensation for health care services and assuming risk as a health maintenance organization. Factors regulators may consider are the range of services encompassed within the scope of the arrangement, whether a regulated entity is also on the risk,\textsuperscript{391} and whether

\textsuperscript{387} \textit{Id.} at 1683.
\textsuperscript{388} 471 U.S. 724 (1985).
\textsuperscript{389} \textit{Id.} at 743.
\textsuperscript{390} \textit{Id.} It should be noted that an arrangement need not meet all three of these criteria to be determined to be in the business of insurance. \textit{See Union Labor Life v. Pireno}, 458 U.S. 119, 129 (1982).
\textsuperscript{391} \textit{See}, \textit{e.g.}, 24-A Me. Rev. Stat. §§ 4331–4343 (2018), establishing a safe harbor within which an unlicensed “downstream entity” is permitted to assume a limited degree of risk if the upstream entity with direct responsibility for providing health benefits to enrollees is a licensed insurance carrier.
the provider or provider group will be performing all the covered services or whether financial risk
is being assumed for services that might need to be performed by third parties. When a managed
care organization sponsored by providers assumes insurance risk, the arrangement between the
employer and the managed care organization is not substantively different from the arrangements
employers enter into with HMOs that are not sponsored by providers. Regulators should be aware,
however, that a few state courts have held that HMOs are not engaged in the business of
insurance.\(^{392}\) Courts place significant weight on how a state’s laws classify an entity’s activities.\(^{393}\)
States should become familiar with the case law on this subject involving HMOs and should be
careful to classify as the business of insurance all insurance arrangements that involve the purposes
of insurance regulation.

**To what extent may states regulate third party administrators (TPAs) that provide
administrative services to ERISA plans?\(^ {394}\)**

The case law reviewing statutes that regulate TPAs is minimal. Of the few cases that involve state
statutes that directly regulate third party administrators of ERISA plans, the majority of the courts
have held that such statutes are preempted by ERISA. At least one court has upheld a TPA
licensing statute that established minimal criteria. However, the analysis used in existing case law
may be altered by the analysis used by the Supreme Court in *N.Y.S. Conference of Blue Cross and
Blue Shield Plans v. Travelers Insurance Co.*\(^ {395}\)

While the weight of the limited existing case law in this area is that state statutes that regulate third
party administrators of ERISA plans are preempted by ERISA, these cases were decided prior to the
*Travelers* opinion. In *Travelers*, the Court held that an indirect economic burden on plans
through taxing entities that provide services that are benefits under plans is not a sufficient
connection to trigger preemption if imposing it does not bind plan administrators to any particular
choice or preclude uniform administrative practices. State regulatory schemes related to third party
administrators that are broad in scope and indirectly affect ERISA plans may survive an ERISA
preemption analysis under *Travelers*.

Prior to the consideration of *Travelers* by the Supreme Court, at least one court permitted licensing
of TPAs of self-funded ERISA plans. This court applied an analysis similar to, but not as broad as,
the analysis used in the *Travelers* opinion. In *Benefax Corporation v. Wright*,\(^ {396}\) the TPA’s
motion for summary judgment was denied in an action for declaratory and injunctive relief from
application of the Kentucky state insurance department’s administrator licensing statute. The
Kentucky statute at issue in that case requires that administrators, as defined by the statute, meet

\(^{392}\) See *New York State Health Maintenance Organization Conference v. Curiale* 18 Employee Benefit Cas. (BNA)
1446 (S.D.N.Y. 1994) rev’d on other grounds, 64 F.3d 794 (2d Cir. 1995); but see *Anderson v. Humana*, 24 F.3d 889
(7th Cir. 1994).

\(^{393}\) See *In the Matter of Estate of Medcare HMO*, 998 F.2d 436 (7th Cir. 1993); *In re Family Health Services*, 143

\(^{394}\) This discussion on TPAs relates to non-risk arrangements. To the extent that a contract involves the TPA assuming
insurance risk on behalf of an employer, this analysis does not apply because the state unquestionably has the authority
to regulate an entity acting as an insurer, even if it calls itself an “administrator.”


minimal eligibility criteria related to age, competency and reputation, level of financial responsibility, and education. The administrator must also have paid the established fee and have not had a previous license or application terminated for cause.397

The court rejected the TPA’s argument that the state statute was preempted by ERISA and thus, the Commissioner lacked the authority to mandate a license as a requirement to conduct business in the state. The court held that ERISA did not preempt the state licensing statute. It reasoned that the statute did not “relate to” ERISA plans since the law applied to administrators irrespective of the type of plans they serviced (ERISA or non-ERISA). The court also explained that, even if the statute related to an ERISA plan in some respect, it fell within the “tenuous, remote and peripheral” exception to ERISA preemption recognized by the Supreme Court in Shaw v. Delta Air Lines.398

Other cases, however, held that state laws relating to third party administrators of ERISA-covered plans are preempted. These cases involved more significant requirements than the Kentucky statute at issue in Benefax. In Self-Insurance Institute of America v. Gallagher,399 the court held that Florida statutes regulating plan administrators were preempted by ERISA because the laws did not regulate the business of insurance. In Gallagher, the Self-Insurance Institute of America (SIIA) objected to a series of state statutes that imposed various requirements upon contract administrators of ERISA employee benefit plans. Among other things, the regulations required that administrators enter into written agreements and identified what must be contained within such agreements. The regulations also required that administrators pay a bonding fee, obtain a certificate of authority to conduct business, and file extensive organizational and financial information.

SIIA asserted that the Florida statute that governed activities of SIIA members was preempted by ERISA. The state argued that the statute regulated insurance and therefore was not preempted by ERISA. The Eleventh Circuit affirmed, without opinion, the district court’s holding that the state's law did not regulate the business of insurance. Consequently, the administrative requirements imposed on employer/plan sponsors or contract administrators of ERISA plans, were preempted by ERISA.

In E-Systems, Inc. v. Pogue,400 the appeals court upheld a district court opinion that granted summary judgment to plan sponsors challenging the Texas Administrative Services Tax Act (ASTA), enjoined further enforcement of the statute as it applied to ERISA plans, and held that the act was preempted by ERISA. The ASTA placed a 2.5 percent annual tax on persons receiving administrative and service fees for services provided to what are essentially ERISA plans. The state claimed that the district court did not have the jurisdiction to enjoin a tax statute under circumstances where the state courts could evoke an efficient remedy under the Tax Injunction Act. The appeals court dismissed this reasoning and held that it was Congress’s intent that any law that contradicted ERISA, including state tax law, was preempted by the federal statute.

399 Self-Insurance Institute of America v. Gallagher, 11 Employee Benefits Cas. (BNA) 2162 (N.D. Fla. 1989), aff’d, 909 F.2d 1491 (11th Cir. 1990).
400 E-Systems, Inc. v. Pogue, 929 F.2d 1100 (5th Cir. 1991).
In *NGS American, Inc. v. Barnes*, the court held that a Texas statute, which indirectly regulated ERISA plans by regulating and taxing third party administrators of such plans, was preempted by ERISA, and the court granted plaintiff’s motion for summary judgment. The state argued that regulation of the administrators was permissible in this case because the administrators were engaged in the business of insurance. The court responded that the administrators were not engaged in the business of insurance and that the law at issue “related to” the plan. In *NGS*, the court distinguished *Benefax* as a “mere licensing statute,” since the Texas statute’s scope was considerably broader, incorporating a TPA tax and bonding requirement.

The appeals court affirmed the district court’s grant of summary judgment in *NGS American, Inc. v. Barnes*. It agreed that the administrators did not conduct the business of insurance, and therefore, the statute did not regulate the business of insurance. Further, the appeals court agreed with the district court’s finding that the Texas statute was more than a mere licensing statute, unlike the statute at issue in *Benefax*. The Texas statute, insofar as it regulated administrators of ERISA-covered plans, impermissibly “related to” ERISA plans because of its intrusive nature, and thus, violated the Supremacy Clause of the United States Constitution.

In *Self-Insurance Institute of America v. Korioth*, the state of Texas did not appeal the district court's holding that ERISA preempted the state law imposing a maintenance tax on contract administrators of ERISA plans in light of the court’s ruling in *NGS*. The state did, however, successfully appeal the district court's award of attorneys’ fees and the refund of taxes and fees paid by ERISA plans and administrators. The appeals court held that the association had standing with respect to seeking an injunction, but no standing with respect to the award of refunds and attorneys’ fees. The court stated that the individual participation of association members would be needed to determine which association members were due the refunds since many members administered both ERISA and non-ERISA-covered plans.

The Supreme Court in the *Miller* opinion, which is not a case directly addressing ERISA preemption of TPA laws, does include a footnote that addresses whether a law that applies to HMOs that act as administrators of self-funded plans is still an “insurance law” within the meaning of ERISA’s saving clause. The Petitioners argued that Kentucky’s “any willing provider” law was not a law that regulated insurance within the meaning of ERISA’s saving clause because it was not “specifically directed at the insurance industry” because it applied to HMOs not acting as insurers, but as administrators of self-funded plans. The Court stated that this argument was not persuasive because “noninsuring HMOs would be administering self-insured plans, which we think suffices to bring them within the activity of insurance for purposes of [ERISA’s saving clause].”

Some may argue that this language gives states permission to regulate TPAs without fear of ERISA preemption. However, this language must be viewed in the context of the entire *Miller* opinion, as well as the rest of ERISA, and clearly, ERISA’s deemer clause prevents states from enacting laws that have the effect of regulating self-funded ERISA plans. It does not appear that the *Miller*

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402 *NGS American, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993).
403 *Self-Insurance Institute of America v. Korioth*, 53 F.3d 694 (5th Cir. 1995).
opinion has shed any light on the analysis for determining whether a state law regulating TPAs is preempted by ERISA. The status of the law remains unclear, and any preemption analysis is going to be particular to the details of a state’s law. Overall, states should be mindful of the Supreme Court’s opinion in *Travelers*, and draft laws that minimize the potential burden on self-funded ERISA plans. State laws that apply broadly and are not overly burdensome should not be preempted.

Can states prohibit the use of discretionary clauses in insurance policies that provide ERISA benefits?

After the Supreme Court suggested in *Firestone* that ERISA plan administrators could avoid de novo judicial review if the plan documents grant them discretionary powers, many insurers responded by adding clauses to their policies that purported to give them discretionary authority to interpret the terms of the policy and to pay or deny claims. Many states, through regulatory action or legislation, refused to permit such clauses, and the NAIC has adopted the *Prohibition on the Use of Discretionary Clauses Model Act*, 404 which prohibits the use of discretionary clauses in disability income and medical insurance policies.

The prohibition is based on the recognition that discretionary clauses are contrary to the nature and purpose of insurance. Discretionary clauses, as the *Firestone* Court recognized, are a feature of certain types of trusts, and the Court relied on the distinction between trust law and contract law. More specifically, as the Court subsequently explained in *Varity Corp. v. Howe*, 405 “The common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries.” Discretion is not inherent in all fiduciary relationships – no one would dream, for example, of allowing a bank the discretion to decide whether to keep or return deposited funds. But it is common to grant a trustee the discretion to choose between multiple deserving claims when a limited trust corpus has been set aside and every dollar that is paid to one beneficiary is a dollar that is unavailable to pay to any other beneficiary.

Insurance presents the opposite situation. It is appropriate for states to apply contract law to insurers, even if the policyholder is an employer with an ERISA plan, because insurance is a contract. An insurance policy is not an arrangement where an entity with a mission to help deserving people obtain health care has the discretion to decide who are the most deserving and how they can best be helped. 406 An insurance policy is an irrevocable commitment, made by a company that is in the business of assuming risk, to pay the specified benefits whenever a covered loss occurs during the policy term. The insurer does not have the discretion to decide the terms of that commitment after it has accepted the premium.

Nevertheless, some advocates contend that state laws prohibiting discretionary clauses are preempted by ERISA. One argument that has been made is that discretion is so fundamental to the

404 NAIC Model Law No. 42, adopted 2002, amended 2004 to extend scope to include disability insurance.
406 Actually, neither is a self-funded health plan. Implicitly recognizing this reality, Congress has now prohibited the enforcement of discretionary clauses in health benefit plans. *See* ERISA § 715; PHSA § 2719(b)(2)(B) (requiring self-insured ERISA plans to submit disputed claims to independent external review).
obligations of ERISA fiduciaries that an implicit exception to the saving clause must be inferred in order to allow insurers to fulfill their fiduciary responsibilities. This is “pure applesauce.”

It is an argument the Supreme Court emphatically rejected in Firestone, holding that any grant of discretionary power must be explicit and the default presumption is that no such power has been granted.

Another argument is that because the Supreme Court made a “clean break” with the MetLife “common sense” methodology in Kentucky Health Plans v. Miller, common sense must now be disregarded entirely, and the saving clause must be interpreted so narrowly that laws prescribing the provisions of insurance policies do not really “regulate insurance.” However, three federal Circuit Courts of Appeals have considered that argument, and all three have rejected it and upheld the states’ authority to prohibit discretionary clauses, observing that the Supreme Court made clear in Kentucky Health Plans that a law that “dictates to the insurance company the conditions under which it must pay for the risk that it has assumed” is one of the paradigmatic examples of the type of law that regulates insurance because it substantially affects risk pooling.

The courts also rejected other techniques designed to bring discretionary clauses outside the scope of the saving clause. For example, in Fontaine v. MetLife, the Seventh Circuit dismissed an argument that the Illinois regulation “is not specifically directed toward entities engaged in insurance because it prohibits a plan sponsor, like Mayer Brown, from delegating discretionary authority to the insurer of an employee benefit plan.”

In that case, the discretionary clause appeared in a side agreement between the employer and the insurer in its capacity as plan administrator, rather than in the terms of the policy itself, but the court held that relying on that distinction was “another too-clever argument” that if taken seriously would “virtually read the saving clause out of ERISA” and “nullify the evident purpose” of the state regulation.

As the Sixth Circuit summarized the underlying issue in ACLI v. Ross, “If, as Glenn reaffirms, there is a conflict of interest when the same plan administrator decides the merits of a benefits plan and pays that claim, and if, as Glenn also holds, it is consistent with [purposes of the saving clause], a state regulation prohibiting the use of a discretionary clause, interpreted to avoid the conflict of interest, is not pre-empted.”

408 See supra page 18; see also ACLI v. Ross, 558 F.3d 600, 608 (6th Cir. 2009); Standard Ins. Co. v. Morrison, 584 F.3d 837, 846 (9th Cir. 2009) (“While it is true that the Commissioner’s practice will lead to de novo review in federal courts, this is hardly foreign to the ERISA statute. Indeed, de novo review is the default standard of review in an ERISA case.”), cert. denied sub nom. Standard Ins. Co. v. Lindeen, 560 U.S. 904 (2010).
409 Fontaine v. Met. Life Ins. Co., 800 F.3d 883 (7th Cir. 2015); Standard Ins. Co. v. Morrison, 584 F.3d 837 (9th Cir. 2009) (upholding administrative practice not expressly required by state law); ACLI v. Ross, 558 F.3d 600 (6th Cir. 2009); accord, Ravannack v. United HealthCare Ins. Co., 2015 U.S. Dist. LEXIS 63922 *5 (E.D. La. 2015) (in a case that did not involve a preemption challenge, noting that ‘every federal decision that this Court could locate has enforced state law bans on discretionary clauses against ERISA plans’). These three cases were also cited in Adele E. v. Anthem Blue Cross and Blue Shield, 2016 U.S. Dist. LEXIS 57055 (D. Me. 2016), where an insurance policy had a discretionary clause but the court conducted de novo review after concluding that the clause violated the Maine Insurance Code.
410 See Fontaine, 800 F.3d at 888; Standard v. Morrison, 584 F.3d at 845; ACLI v. Ross, 558 F.3d at 607, all quoting Kentucky Health Plans v. Miller, 538 U.S. at 339 n.3.
411 Furthermore, that argument begs the question because a policyholder never has any discretion over insurance claims that it could “delegate” to the insurer – no insurer would ever write a policy on such terms.
412 800 F.3d at 887.
413 Id. at 887, 891–92 (citations and internal punctuation omitted).
ERISA to account for that conflict of interest in reviewing a plan administrator’s decision, it is
difficult to understand why a State should not be allowed to eliminate the potential for such a
conflict of interest by prohibiting discretionary clauses in the first place.”414

414 558 F.3d at 609.
ACA CHANGES INCORPORATED INTO ERISA

Historical Background: HIPAA and the ACA

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Amendments to the Affordable Care Act made through the Health Care Education and Reconciliation Act (Reconciliation Act) were signed into law on March 30, 2010, and some additional amendments have been made since that date, notably the Protecting Affordable Coverage for Employees Act (PACE Act), enacted in 2015, which preserved the pre-ACA upper limit of 50 employees for “small employer” status, unless a state chooses to raise its threshold to 100 employees. In 2017, Congress considered several initiatives to repeal or substantially revise the ACA, but at this writing, all the major ACA provisions remain in effect.

Generally, the ACA’s market reform provisions amend title XXVII of the Public Health Service Act (PHS Act), which is administered by the Department of Health and Human Services. The Affordable Care Act also adds a new section 715 to ERISA, administered by the Department of Labor, Employee Benefits Security Administration, and a new section 9815 to the Internal Revenue Code (IRC), administered by the Department of Treasury, Internal Revenue Service (IRS). These sections incorporate most of the health benefit standards of the PHS Act into ERISA and the IRC, and make them applicable to group health plans and health insurance issuers providing group health insurance coverage.

Title XXVII, as originally enacted by HIPAA, required health insurance issuers to make all health coverage guaranteed renewable, limit pre-existing condition exclusions on group coverage to at most one year, and offer all their small group health plans on a guaranteed-issue basis to eligible employers. The ACA introduced a much more extensive federal role in insurance regulation. It extended guaranteed issue to apply to the individual and large group markets, required modified community rating in the individual and small group markets (limiting variation based on age to 3:1 for adults, and prohibiting all other rating factors except geography, tobacco use, and the number of covered family members), and phased out the use of pre-existing condition exclusions entirely. Small employers are also now eligible for an annual open enrollment period in which they are exempt from otherwise applicable minimum participation and contribution requirements, and those requirements may no longer be applied to large employers at any time. The ACA also enacted a number of additional, more detailed requirements, as discussed below.

The PHS Act sections that have been made applicable to ERISA plans are sections 2701 through 2728, except that self-insured plans are not subject to provisions that specifically relate to insurance, such as community rating and minimum medical loss ratio. Sections 2701 through

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415 Pub. Laws 111-148 (PPACA), 111-152 (Reconciliation), 114-60 (PACE).
416 Under the ACA as originally enacted, states were given the option to retain the 50-employee threshold until a uniform 100-employee threshold took effect in 2016. See supra note 347.
417 Guaranteed issue was also extended from the small group market to the individual and large group markets, but there have not been reports of any significant impact on the large group market.
2719A incorporate, in revised form, the basic portability framework originally enacted by HIPAA, and add many new protections. Sections 2722 through 2728 are sections of prior law renumbered with some, mostly minor, changes. Thus, all these ACA provisions now apply to both insured and self-insured health benefit plans, with one noteworthy exception. Certain plans existing on the date of enactment of the ACA, March 23, 2010, are designated as “grandfathered plans” and are exempt from many of the new provisions of the PHS Act if they remain in force without material changes. In addition, these provisions do not apply to retiree-only or excepted benefits plans (See ERISA Section 732). The USDOL, HHS, and the Treasury (the “Tri-Agencies”) have been issuing guidance and regulations on an ongoing basis since May 2010.

Generally, the relationship between ERISA and state law is unchanged. Section 731 (formerly numbered 704) of ERISA mirrors Section 2724 of the PHS Act, and provides that the requirements of the ACA are not to be “construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent such standard or requirement prevents the application of a requirement” of the ACA. Accordingly, state laws that exceed the ACA’s minimum standards for health insurance or impose additional requirements will generally not be superseded by the ACA. However, ERISA § 734(a)(2) clarifies that state laws that apply directly to “group health plans” are still preempted. The ACA’s definitions must be read carefully. In particular, a “group health plan” is not a type of “health plan.” The term “group health plan” includes both insured and self-insured group health plans, but does not include the insurance policies issued to insured plans, leaving them subject to state regulation. The term “health plan,” on the other hand, includes individual and group health insurance coverage, but does not include self-insured group health plans that are exempt from state regulation under ERISA.

Incorporating these new sections into ERISA is significant because for the first time a comprehensive structure of benefit mandates was added to ERISA requirements. Although HIPAA had added a few provisions to ERISA and the IRC that echoed similar language in the PHS Act, notably the limitations on pre-existing condition exclusions, those had been the exception rather than the rule. Traditionally, ERISA did not dictate to employers what benefits and protections had to be contained in employer health plans. A good example of this is the Mental Health Parity and Addiction Equity Act of 2008, which provides: IF the employer offers any mental health benefits, then those benefits must meet the requirement of full parity with physical health benefits generally.

418 ACA § 1251 (42 U.S.C. § 18011), as modified by ACA § 10103 and Reconciliation Act § 2301. The specific federal provisions that apply to grandfathered plans depend on whether the plan is an individual or group plan, and whether it is insured or self-insured. Through administrative guidance, CMS has also allowed insurers, if permitted by state law, to continue renewing certain non-grandfathered insurance policies that were ACA-compliant when issued but do not comply with certain additional requirements that took effect on January 1, 2014. These policies are popularly known as “grandmothered” policies. The guidance specifies that “grandmothering” is allowed only as a transitional measure, but at this writing, CMS has always extended the deadline for terminating these policies or modifying them to bring them into compliance.

Another example is the Newborns’ and Mothers’ Health Protection Act: **IF** the health plan covers maternity benefits, it has to include the “minimum stay” requirements.

**The Large Employer “Shared Responsibility” Requirement**

By contrast, the ACA applies relatively extensive requirements to employer health plans. Because substantial parts of the ACA have been incorporated into ERISA, the nature of ERISA has been changed. In addition, even though the ACA preserves the employer’s right to decide whether to offer a health plan at all, the ACA includes an employer “shared responsibility” provision, sometimes called “play or pay,” that gives certain employers (those with 50 or more fulltime or fulltime equivalent (FTE) employees) a strong incentive to provide “affordable” health plans to employees and their child dependents.420 The Tax Code uses the phrase “applicable large employer” to describe the employers that are subject to this requirement, and they are commonly referred to by the abbreviation “ALE” because the definition of ALE is not quite the same as the definition of “large employer” for other ACA purposes. For example, an employer with exactly 50 employees is an ALE even though it is a “small employer,”421 and the AHP Rule operates from the premise that the association is a “large employer” but not an ALE, so that small employer members remain exempt from “shared responsibility.”422 This requirement took effect in 2015, subject to transitional measures that reduced the impact of the penalties until 2017. Employers with fewer than 50 FTE employees are not subject to the “shared responsibility” requirement;423 however, because states may apply different counting rules, it is possible to be a “small employer” with fewer than 50 employees under state law and still be an ALE. Also, even though an AHP is considered a “large employer” under the ACA, the IRS does not consider an AHP to be an ALE, so membership in an AHP does not subject a small employer to the “shared responsibility” requirement.424

Although this law is sometimes referred to as the “large employer mandate”, it does not literally mandate that ALEs offer such plans. However, even though ALEs do not violate any ACA requirement by choosing not to offer insurance, they may be subject to substantial financial penalties under the “shared responsibility” law. Specifically, the penalty is triggered if one or more of an ALE’s full-time employees is enrolled in subsidized coverage on the Exchange.425 There are

421 The threshold is 50 FTE employees regardless of the state’s applicable small group threshold. On the other hand, another difference that was expressly intended by the drafters of the ACA was eliminated by CMS regulation. The FTE methodology is a measure of the size of the business, whereas rating methodologies focus on the number of covered lives. The ACA counts employees on an FTE basis “Solely for purposes of determining whether an employer is an applicable large employer” under the shared responsibility law, IRC § 4980H(c)(2)(E), but CMS regulations now apply this methodology to determine group size for community rating purposes. As a result, group insurance policies with very few covered lives might be subject to experience rating, despite the lack of a credible rating pool, if the employer also has many uncovered part-time employees.
422 See Preamble to AHP Final Rule, 83 F.R. 28917, 28933.
423 The ACA does provide a two-year tax credit as an incentive for certain small employers to establish health plans. IRC § 45R (26 U.S.C. § 45R), added by ACA § 1421.
425 Although employer size is calculated on the basis of the number of “full-time equivalent” employees, only
three ways an employee might qualify for premium tax credits or cost-sharing reductions: (1) if the employee is not eligible for “minimum essential coverage” outside the Exchange; (2) if the employer offers minimum essential coverage but it is not “affordable” (i.e., costs more than 9½% of the employee’s household income); or (3) the employer’s coverage fails to provide a “minimum value” (MV) of at least 60%. MV is an actuarial value standard, but it is never referred to that way, in order to avoid confusion with the actuarial value (AV) calculation used to determine a health insurance policy’s “metal level” (bronze, silver, gold or platinum). AV and MV are calculated using software programs that produce different numerical results because they incorporate parameters derived from different assumptions.

The amount of the penalty depends on the reason the employer has employees who qualify for subsidies. A penalty based on the size of the entire full-time workforce applies unless the employer offers a plan qualifying as “minimum essential coverage” to at least 95% of its full-time employees and to their children under age 26. (The statute refers broadly to “dependents,” but the implementing regulation defines the term to mean children, other than stepchildren, foster children, and children who are not U.S. citizens.) On the other hand, if coverage is offered, but it is unaffordable or does not provide 60% MV, the penalty is based only on the number of employees receiving subsidized coverage. Under a provision often referred to as the “family glitch,” the affordability test compares the cost of employee-only coverage to total household income. The consequences include making spouses and dependents ineligible for Exchange subsidies if they are offered coverage even if the employer contributes nothing at all. The dependent coverage requirement of the shared responsibility law would appear to reward ALEs for imposing this burden on families. However, as long as an employer offers affordable employee coverage with 60% MV to each of its full-time employees, they will not be eligible for subsidies, so the penalty for failing to offer dependent coverage will be zero even if the employer is an ALE.

Another complication arises from the flexibility that large employers and self-insured small employers have in structuring their benefit designs. The ACA has established some minimum standards that apply to all individual and group plans, but the ACA’s requirements to include all “essential health benefits” (EHBs) and provide at least a “bronze” level of coverage (60% actuarial value) apply only to the individual and small group insurance markets. CMS has

employees actually working at least 30 hours a week are counted when calculating the penalty. IRC § 4980H(c)(2)(E). (26 U.S.C. § 4980H(c)(2)(E)).

426 IRC §§ 36B(c)(2)(B) & (C).


428 26 CFR § 54-4980H-4(a). The penalty is $2000 per year, times the number of full-time employees in excess of 30 employees, calculated on a monthly basis for each month the employer is subject to the penalty. IRC § 4980H(a). (The law does not call this “payment” a penalty, since the employer is technically in full compliance if it “chooses” to make a payment in lieu of offering coverage, but that is not the way employers typically view this obligation.)


430 $3000 per year, times the number of full-time employees receiving subsidies, calculated on a monthly basis, but capped at the amount the employer would pay if it failed to offer coverage at all. IRC § 4980H(b).

431 The ten essential benefit categories are: outpatient services, emergency services, hospitalization, maternity and newborn care, mental health/substance abuse disorder services, prescription drugs, rehabilitative/habilitative services and devices, laboratory services, preventive benefits and chronic disease management, and pediatric services, including dental and vision. ACA § 1302(b)(1)(42 U.S.C. § 18022(b)(1)).

432 PHS Act § 2707(a) (42 U.S.C. § 300gg-6(a)). Catastrophic plans in the individual market are also exempt from
required other plans to provide comparable value in order to meet MV requirements by designing its calculator to measure the extent to which the plan covers such categories as prescription drugs, maternity, mental health, and hospital and physician services. But what if an ALE decides not to try to provide MV, and instead to offer the least expensive plan that will allow employees to satisfy their requirement to buy “minimum essential coverage,” and hope that few of them would prefer to buy subsidized coverage on the Exchange? Although the ACA deems any “group health plan” to qualify as minimum essential coverage, the drafters sought to prevent abuses by adding an exception for insurance coverage consisting only of “excepted benefits” as defined in the PHS Act.\textsuperscript{433} However, the concept of “excepted benefits” was created long before the ACA, for a completely different purpose. When HIPAA was enacted in 1996, it was recognized that many plans providing only limited or incidental benefits should not be regulated under the same framework as comprehensive health plans, so those plans were exempted from the requirements of PHS Act Title XXVII. Nobody contemplated at the time that anyone would have a motive to design around the list of excepted benefits in order to keep a limited-benefit plan off the list, so we are now seeing innovative plan designs, such as coverage consisting of outpatient preventive services only, offered with the representation that they are sufficient to meet minimum essential coverage requirements.

Additional concerns have been raised that a provision intended to encourage employers that previously did not offer coverage to begin providing this benefit might have the opposite effect in practice. To prevent employers from circumventing the law by reducing the normal work week to 39 hours, the ACA defines all employees who work at least 30 hours a week to be “full-time” employees for shared responsibility purposes. However, there are reports that some employers have responded by reducing hours even further, though some ERISA experts argue that this could violate ERISA Section 510, which makes it unlawful for a person to interfere with the attainment of any right a participant may become entitled to under a plan. At the time of this writing, some stakeholders are urging Congress to eliminate or modify the “play or pay” law, and one frequent proposal is to raise the “full-time” threshold to 40 hours.

**Significant Regulatory Standards Applicable to Group Health Plans**

The Tri-Agencies have issued a series of regulations implementing PHS Act Sections 2701 through 2719A.\textsuperscript{434} The first phase of these ACA requirements, known as the “immediate market reforms,” became effective on September 23, 2010, six months after the effective date of the ACA. Other provisions took effect later, primarily on January 1, 2014. Most apply only to non-grandfathered plans, but some apply to all individual and group health plans. Significant ACA provisions that only affect the individual and small group insurance markets, but do not apply to self-insured plans or large group insurance, include rating rules, the requirement to provide EHBs, and tiers of coverage based on actuarial value.

\textsuperscript{433} IRC § 5000A(f)(1)(B) & (2), \textit{as modified by IRC § 5000A(f)(3)}.

\textsuperscript{434} When a Tri-Agency Regulation is cited in this section, the version cited is the USDOL regulation found in CFR Title 29. The corresponding IRS and HHS regulations appear in Titles 26 and 45 respectively.
The following discussion of the significant benefit standards added to ERISA by the ACA is based largely on a compliance checklist prepared by the USDOL. For the most up-to-date USDOL guidance, see EBSA’s Website: https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans This guidance also includes information about other significant legislation such as COBRA, HIPAA, the Genetic Information Nondiscrimination Act of 2008 (GINA), Mental Health Parity Provisions, the Newborns’ and Mothers’ Health Protection Act, and the Women’s Health and Cancer Rights Act. Generally, it is the responsibility of the employer-sponsored group health plan to ensure that the plans it offers to employees meet all requirements. However, state insurance departments approve and regulate the group insurance policies that employers offer to their employees, and would include enforcement relating to these reforms.

1. Grandfathered Status – (29 CFR § 2590.715-1251(f))

If a plan is grandfathered, it is exempt from most provisions of the Affordable Care Act (ACA). Grandfathered status is intended to allow people to keep their coverage substantially as it existed on March 23, 2010. The grandfathering regulation protects individuals from significant reductions in coverage, while giving plans some flexibility to make “normal” changes while retaining grandfathered status, in addition to any changes that are required by law. An insurance policy’s grandfathered status under federal law does not preclude a state from making the policy subject to state regulatory reforms, but the state may not require the insurer to include the policy in the same risk pool as nongrandfathered policies.

2. Wellness Programs – (29 CFR §§ 2590.702 and 2590.715-2705)

Wellness programs are programs of health promotion or disease prevention. Employers may provide a wide range of wellness programs, but the regulations generally prohibit discrimination based on health factors, with exceptions for benign discrimination (e.g., making benefits specifically available to persons with designated health conditions) and participation incentives. “Health contingent” incentives (incentives that depend on health outcomes or on participation in specified activities such as exercise) are subject to financial limits and must provide an opportunity to earn the incentive through reasonable alternatives or to waive the standard for participants with medical limitations or, in some cases, with other limitations. Wellness programs are also regulated by the EEOC under the Americans with Disabilities Act (ADA) and GINA. A 2017 court decision has remanded the EEOC’s regulations and directed the agency to reconsider whether the ADA and GINA further limit the range of wellness program penalties otherwise permitted under the PHS Act if employees refuse to provide health information on themselves or their spouses. The regulations will be vacated if the agency does not act by January 1, 2019. The EEOC has announced its intention to propose new regulations, but not until later in the year, leaving it uncertain what incentives can lawfully be provided until these questions are finally resolved.

436 ACA § 1312(c)(4).
3. **Mental Health Parity – (29 CFR § 2590.712)**

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits financial requirements (such as copayments and deductibles) and treatment limitations (such as visit limits) that are more restrictive for mental health or substance use disorder benefits than the predominant requirements or limitations applied to medical/surgical benefits. The regulations also requiring parity for “non-quantitative treatment limitations,” meaning actions such as pre-authorization requirements that discourage claims. An earlier law, the Mental Health Parity Act of 1996 (MHPA), already required parity for aggregate lifetime and annual dollar limits.

MHPAEA does not apply to plans that do not offer any mental health or substance disorder benefits. However, all non-grandfathered individual and small group health insurance policies required to include such benefits as part of the EHB package, and large group policies are required to include them under the laws of most states.


Applicable only to plans that provide coverage for dependent children. A child who is under age 26 must be eligible for coverage as long as the relationship between the child and the participant would generally entitle the child to coverage under the terms of the plan. Thus, plans cannot deny or restrict dependent coverage for a child who is under age 26 based on factors such as residency, absence of financial dependency, student status, employment or marital status. The terms of the plan cannot vary based on age, except for children who are age 26 or older. This provision applies to both grandfathered and non-grandfathered plans. Note that if an ALE (50 or more FTE employees) fails to offer coverage to employees’ children under age 26, it may be subject to a “shared responsibility” payment, as discussed earlier.


Coverage may only be rescinded after it is in force if the covered individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

6. **Prohibition on Lifetime and Annual Dollar Limits on EHB – (29 CFR § 2590.715-2711(a)(1))**

A group health plan may not establish any annual or lifetime limits on the dollar amount of benefits for any “essential health benefit” for any individual. This applies to both grandfathered and non-grandfathered plans. USDOL and Treasury have issued guidance and FAQs on how this prohibition impacts Health Reimbursement Arrangements. For purposes of requirements that apply only to essential benefits, large group insurers and self-insured employers must define

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438 The statute refers to “substantially all” medical and surgical benefits, but the implementing regulation redefines “substantially all” to mean “at least two-thirds.” 29 CFR § 2590.712(c)(3)(i)(A).
“essential health benefits” consistent with one of the state or federal-employee benchmark plans, supplemented as necessary to meet minimum coverage standards for all ten categories.\footnote{29 CFR § 2590.715-2711(c). Any state’s EHB benchmark may be used, regardless of where the plan provides coverage.}

7. **Limits on Cost Sharing** – (PHS Act § 2707(b))

All group health plans (including self-insured plans) must comply with the ACA’s limits on cost sharing, which require the plan to have a Maximum Out-Of-Pocket expense (MOOP) that does not exceed a limit that is adjusted annually for inflation by CMS. In 2018, that limit is $7,350 for “self-only coverage” and $14,700 if additional individuals are covered. The regulations do not require the MOOP to apply to services that are provided out-of-network or to services that are not covered EHBs, but plans are not prohibited from counting such expenses.\footnote{45 CFR §§ 155.20, 156.130(c), The ACA set the maximum MOOP for 2014 to equal the corresponding limit for HSA-qualified high-deductible plans, but applies a different inflation-adjustment formula, so the limits are no longer the same. Compare ACA § 1302(c)(1)(B) with IRC § 223(g).}

8. **Prohibition on Pre-existing Condition Exclusions** – (29 CFR § 2590.701-2)

Plans may not impose pre-existing condition exclusions, defined to include any limitation or exclusion of benefits applicable to an individual as a result of information relating to his or her health status before the effective date of coverage (or if coverage is denied, the date of denial), such as information obtained from a pre-enrollment questionnaire, a physical examination or a review of medical records. This provision applies to both grandfathered and non-grandfathered plans.

9. **90-day Waiting Period** – (29 CFR § 2590.715-2708)

This provision prevents an otherwise eligible individual from being required to wait more than 90 days before group coverage becomes effective. The regulation specifies allowable exceptions to the 90-day waiting period, such as orientation periods or limited assessment periods, but does not permit extending the waiting period beyond 90 days to coincide with the end of a calendar month. This provision applies to grandfathered health plans and non-grandfathered plans.

10. **Summary of Benefits and Coverage and Uniform Glossary** – (29 CFR § 2590.715-2715)

The ACA created two standardized disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options. Generally, group health plans and health insurers are required to provide the SBC and Uniform Glossary free of charge. HHS may update the SBC and glossary template periodically, to ensure that they reflect the status of current federal requirements, so employers and insurers should verify that they are using the current version.

If a plan provides for the designation of a primary care provider, each participant or beneficiary must be permitted to designate any participating primary care provider who is available to accept the participant or beneficiary. The plan or issuer must permit the designation of any available physician who specializes in pediatrics and participates in the network as a child’s primary care provider. A plan that provides obstetrical or gynecological (OB/GYN) care may not require authorization or referral (including any otherwise applicable requirement for authorization by a designated primary care provider) for OB/GYN care provided by a participating health care professional who specializes in OB/GYN care, including a non-physician if authorized by applicable state law.


A plan that “provides any benefits with respect to services in an emergency department of a hospital” must cover medical screening for emergency conditions and such further services as are necessary to stabilize the patient. (Transportation and other services provided before the patient reaches the hospital are not considered “emergency services” for purposes of this provision.) A plan may not require prior authorization for emergency services. For emergency services received out-of-network, a plan may not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply in network, and may not impose cost-sharing requirements that exceed the in-network requirements. However, the plan is not required to cover out-of-network charges that exceed the greatest of: 1) its network rate, 2) its typical out-of-network allowable charge (e.g., the UCR rate), or 3) the Medicare rate. Unless prohibited by contract or applicable law, the provider may balance-bill the patient and such balance bills are not subject to the cost-sharing limitation.


Group health plans must provide coverage for all designated preventive care services, and may not impose any cost sharing requirements unless the services are provided out-of-network. The designated services are based on guidelines issued by United States Preventive Services Task Force and certain other federal agencies. A complete list of services that are currently required to be covered can be found at www.healthcare.gov/coverage/preventive-care-benefits New requirements apply to all plan years beginning one year or more after the date the recommendation or guidance is issued. Plans must continue covering services removed from the list for the remainder of the plan year, with limited exceptions such as safety recalls. The plan may not apply cost sharing for office visits if designated preventive services are the primary purpose of the visit and no other services were provided that are billable as a separate encounter. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the preventive services to the extent not specified in the applicable federal guidelines. The Tri-Agencies have issued an extensive number of FAQs on preventive services.

441 Except that employers may decline to provide or fund benefits for contraception if they have a sincerely held religious objection.
442 These may be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-
14. Clinical Trials – (PHS Act § 2709)

Plans may not prevent individuals with cancer or other life-threatening conditions from prohibiting in approved chemical trials if they have been referred by a participating provider or otherwise demonstrate that participation is appropriate. The plan is not required to waive “experimental/investigational” exclusions for the drug or other item that is the subject of the trial, but may not deny benefits for other services provided in connection with the trial that would otherwise be covered, or otherwise discriminate against participants in clinical trials.


The ACA requires all group health plans and group health insurance issuers to “implement an effective appeals process for appeals of coverage determinations and claims.” This requirement incorporates by reference the pre-ACA USDOL claims procedure rule, and adds some additional minimum standards, including an external review requirement. A federal external review process has been established for self-funded plans and for states that have not implemented processes consistent with the NAIC’s Uniform Health Carrier External Review Model Act, under which the insurer or plan sponsor must contract with at least three accredited Independent Review Organizations and assign them on a rotating, impartial basis. Self-funded plans may also opt into the state process if permitted by the state.

16. Qualified Small Employer Health Reimbursement Arrangements – (26 U.S.C. § 9831(d); PHS Act § 2791(a)(1))

The 21st Century Cures Act, enacted in December of 2016, includes a provision allowing businesses that are not ALEs and do not offer group health plans to establish Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs). A QSEHRA may reimburse workers up to $4,950 per year for single coverage and up to $10,000 per year for family coverage, adjusted for inflation, to pay for individual health insurance premiums and qualified medical expenses. Employees must provide proof of their actual medical costs to receive reimbursement. Qualified individuals with QSEHRAs do not automatically lose eligibility for Exchange-based premium tax credits, but they must report their QSEHRA and any tax credit is reduced by the amount of the QSEHRA. The IRS has issued guidance outlining the procedures employers must follow to maintain QSEHRA eligibility. QSEHRAs are deemed not to be group health plans, and it remains unclear at this writing what plan documents are required and what penalty scheme applies to violations. In addition, the Tri-Agencies proposed a new federal regulation in October of 2018 that would further expand the availability of HRAs and other options for individuals and employers, and which could give rise to additional interpretive and compliance questions.

employers-and-advisers/aca-implementation-faqs

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443 P.L. 114-255, § 18001.

444 NPRM, Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 83 F.R. 54420, October 29, 2018.
GLOSSARY

1. COLLECTIVE BARGAINING AGREEMENT means an agreement between an employer and a labor union that regulates the terms and conditions of employment. See Black’s Law Dictionary.

2. CONTRIBUTIONS means premiums, contributions or any other sums collected to pay health and welfare benefits whether paid by an employer or an employee.

3. EMPLOYEE means a person who works for salary or wages, under the control and direction of an employer. See 29 U.S.C. § 1002(6).

4. EMPLOYEE ORGANIZATION means a labor union or other organization representing employees concerning employment benefits. See 29 U.S.C. § 1002(4).

5. EMPLOYEE WELFARE BENEFIT PLAN means a plan, fund or program established or maintained to provide health care or other employment benefits to employees. See 29 U.S.C. § 1002(1).

6. EMPLOYER means a person who employs or hires other persons and who controls their performance and pays their salaries or wages. See 29 U.S.C. § 1002(5).

7. INSURANCE SERVICE ORGANIZATION means a type of medical service corporation or other entity assuming any risk of loss for benefits to be paid and qualified to conduct business in a state.

8. LABOR ORGANIZATION means an organization described in 29 U.S.C. § 1002(5) in which employees participate for the purposes described in that provision. See 29 U.S.C. §§ 151 through 186.

9. MULTIEMPLOYER PLAN means a plan maintained pursuant to collective bargaining agreements between one or more employee organizations and more than one employer and to which more than one employer is required to contribute. See 29 U.S.C. § 1002(37)(a); 29 CFR § 2510.3-37.

10. MULTIPLE EMPLOYER TRUST (MET) is a generic term used to market several types of health and welfare plans which may or may not be: (a) subject to ERISA; or (b) insured or self-funded.

11. MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA) means a plan, established by two or more employers to offer health and welfare benefits to their employees, but does not include arrangements established pursuant to bona fide collectively bargained agreements or a rural electric cooperative. See 29 U.S.C. § 1002(40)(a).
12. PLAN means a written document or trust fund, a method or action, procedure or arrangement. It is not a person or corporation.


14. TAFT-HARTLEY TRUST means a trust established by a labor organization, pursuant to 29 U.S.C. § 186(c)(5), to receive payments made by employers for benefits described in that statute. See 29 U.S.C. §§ 151 to 186, inclusive.

15. UNION means an organization, association or group of employees joined together to resolve grievances with employers or to review rights of employees related to employers.

16. WELFARE PLAN means an employee welfare benefit plan.
APPENDICES

Appendix 1 – Consumer Alert

CONSUMERS BEWARE—ILLEGAL “ERISA” AND “UNION PLAN” SCAMS

If it seems too good to be true, it probably is. Nationwide, the health insurance marketplace is facing tougher times. The cost of health insurance is rising. Criminals, seeking to make a profit by selling fraudulent health insurance, claim that state insurance laws don’t apply. These entities recruit insurance agents to sell “ERISA plans” or “union plans” falsely claimed to be exempt from state law.

Legitimate ERISA plans (plans governed by the federal Employee Retirement Income Security Act of 1974) and union plans may be exempt from state insurance regulation, which is why criminals try to fool people by making these claims. However, legitimate ERISA or union plans are established by unions for its own members or by an employer for the employer’s own employees. They are not sold by insurance agents.

Consumers and employers should take care to ask their agents whether the health coverage they are purchasing is fully insured by licensed insurers. A “union plan” sold by an agent, health coverage that seems unusually cheap, health coverage that is issued with few questions about the applicant’s health condition, or plan material that refers only to a “stop-loss” insurer should alert a consumer to question the selling agent or contact the state insurance department.

A typical fraudulent health insurance scam attempts to recruit as many local insurance agents as possible to market the coverage. The health coverage is not approved by the state insurance department. Agents are told it is regulated by federal, not state law. In fact, it is totally illegal. The coverage is typically offered regardless of the applicant’s health condition and at lower rates and with better benefits than can be found from licensed insurers. The scam seeks to collect a large amount of premium as rapidly as possible. While claims may be paid initially, the scam will soon begin to delay payment and offer excuses for failure to pay. Unsuspecting consumers who thought they were covered for their medical needs are left responsible for huge medical bills. Employers may be liable for the medical bills of their employees as well.

How can the average consumer avoid becoming the next victim? Be suspicious, ask hard questions and do your homework. Read all materials and scrutinize websites carefully. Most insurance agents will reject these scams but some are selling them:

- Coverage that boasts low rates and minimal or no underwriting should be a signal to look deeper.
- Make sure that your insurance agent is selling you a state-licensed insurance product.
- If an insurance agent is trying to sell you a union plan, contact the [state department of insurance].
• Deal with reputable agents. If the person trying to sell you the coverage says he or she
doesn't need a license because the coverage isn't insurance or is exempt from regulation,
watch out. Contact your insurance department if you have any questions.
• Ask your agent for the name of the insurer and check the benefit booklet you receive to see
whether it names a licensed insurer that is fully insuring the coverage.
• If your agent or the marketing material says that the plan is covered only by “stop-loss
insurance” or that the plan is an “ERISA” plan or “union” plan, call the [state insurance
department.]

In sum: if you suspect that an insurance agent is trying to sell you fraudulent health insurance,
contact your state department of insurance right away.
Appendix 2 – Agent Alert

AGENTS BEWARE—ILLEGAL “ERISA” AND “UNION PLAN” SCAMS

Nationwide, the health insurance marketplace is facing tougher times. Across the country, the cost of health insurance is increasing and consumers cope with difficult choices. Into this climate enter shady operators seeking to take advantage of consumers. Calling themselves “ERISA exempt,” “ERISA plans,” “union plans,” “association plans,” or some variation thereof, these entities boast low rates and minimal or no underwriting.

Remember, if it seems too good to be true, it probably is. There is a good chance that these entities are not legitimately exempt from state laws, but instead are offering unlicensed health insurance.

These entities claim that they are not subject to state insurance regulation because of “ERISA.” Some claim that agents are used only as “labor consultants” or “business agents” to “enroll” or “negotiate” with potential members, and not to sell. Such claims should be viewed with skepticism. It is a crime to solicit or sell an unauthorized insurance product.

Legitimate ERISA plans (plans governed by the federal Employee Retirement Income Security Act of 1974) and union plans may be exempt from state insurance regulation, which is why criminals try to fool people by making these claims. However, legitimate ERISA or union plans are established by unions for its own members or by an employer for the employer’s own employees. They are not sold by insurance agents.

Read all materials and websites carefully. Consider the following list of some circumstances and plan characteristics that should prompt your very careful investigation, including contacting the insurance department:

- The plan operates like insurance but claims that it is not.
- You are asked to avoid certain insurance terminology, even though the plan operates like insurance.
- The plan is covered only by “stop-loss insurance” or refers to “reinsurance.”
- You are asked to sell an “ERISA” plan or “union” plan.
- You are asked to sell an “employee leasing” arrangement with self-funded health coverage.
- The plan targets individuals or groups with employees that have pre-existing conditions.
- The plan advertises unusually low premiums and/or unusually generous benefits, low (or no) minimum requirements for participation, and loose (or no) underwriting guidelines.

Insurance agents should contact the [state department of insurance] anytime they are approached by an entity that seems suspicious. If you are asked to sell health coverage and it is represented as exempt from insurance regulation under “ERISA” or as a “union” it is probably illegal. The insurance agent who does not inform the insurance department takes an enormous risk. An agent who fails to report, and sells, an “ERISA” or “union” plan should expect to lose his or her license, to possibly be subject to criminal prosecution and to face personal liability for any claims incurred under the unlicensed coverage.
Anyone with information about an entity offering health coverage without a state license should contact [state insurance department contact information].
Appendix 3 – Regulatory Alert to Stop-Loss Carriers and Third Party Administrators

You are asked to immediately review your internal controls and business practices to ensure that your company does not become an unwitting supporter of unlicensed (illegal) health insurance plans. Your company’s urgent effort to strengthen its internal controls in this area is warranted by your company’s commitment to good business practices. Unlicensed (illegal) health plans have left millions in unpaid claims. Moreover, your company’s failure to establish or strengthen appropriate internal controls may lead to substantial liability. Your company may be subject to regulatory penalties and may be liable for all unpaid claims under [insert reference to your state’s equivalent to Section 4 of the Nonadmitted Insurance Model Act].

The department asks you to establish or strengthen internal controls designed to ensure that:

Unlicensed MEWAs

Your company will not issue or purchase a stop-loss policy or undertake to administer unlicensed “self-funded” health plans that cover the employees of two or more employers unless all covered employers are under common ownership [or the plan is licensed in this state as a multiple employer welfare arrangement]. These plans are insurers under the laws of this state and are transacting the business of insurance without a license. They commonly, and wrongly, claim to be exempt from state insurance law under the federal Employee Retirement Income Security Act of 1974 (“ERISA”). Since these entities meet the definition of “multiple employer welfare arrangement” (“MEWA”) under ERISA they remain subject to state insurance law.

Note: States that have MEWA-specific licensing laws should add the language in brackets or make other modifications to this paragraph consistent with their laws.

Unlicensed Professional Employer Organizations (“PEOs”) Health Plans

Your company will not issue or purchase a stop-loss policy or undertake to administer an unlicensed “self-funded” health plan for a professional employer organization or employee leasing company based in this state or offering coverage to client employers in this state. These firms commonly refer to their clients’ employees as “co-employed” or as “leased” employees of the PEO. These self-funded health plans are Multiple Employer Welfare Arrangements under ERISA rather than single employer plans. Regardless of the employee’s status under state law, a business is a direct employer under ERISA only if the facts and circumstances of the case demonstrate that the employer actually controls and directs the individual’s work. As long as the participating workers are employed by the various client employers, the health plan covers multiple employers. That makes the plan a MEWA, even if the PEO is also an indirect employer or co-employer. As indicated above, MEWAs that are not fully insured are subject to state regulation as insurers, and state insurance laws applying to PEOs are not preempted by ERISA. Your company should exercise care that it does not assist a “self-funded” benefit plan of a PEO or employee leasing company that is an unlicensed insurer under the laws of this state.

Note: Some states have statutes allowing PEOs or employee leasing firms to self-fund health benefits or obtain a license allowing them to self-fund health benefits. Other states have laws expressly recognizing PEOs’ “co-employer” status but explicitly prohibiting self-funding. If
applicable, individual insurance departments should modify this paragraph to incorporate a description of the specific requirements of your state law.

**Out of State Trusts / Stop-Loss “Reinsurance” For Unlicensed Health Plans**

Your company will not issue or purchase unapproved stop-loss coverage for employers located in this state through an out of state trust, and will not undertake to administer an unlicensed “self-funded” health plan for employers located in this state unless all stop-loss coverage has been approved by this state. Operators of these arrangements purport to be exempt from this state’s insurance laws because they solicit employers in this state to apply for stop-loss coverage through a trust established in an out of state bank. Often these schemes falsely characterize the stop-loss policy as “reinsurance.” They also represent that all claims will be paid under the “self-funded” plan in return for a fixed contribution.

Each of these claims is legally wrong and factually false. An insurer or producer that solicits the sale of stop-loss coverage in this state is subject to this state’s laws. Stop-loss coverage is insurance, not “reinsurance,” and usually there are substantial gaps in the coverage. Most important, only licensed insurers and producers may solicit the sale of stop-loss policies in this state. A licensed insurer may offer only a filed and approved policy form.

The department asks that you take immediate steps to ensure that your company will avoid providing unwitting support to these illegal operations. You can find a discussion of ERISA provisions governing this topic on the U.S. Department of Labor website at [http://www.dol.gov/ebsa/Publications/mewas.html]. You may contact [insert contact information for the department MEWA contact] to discuss any questions you may have regarding this bulletin. Your company is encouraged to work with the department MEWA contact to resolve any questions about a particular operation. The insurance departments of other states will provide the same assistance, and may be contacted through the MEWA contact listed on the NAIC website [insert web address]. The department also asks you to establish policies that direct your company’s staff and agents to promptly report any operation described in this bulletin to the MEWA contact.
NAIC Medicare Supplement Insurance Model Regulation Compliance Manual

January 2019
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SECTION I: INTRODUCTION

OVERVIEW AND PURPOSE OF THE MANUAL

This manual has been produced by the NAIC for use by the states in their review of Medicare supplement rate filings, experience reports, and refund calculations. The manual was written to assist the states in complying with the directives set forth in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) amendments to Section 1882 of the Social Security Act. The passage of the Social Security Amendments Act of 1994 (SSAA-94) necessitated an update of this manual, completed in 1996. The passage of the Balanced Budget Act of 1997 (BBA-97) created a new Part C of Medicare, commonly known as Medicare Advantage, and also created new standards for Medicare supplement insurance. Passage of the Balanced Budget Refinement Act (BBRA) in 1999 resulted in additional changes. Passage of the Medicare Modernization Act of 2003 (MMA) created new Medicare Part D, prescription drug coverage, and affected certain other aspects of Medicare supplement plans. The BBA-97, BBRA, and MMA changes have necessitated an update of this manual. This manual addresses many of the issues associated with Medicare supplement standardization and filing requirements as outlined in the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (the model regulation).

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) created a new set of standardized plans that differ from those adopted by the NAIC as a result of the above laws. The model regulation adopts terminology to differentiate the plans by naming the original standardized plans as 1990 Standardized Benefit Plans and the new plans (effective June 1, 2010) as 2010 Standardized Benefit Plans. Several of the new plans have the same letter designation as the original plans even though there have been changes in benefits. Four of the original plans (E, H, I and J) are no longer available. Two new plans (M and N) are being added so that the new available plans will be: A, B, C, D, F, F (high deductible), G, K, L, M and N.

The model regulation as amended Aug. 29, 2016 defines a newly eligible individual for Medicare on or after January 1, 2020 (“newly eligible”) as an individual who becomes eligible for Medicare on or after January 1, 2020 by reason of attaining age 65 on or after January 1, 2020, or by reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed the available Medicare supplement plans with respect to those who become newly eligible for Medicare on or after January 1, 2020. MACRA requires that Medicare supplement plans that cover the Medicare Part B deductible cannot be available to those who become newly eligible for Medicare on or after January 1, 2020. Plans C and F may not be issued to those who become newly eligible for Medicare on or after January 1, 2020, but may be available to anyone eligible before January 1, 2020. In addition, MACRA revised the Plans that must be offered to those who become newly eligible for Medicare for guaranteed issue under model regulation Section 12, effective January 1, 2020. Finally, the model regulation provides for the availability of Plan G (high deductible) effective January 1, 2020.

As a public document, this manual may be useful to issuers of Medicare supplement coverage. However, it should be understood that its exclusive purpose is to be a tool for the states; specifically, it is not intended to be the definitive source of a state’s regulatory requirements for Medicare supplement insurance policies. It should be expected that some states may modify the procedures, data requests, or other aspects of their review from what is included in this manual, as the ultimate responsibility for approval of the rates, reporting, and refunds rests with the states. In this connection it should be noted that while this manual discusses recent changes to the model regulation as adopted by the NAIC, many states have enacted their own variations of the changes made pursuant to BBA-97. Therefore, states need to be aware of variations in their own laws and regulations.

The model regulation provides limitations on groups of benefits, uniform language and definitions, uniform format, and other standards as specified in OBRA-90 and subsequent amendments and legislation. This introduction provides insight into interpretation of the model regulation.

The second section of this manual, ISSUES AND COMMENTS, addresses a number of questions that have been raised by state insurance departments in their review of the initial rate filings of standardized plans. These issues are discussed with reference to the guiding principles set forth below and the model regulation.

The final sections of the report provide specific recommendations for the review of the various types of filings and a discussion of Medicare SELECT issues.
GUIDING PRINCIPLES OF THE MODEL REGULATION

#1: Simplification

A clear intent of the model regulation is to reduce consumer confusion by simplifying the marketplace. Benefit options that may be offered have been standardized. Also, the number of form option variations for features other than benefit options (e.g., underwriting) are limited.

#2: Medicare Supplement Policies Must Be Guaranteed Renewable

In addition to the contractual requirements of guaranteed renewability, the model regulation intends to ensure that policies are renewable “in effect.” This means that sub-blocks of policies are not exposed to very large rate increases. This is accomplished by restrictions on closing blocks of business and by limiting the number of Medicare supplement forms that an issuer can write (displayed in Diagram 1).

Within each of the Medicare standardized plans, four “types” of coverage may be offered:

- individual policy
- group policy
- individual Medicare SELECT policy
- group Medicare SELECT policy

When the companies file policy forms for the 2010 Standardized Benefit Plans, the new forms may be a replacement for the 1990 Standardized Benefit Plan policy form (or may not if the form is for one of the new 2010 Plans with no comparable 1990 Plan). For a short transition period, there can be two policy forms approved for each type above, prior to the variations noted in the next paragraph. However, the effective date of coverage precludes the actual availability of multiple forms in the same plan type combination.

MACRA has no requirement for new policy forms as the benefits under each plan remain unchanged.

Within each type of policy, an issuer is permitted up to five policy forms with variations based on inclusion of innovative benefits, marketing methods, underwriting methods, and eligibility for Medicare (aged versus disabled). These forms represent “reporting classes,” which are the level at which experience will be presented to the states for experience rating purposes. Note, however, that refund calculations are made at the “type” level. See the Refund and Recipients paragraphs of the Refund Issues subsection of the Issues and Comments section for discussion of refund calculations for 1990 and 2010 Plans with the same Plan letter.

Diagram 1
Medicare Plans

2010 Standardized §8.1

Plan Level

A  B  C  N

Type Level

Individual  Group  Ind. SELECT  Group SELECT

Form Level

Up to 5 forms per type are allowed with variations based on:
- inclusion of innovative benefits
- marketing method
- underwriting method
- eligibility for Medicare as aged vs. disability

1990 Standardized §8

Plan Level

A  B  E  L

Type Level

Individual  Group  Ind. SELECT  Group SELECT

Form Level

Up to 5 forms per type are allowed with variations based on:
- inclusion of innovative benefits
- marketing method
- underwriting method
- eligibility for Medicare as aged vs. disability

Pre-Standardized

Plan Level

Pre-Standardized

Type Level

Individual  Group

Form Level

Additionally, SSAA-94 created two “type level” categories for pre-standardized plans—individual and group.

The BBA-97 amendments added two high-deductible options as variations of plans F and J. As such, these two high-deductible options should be reported with the experience of plans F and J. The high-deductible options are not considered as “filling” the form level limit of five forms.

Finally, three states (Massachusetts, Minnesota and Wisconsin) were grandfathered by OBRA-90 from certain of its provisions. They were not required to change to the 10 standardized plans, but they were subject to the regulation of rates (filing approval and refunds), the Medigap open enrollment and guaranteed issue provisions, and the rules regarding duplication of Medicare or Medicare supplement policies. They were also allowed to be involved in the Medicare SELECT program.

#3: Medigap Open Enrollment

As a result of OBRA-90, the model regulation required a Medigap open enrollment period for individuals 65 years and older during the first six months of initial enrollment in Medicare Part B. SSAA-94 added a Medigap open enrollment for any individual who attains age 65 and has been receiving or has ever received Medicare Part B due to disability or end-stage renal disease (ESRD) prior to age 65. All plans that the carrier offers for sale must be available during these open enrollment periods. Both the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration have always held that an individual “attains age 65” as of the first day of the month in which the individual turns 65 unless the individual’s birthday occurs on the first day of the month, in which case the individual is deemed to be 65 as of the first day of the
preceding month. In the case of an applicant whose application for a policy or certificate is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B, an issuer is prohibited from discriminating in the availability, sale, or pricing of a policy because of the health status, claims experience, receipt of health care, or medical condition of the applicant. For this open enrollment period to be “real,” the offered rates during the Medigap open enrollment period must be calculated by a method that is consistent with the method used for underwritten business. Consistency would not be maintained if the rate charged during Medigap open enrollment effectively discourages new entrants, or if it reflects the full load for anti-selection and individuals are allowed to “re-enter” a specific block of business after the Medigap open enrollment period ends.

#4: Portability/Use of Preexisting Conditions Exclusions

While OBRA-90 limited the use of preexisting condition exclusions to a six-month period, and eliminated their use for replacement Medicare supplement coverage, BBA-97 includes HIPAA-like language dealing with portability issues. The concept of portability is only applicable to the Medigap open enrollment period. If a beneficiary applying during Medigap open enrollment has a continuous period of prior creditable coverage that is less than six months (defined in Section 4, subsections E and F, of the NAIC Model Regulation), the carrier must credit such prior creditable coverage against the preexisting condition exclusion period. If the beneficiary has six months or more of prior creditable coverage, then a preexisting condition exclusion is not allowed.

#5: Medigap Guaranteed Issue Rights for Certain Eligible Persons

BBA-97 provides for a 63-day Medigap guaranteed issue period following any of the events listed in 1 through 6 below (see the NAIC Model Regulation, Section 12 for details). Persons eligible for guaranteed issue are entitled to purchase certain Medigap plans (if otherwise offered by an issuer) on the same underwriting and premium basis as apply during open enrollment. Additionally, a preexisting condition exclusion cannot be applied to a guaranteed issue policy.

1. Termination of an employee welfare benefit plan in its entirety, or benefits under the plan that are supplemental to Medicare.

2. Termination of Medicare Advantage coverage, movement of the beneficiary out of the service area, violation of a material provision of the contract, marketing abuse, or failure to provide quality care.

3. Cessation of enrollment in a Medicare cost contract, demonstration project, or Medicare SELECT contract.

4. Loss of Medicare supplement coverage due to the issuer’s insolvency or substantial violation of a material provision.

5. A person dropped Medicare supplement coverage, enrolled in a Medicare Advantage contract and terminated such contract within 12 months.\(^1\)

6. A beneficiary enrolled in a Medicare Advantage plan, when first eligible for Medicare at age 65, then disenrolled within the first 12 months.

7. A Medigap Rx insured enrolled in Part D during the initial enrollment period and terminated the Medigap Rx policy.

Following any event listed in 1 through 4 above, eligible persons are entitled to plan A, B, C, or F available from any issuer. Following the event described in 5, an eligible person is entitled to the Medicare supplement plan the individual had just prior to enrolling in Medicare Advantage, if that plan is still available from the original issuer. If that plan is not available, the individual is entitled to plan A, B, C, or F available from any issuer. Following the event described in 6, eligible persons are entitled to any plan available from any issuer. Following the event described in 7, eligible persons are entitled to A, B, C, F, K or L from the same issuer. Effective January 1, 2020, Plan D replaces Plan C and Plan G replaces Plan F for all the events where offering Plan C or Plan F is required with respect to newly eligible individuals who may not be issued Plan C or Plan F.
For this guaranteed issue option to be “real,” the offered rates during the Medigap guaranteed issue period must be calculated by a method that is consistent with the method used for underwritten business. Consistency would not be maintained if the rate charged during the Medigap guaranteed issue period effectively discourages new entrants or if it reflects the full load for anti-selection and individuals are allowed to “re-enter” a specific block of business after the Medigap guaranteed issue period ends.

#6: Requirements under the Medicare Modernization Act of 2003 Prohibition Against Use of Genetic Information and Requests for Genetic Testing

Effective May 21, 2009, the Genetic Information Nondiscrimination Act of 2008 (GINA) limits the information that a company may ask a prospective policyholder about the insured or the insured’s family members (see Section 24 of the NAIC Model Regulation for details). These limitations apply to both new issues and any request for replacement after that date. The limitations apply to issuing the policy, the effectiveness of the policy, the application of preexisting conditions and the pricing of coverage. These rules apply to the company as well as any third-party administrator a company may use.

#7: Rates Must Be Reasonable in Relationship to Benefits

Another guiding principle is that rates must be reasonable in relationship to benefits. This principle has not changed from that in most individual rate filing requirements. However, the loss ratio standards implemented are both prospective and retrospective in nature.

Prospectively, the expected loss ratio (the present value of incurred claims divided by the present value of earned premiums) over the period for which the rates are computed to provide coverage must meet or exceed the minimum standard. These minimum standards are 65% for individual policies and 75% for group policies. These loss ratios now apply to all Medicare supplement policies, including pre-standardized policies still in effect that were issued prior to the implementation of OBRA-90. For the pre-standardized plans, minimum loss ratios apply to experience of the policy after the SSAA-94 effective date. Policies issued as a result of mass media advertising are deemed to be individual policies under OBRA-90; however, the NAIC has encouraged states to retain a 75% loss ratio for group policies issued on this basis. Many state regulations have implemented this change. The target loss ratios are not intended to apply to each rating cell. Expense levels may vary by rating cell, and some rating cells may be expected to subsidize others (e.g., the cost of Medigap open enrollment may be spread over all policyholders). One of the roles of the initial rate review is to ensure that the subsidies by rating cell are reasonable and appropriate.

Retrospectively, the issuer of a policy must provide for a refund or credit of the amount necessary to comply with refund targets representing minimum thresholds of incurred claims (as compared to premiums) by duration. The refund requirement provides a sound foundation to protect policyholders from excessive rates. However, it was never intended to replace existing rate review practices.

Loss ratio standards provide guidance in determining when a rate is not reasonable in relation to benefits because it is too high. An equally important issue is when the rate is not reasonable because it is inadequate. The model regulation does not provide any basis by which to measure adequacy. This manual provides some guidance in this area (e.g., what is considered a reasonable rate relationship by age).

#8: Annual Filing and Approval of Rates

The model regulation provides that an issuer must annually file its rates, rating schedules, and experience by policy duration for approval by the states according to each state’s filing and approval requirements. This filing is required whether or not an issuer is seeking a rate revision.

#9: Permitted Compensation Arrangements

The model regulation discourages compensation arrangements that would promote churning Medicare supplement policies. This is done by “levelizing” commission schedules so that the first-year commission can be no more than twice the commission in renewal years two through six. In addition, only renewal commissions are payable when a policy is replaced after October 31, 1994, even if benefits are upgraded.
WHAT ARE THE REGULATOR’S RESPONSIBILITIES?

OBRA-90, SSAA-94, BBA-97, BBRA, MMA2003, MIPPA, GINA and MACRA amended Section 1882 of the Social Security Act, which provides for federal certification of Medicare supplement insurance policies unless a state’s regulatory program is approved by CMS. In order for a state to qualify for approval it must, among other things:

- Provide for the application and enforcement of Medicare supplement standards that are at least as stringent as the NAIC Model standards.
- Meet or exceed notice and reporting standards.
- Require periodic reporting of experience.
- Provide to CMS a list of the names and addresses of issuers of Medicare supplement policies in the state.
- Report to CMS on the implementation and enforcement of standards and requirements of Section 1882 of the Social Security Act as amended (including information regarding loss ratios of policies sold in the state and state programs implementing consumer protection).
- Maintain a file for public access of each issuer’s experience loss ratios, rates, forms and advertising.
- Provide for a process of approving or disapproving initial rates and proposed rate revisions.

If a state wishes to regulate Medicare supplement insurance, it must have been initially approved by CMS and will be periodically reviewed for re-approval.

WHAT ARE AN ISSUER’S RESPONSIBILITIES?

In addition to complying with the regulation in the state regarding the marketing, disclosure, policy provisions, pricing and administration of Medicare supplement policies, an issuer of Medicare supplement policies must provide state insurance departments with:

- **Annual Filing of Premium Rates**
  
  Each issuer must file its historical and proposed rates, rating schedules, historical and projected loss ratio analysis, and supporting documentation.

- **Refund or Credit Calculation**
  
  By May 31 of each year, each issuer must file in each state, for each refund class, the Refund Calculation Form. If a refund is indicated, the refund must be made (with interest from the end of the calendar year) before September 30 following the reporting year.

- **Additional Experience Reports**
  
  Each issuer must file several experience reports as required by OBRA-87 and OBRA-90. These include:
  
  — The MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT, which is filed with the annual statement
  
  — The FORM FOR REPORTING DUPLICATE MEDICARE SUPPLEMENT POLICIES.
SECTION II: ISSUES AND COMMENTS

MEDIGAP OPEN ENROLLMENT ISSUES AND MEDIGAP GUARANTEED ISSUE

What is the difference between Medigap open enrollment and Medigap guaranteed issue?

Medigap open enrollment is the six-month period following initial eligibility for Medicare Part B. Medigap open enrollment was created by OBRA-90 and entitles a beneficiary to the issuance of any Medigap plan offered by an insurer and available to the individual. Benefits under a Medigap plan issued during the open enrollment period may be subject to preexisting condition exclusions, though the exclusion must be reduced or waived if there is prior creditable coverage.

Medigap open enrollment should not be confused with the Medigap guaranteed-issue period provided for by the Balanced Budget Act of 1997, and modified by the Balanced Budget Refinement Act of 1999. A beneficiary is eligible for a 63-day Medigap guaranteed-issue period following the occurrence of certain events specified in Section 12 of the NAIC Model Regulation (see Section I, #5 above). During the guaranteed-issue period, an eligible beneficiary is entitled to the issuance of certain specified Medigap plans. Unlike plans issued during open enrollment, preexisting condition exclusions cannot be applied to benefits under plans sold on a guaranteed basis.

It is important to note that medical underwriting is prohibited under both the Medigap open enrollment and guaranteed issue periods.

Medigap Open Enrollment

There is a six-month Medigap open enrollment period following initial eligibility for Medicare Part B (at age 65 or older under the Model Regulation; some states also require open enrollment following initial Part B eligibility for beneficiaries under 65). During this period, the issuer may not deny or condition coverage due to health status, claims experience, receipt of health care or medical condition (Section 11). Can the issuer charge higher rates at age 65 (when most of the Medigap open enrollment is expected) to cover the anticipated anti-selection?

No. To do so would violate the principle of Medigap open enrollment and be contrary to statute. Those insureds who could pass medical underwriting would then simply be reissued at age 66. This also means there cannot be a higher rate for insureds age 65 compared to age 65½.

Issuers are required by federal law and Section 11 of the model regulation to issue all currently available policies to eligible individuals during the Medigap open enrollment period. In addition to other federal and state penalties, many states have made it an unfair trade practice if an issuer did not market to individuals who are in their Medigap open enrollment period. This means that an issuer cannot:

- Reduce commissions at age 65.
- Reduce commissions from a policy issued during the Medigap open enrollment period where the insured is in poorer health.
- Eliminate individuals age 65 from mass marketing efforts.
- Engage in other activities that treat insured applicants who are in their Medigap open enrollment period more restrictively than other applicants of like characteristics.

Medigap Open Enrollment and Medigap Guaranteed Issue Rate Differentials

What, if any, rate differentials may be imposed during Medigap open enrollment and Medigap guaranteed issue?

In 1993 the Medicare Supplement and Other Limited Benefit Plans (B) Task Force determined that allowable rate differentials during the Medigap open enrollment and guaranteed issue periods include, but are not limited to, those for age, gender and geographic area; coverage of more than one life; and modal payment. Rates must be at least as favorable as those offered outside of open enrollment and guaranteed issue. There is no explicit guidance from the federal government or any other regulatory body whether discounts should be permitted for non-tobacco users during the open enrollment period.
If an insured first enrolled in Medicare Part B at his/her 65th birthday but does not enroll in a Medicare supplement plan until after the Medigap open enrollment period, the insured may be underwritten for rating and issue purposes.

The cost of Medigap open enrollment should be spread over all policyholders of the form. This means that issue-age groups that are more likely to be exposed to Medigap open enrollment entrants are likely to have higher loss ratios.

**EFFECTIVE DATE ISSUES**

**What are the important effective dates for various parts of the regulation?**

Each state will have several dates that are important in the regulation of Medicare supplement policies in that state. The first one is the state’s effective date for the 1990 Standardized Benefit plans (OBRA-90 date). This effective date defines the starting date for the new loss ratios and the refund requirements for standardized plans A-J. The second date is the effective date of the state’s changes dealing with the new loss ratios for pre-standardized Medicare supplement policies (SSAA-94 date). The third date is the effective date of the new requirements under the Medicare Modernization Act of 2003, including addition of two new standardized plans—K and L—and stripping all prescription drug benefits from plans with such benefits for insureds who enroll in Medicare Part D. (This includes plans H, I, J, high-deductible J, pre-standardized plans with drug benefits, and the prescription drug plans in Minnesota, Wisconsin and Massachusetts.)

The effective date of the 2010 Standardized Benefit plans will be June 1, 2010, except in very unusual cases. The 1990 Standardized plans cannot be issued with an effective date after May 31, 2010. Both the 1990 plan policy forms and the 2010 plan policy forms will likely be marketed for a period prior to June 1, 2010. Which form is used depends on the effective date of coverage.

There are several areas of regulation for which applicable dates are not based on the state’s action. For example, the effective dates for new rules relating to compensation patterns are set by federal law. Appendix E provides a historical context for the development of effective dates and notes that some effective dates were applicable in the past for a limited period of time.

**Is there any flexibility in the effective dates?**

Generally, no. The change from 1990 Plans to 2010 Plans is to occur on June 1, 2010, in all states. The requirements relative to the grandfathered states (Massachusetts and Wisconsin) are:

- **Massachusetts:** The state will not offer the new coverages.
- **Wisconsin:** The new coverages will be effective on June 1, 2010. Coverages eliminated must not be included in policies issued with effective dates after May 31, 2010.

However, administrative flexibility is allowed to carriers in two instances where the policyholders will benefit.

If a carrier wishes to use a common SSAA-94 effective date for a group of states (all of which have a SSAA-94 date equal to or later than the one chosen by the carrier for administrative simplicity) in the accumulation of experience for loss ratios and/or refunds, this should be acceptable.

If a carrier has included business in refund calculations that would not normally need to be included (standardized policy forms written before the state’s OBRA-90 date), that practice should be allowed to continue. The alternative of requiring transfer of these policies’ experience from the standardized benefit plan to the pre-standardized pool is not in the policyholders’ interests.

**GENERAL RATING ISSUES**

**Rate Schedules**

**How many different rate schedules may apply to any policy form?**

The model regulation designates a maximum of five policy forms within each type of a standard plan that may be offered at any one time. A new policy form is allowed to replace an existing form, and it is expected that some companies will utilize
this to make the change from 1990 to 2010 Plans as smooth as possible. The model regulation lists the bases on which the forms may vary. The clear intent of the model regulation is to simplify the number of options available to a consumer (see guiding principle #1). Although the regulations do not specify the criteria by which rates may vary, the following are commonly used:

- Age
- Gender
- Family status
- Smoking status or use of tobacco
- Underwriting class (standard or substandard)
- Area
- Rating methodology (if there has been a change, with new issues only on the new methodology)
- For Plan F, Plan G, and Plan J, separate rates for the normal and high-deductible options

There may be quite a variation between issuers as to how substandard rates and area rates are determined. Some may apply separate schedules by area, while others apply area factors. Substandard rates may be a single new rate schedule, multiple schedules (depending on the degree of expected extra morbidity), or a flat dollar amount or a percentage adjustment.

MACRA modifies which Standardized Benefit (SB) Plans must be available to applicants who become newly eligible for Medicare on or after January 1, 2020, and have a guaranteed issue right, requiring Plans D and G be offered in place of Plans C and F. That change does not provide issuers any new opportunity to create an additional policy form or utilize different rate schedules for policies issued after the MACRA changes apply. States should evaluate any requests for new policy forms or rate schedules against the allowances under their state laws and regulations.

Section 17C(3) of the model regulation requires disclosure of all possible premium rates offered to the applicant on either the cover page or the next page following. Regulators must require and examine this aspect of the form to assure clarity.

**Subsidies**

**What rate subsidies are allowed or encouraged between plans or rate cells?**

One cell or rating class subsidizes another if they are pooled for refund or re-rate purposes and the loss ratio of the first is less than the other (after adjustment for expected underwriting and expense differences). Nothing in the model regulation explicitly prohibits subsidies. In fact, some subsidy of the Medigap open enrollment age groups is expected.

**Subsidies of In-Force Blocks**

**What rate subsidies are permitted between policies in force when the Medicare supplement regulation became effective and policies issued after that date?**

While subsidies between standardized and pre-standardized blocks of Medicare supplement policies are not prohibited, each block is subject to certain requirements. This also applies to the new 2010 Standardized Benefit plan policies versus the 1990 Standardized Benefit Plan policies.

All Medicare supplement policies must meet the new minimum loss ratio requirements (regardless of whether it was a standardized benefit plan or not). Policies issued prior to November 5, 1991 (pre-standardized policies) are now subject to the regulation’s requirements on refunds or credits if the loss ratios do not meet the regulation’s standards (see Appendix E for additional explanations concerning effective dates).

Therefore, the loss ratio cannot be lower than the thresholds, even if the excess is used to subsidize another block of business.

**Rating Methodology Options**

**Can an issuer offer more than one rating methodology on a single policy form at the same time?**

Each state should decide this question. This manual does not advocate the use of multiple rating methodologies. However, if more than one rating methodology on a single policy form at the same time is allowed, the following regulatory provisions should be applied in such circumstances:
1. Under individual insurance policies, the individual policyholder should have a choice as to whether to elect an issue-age or attained-age rating methodology. For a group policy, it is the group policyholder, not the certificateholder, who has this choice.

2. The dollar level of first-year commissions should be no more than twice the dollar level of second-year commissions and shall not vary based on the rating methodology selected by the policyholder. Renewal commissions for years two through six may be a constant dollar amount that does not vary based on the rating methodology or may be defined as a constant percentage of the issue-age premium.

3. Consumers should be allowed to switch from an attained-age rating basis to an issue-age rating basis. However, consumers should not be allowed to switch from an issue-age rating basis to an attained-age rating basis.

4. The review of rates would be done in the following fashion:
   a. New business rates
   Essentially, the company would make two demonstrations. First, for the attained-age rating structure, it would demonstrate that the discounted value of future claims divided by the discounted value of future premiums was at least at the 65% level (75% for group). The company would make a second demonstration that this loss ratio requirement was met for an issue-age rating structure. Assuming the company had other policy forms that were issued on the proposed rating bases, the company would be expected to modify that other experience (if it were credible) to fit the benefit structure of the new policy form. If the company had credible experience under other policy forms but did not have credible experience under the proposed rating structures, then the initial relativities would have to be established, assuming that the morbidity and other pricing assumptions under all of the proposed rating methodologies were the same as the experience for the other forms. If the company had no credible experience, then outside sources of credible data would be utilized to produce the morbidity and other pricing assumptions, which would again be assumed to be the same for all rating methodologies.
   b. Renewal business
   Three tests would be required for renewal business. First, all experience for issue-age and attained-age rating structures would be combined. The total accumulated past claims would be added to the present value of future projected claims, and that sum would be divided by the accumulated value of past premiums plus the present value of premiums on the new rating structure. This first ratio would be compared against the 65% standard. The second and third tests are comparable to the tests described for new business. Both the attained-age and issue-age rating structures would have to be shown to be meeting the 65% loss ratio prospectively. For the issue-age rating structure, some estimate of the active life reserve would need to be incorporated in the demonstration that the 65% loss ratio was anticipated to be met.

5. Insurers will develop materials that disclose both rating options, an explanation of how they differ both in the near term and the long term, and an explanation of the policyholder’s right to switch from one rating option to another.

Changes to Rating Characteristics

Can a policy form change characteristics (e.g., mass-marketed, agent-produced, guaranteed issue)?

Generally, no. The clear intent of the model regulation is to prohibit an issuer from closing a block of business and selling another in its place. If an issuer were allowed to change the characteristics of a policy form, this could effectively be accomplished. An issuer is allowed to change the characteristics of its standardized plan offer by introducing a new form with the revised characteristics (for up to five forms per type). In situations where new statutory requirements (federal or state) would require a change or elimination of one or more rating characteristics, a company may use new rating characteristics for new issues of the policy form. Experience of old and new issues must be combined for reporting and rate filings. The aim would be to avoid the necessity of filing new policy forms for approval.

Definition of Claims/Premium

What specific items are to be included or excluded from the loss ratio calculation?

Incurred claims should exclude claims expenses and claims management expenses—i.e., only paid claims and liabilities for unpaid claims should be included. Earned premiums should include modal loadings and policy fees. Active life reserves should be excluded from all calculations. Premiums and claims should be reported for direct business only, and should not reflect adjustments for assumed or ceded reinsurance arrangements except assumption reinsurance.
What types of items are not to be included in the loss ratio calculations?

Issuers may offer discount cards or other offers that allow the insured to receive lower-than-normal prices for certain services (e.g., drugs, eyeglasses, etc.) when specific providers are used. Since the insured is responsible for the full amount of the discounted charges for all such services, there is no real insurance. Consequently, any charges for such discount cards or offers are not insurance premiums to be added as a separate component in the Medicare supplement forms experience, and no payments by the issuer are to be considered part of the Plan’s benefit package.

Period for Which Rates Computed

The model regulation states that loss ratio standards must be met over the period for which rates are computed to provide coverage. What is this period?

Since the policies are guaranteed renewable, it is reasonable to define this period as the total life of the policy. This does not detract from the ability to reflect reasonable assumptions for persistency, interest, medical inflation, and rate revisions.

Reporting Basis

Can the rate refund exhibits be used as the basis for filing rate revisions?

No. The rate refund filing is distinct from the annual experience filing or any filing for a rate revision. The refund filing is retrospective in comparing emerged experience to benchmark assumptions. The rate filing must be prospective in its analysis of whether expected experience now differs from the assumed target experience used in the current premium rates based upon issuer-specific assumptions as to lapse, selection, durational loss ratios, and trend rates.

Rate Revisions

May renewal rates be based on the state of residence?

Companies must adopt a consistent approach to renewal premiums when the state of residence is different from the state of issue. The company is to document in the original filing and with each annual rate filing whether its applicable rates will be based on state of issue, or if rates will be revised to reflect the state of residence. If the company will be basing the rates on the state of residence, an explanation of the approach to be used must be included in the documentation. The approach to be used may not be revised without the approval of the commissioner.

Note that the experience for refund purposes is to be included based on the state of issue.

What are some alternative approaches to reflect the state of residence in renewal rates?

One method is to use a table of geographical factors to determine a ratio of new residence to original state. This ratio would be applied to the approved renewal rate for the state of issue. The table is not expected to be subject to approval. Another method would be to use the approved rate in the state of residence.

Are Medicare supplement issuers restricted as to when rate revisions may be implemented?

Section 14C of the model regulation requires an issuer “to annually file its rates, rating schedule and supporting documentation.” Regulators may use their own judgment in interpreting whether this means once per calendar year or once per 12-month period. The commissioner is directed to approve the rates “in accordance with the filing requirements and procedures prescribed by the commissioner.” This provides flexibility to permit rate filings more often than annually where appropriate.

In the event of changes in Medicare benefits, an issuer shall file rate adjustments “as soon as practicable” and before the change takes effect, if possible.
INNOVATIVE BENEFIT ISSUES

The guidance provided in this section is intended to assist states and is not binding on any state or party. It is anticipated that some states may use an alternative decision-making process. The decision to approve or deny a proposed new or innovative benefit, according to the federal law, rests solely with each state where the benefit is filed.

The model regulation allows for “New or Innovative Benefits” as set forth in federal law only with the approval of the commissioner. Federal law requires that new or innovative benefits do not adversely impact the goals of Medicare supplement insurance simplification and that they be offered in a manner consistent with the goal of simplification of Medicare supplemental policies. New or innovative benefits should not otherwise be available and should be cost-effective to the delivery of health care services in the Medicare program.

What are “New or Innovative Benefits”? 

New or innovative benefits are benefits that are not available as part of the standardized Medicare supplement benefit design. Examples of new or innovative benefits may include, but are not limited to, the following services not already covered by Medicare:

1. Coverage for hearing services
2. Coverage for vision services
3. Coverage for dental services
4. Coverage for preventive care services

Benefits such as discounts for eyeglasses or frames, discounts for hearing aids, membership in health clubs, or other types of ancillary services or programs should not be considered new or innovative benefits. Insurance companies should be aware of individual state insurance department policy before offering the benefits, discounts or services.

Alternative cost-sharing provisions from those in the applicable standard plan designs—such as deductibles, copays, coinsurance and out-of-pocket maximums—should not be considered new or innovative benefits and should not be approved as a new or innovative benefit. Alternative cost-sharing could severely impact the successes of standardization and simplification of Medicare supplement policies.

How should new or innovative benefits be filed and approved?

New or innovative benefits should be filed and approved according to the states’ policy form and rate filing and approval requirements and consistent with Section 15 of the model regulation. The benefit should be easily understood by the customer and add value to the standard benefit plan designs.

States should review the filings in the context of the definition of new or innovative benefits as set forth in Section 1882(p)(4)(B) of the Social Security Act and Section 9.1F of the model regulation. Review standards should include those that pertain to the policy form being filed, but should also take into account the goal of simplification and standardization of Medicare supplement policies as contemplated in the federal law and the model regulation.

How should new or innovative benefits be added to the existing benefit plan designs?

States should consider adopting practices and developing materials to provide information to consumers about any new or innovative benefits approved for sale. For example, states should consider developing state-produced materials describing any new or innovative benefits.

States should consider whether new or innovative benefits take the form of a rider that is added to an existing benefit plan design, or are an integral part of the underlying standardized policy form. In either case, the cost/premium for the new or innovative benefit should be disclosed to the customer separately from the cost/premium for the standardized benefits.

If the issuer does not provide coverage without the innovative benefit for any of its plans, states should require a clear disclosure by the issuer that the coverage without the innovative benefit is available in the marketplace from other issuers. States should require issuers selling products that include innovative benefits to separately identify the new or innovative benefits in the individual plan description of benefits.
New or innovative benefits are part of the policy even if added by rider, so open enrollment provisions as set forth in Section 11 of the model regulation and guaranteed issue provisions as set forth in Section 12 of the model regulation shall apply. Subsequent purchases of plans with new or innovative benefits could be subject to a company’s underwriting standards.

The limitation on the number of policy forms an insurer is allowed to sell contained in Section 15 of the model regulation also applies. This means that, for example, an issuer that sells a Plan F with innovative benefits imbedded in the contract could not offer a Plan F with different innovative benefits imbedded in the contract. Under the model regulation, there can be only one policy with innovative benefits per plan/type combination.

**How are the premiums, premium changes and claims experience of new or innovative benefits to be handled?**

It cannot be determined at this time that all new or innovative benefits will be easily segregated from the basic benefits of Medicare supplement Plans, although some will (e.g., coverage for vision, hearing or dental services). Some new or innovative benefits will, of necessity, be interwoven with the Plan benefits (e.g., alternative treatment options).

It is possible that for some new or innovative benefits, the same benefits can be easily attached to multiple Plans, while others coordinate with only certain Plans.

As such, companies that request approval of a form with new or innovative benefits will need to provide the following information with respect to the initial premium and the intended basis for changes to the premiums for the policies containing the new or innovative benefits (or the riders providing them):

1. The initial premium for the new or innovative benefit should not be inconsistent with the rating basis for the policy to which it is to be attached (e.g., attained age rates for rider attached to an issue age rated policy). It can be expected that the pattern of claims for some new or innovative benefits could have some differences from the assumptions for the basic coverage. In situations where there is expected to be only minimal change in the assumed claims for the new or innovative benefit by age or duration, a simple rating structure should be allowed (e.g., a single rate for all ages and durations) even though the basic coverage premiums vary. Sufficient documentation of assumptions should be provided by the company to demonstrate that the premium scale is reasonable and that the minimum lifetime loss ratio will be met.

2. Experience reporting for demonstration of loss ratio compliance and rate revisions shall be consistent with state requirements. To the extent consistent with state requirements, it should be specified where the company desires to have the same new or innovative benefit with the same premium be available with multiple Medicare supplement Plans. In this case, the experience of the new or innovative benefit should be combined for all Plans to which it is attached, and premium changes based on such combined experience, which would be subject to the loss ratio requirements. Alternatively, it should also be specified where the company’s desire is to have the premium for the innovative benefits coordinated with the premium for the basic Plan, in which case the experience of the new or innovative benefit is reviewed as part of the basic Plan experience.

3. Both as a result of the possible differences in claims patterns noted in #1 above and the potential impact of policyholder selection of a Plan with or without the new or innovative benefits, it is likely that the experience for the basic coverage of the policies with vs. without the additional benefits may diverge. The company’s choice per #2 above, as allowed by state law, should be reflected in the regulatory review of premium changes. If the experience of the new or innovative benefit is being kept separate, the experience of the basic coverage should be combined. If the experience of the new or innovative benefit is combined with the experience of the basic coverage, and there are two unique policy forms, then the experience of each should be the basis for the premiums for that policy form.

4. For refund calculation purposes, the premiums and claims for innovative benefits are to be included with the premiums and claims for the Plan and state of each policy. Since many anticipated new or innovative benefits will be relatively small, reasonable approximations and allocations should be allowed.

**Availability of new or innovative benefits in the marketplace**

In order to maintain standardization and simplification in the Medicare supplement marketplace, states who approve new or innovative benefits should report each such approval to the NAIC Senior Issues (B) Task Force. The Senior Issues (B) Task Force will maintain a record of all new or innovative benefits approved throughout the country. States and insurers will have access to these records in order to evaluate their possible use in their market. The Task Force will periodically review the
new or innovative benefits approved in the states and will determine, in collaboration with CMS and other interested parties, whether any of the new or innovative benefits approved for use in the states should be made part of the standard benefit designs and benefit plan designs contained in the Medicare Supplement Model Regulation.

In addition, each state should consider publishing all the new or innovative benefits it has approved in order for the benefits to be available to all insurers in the marketplace. An expeditious review and approval process might be considered for those Medicare supplement carriers that wish to provide already-approved new or innovative benefits and that certify the benefit they are filing for approval is exactly the same as a previously approved new or innovative benefit.

CHANGE IN RATING METHODOLOGY ISSUES

Change in Methodology

Section 15D(3) of the model regulation indicates that a change in rating methodology shall be considered a discontinuance unless certain criteria are met. What constitutes a “change in rating methodology”?

The model regulation does not define what events constitute a change in rating methodology. A reasonable definition would be a change in demographic rating classes, which is actuarially equivalent to the current rating practice under reasonable assumptions. Examples of different rating structures that could produce the same overall revenue requirements are:

- Age structure (community rates vs. issue-age rates vs. attained-age rates).
- Class structure (single class vs. smoker/non-smoker classes, unisex vs. male/female classes).
- Rates for each age vs. age-banded rates.

Such a change in methodology does not change the experience pool (i.e., the form) that an insured is in. It changes the rate that new entrants into the pool must pay.

If a state has allowed more than one rating methodology on a single policy form at the same time and an individual elects to switch from an attained-age rating basis to an issue-age basis, that switch should not be viewed as a change in rating methodology, because the mechanics for allowing this switch has already been built into the policy.

Rating Methodology Requirements

What requirements must be met in order to change the rating methodology?

An issuer must clearly state in its rate revision request if it is changing rating methodology. The issuer must provide an actuarial memorandum supporting the new rating structure. Also, the rates must always remain in the same relativity from that time forward (unless the commissioner deems it in the public interest to change the differential). This effectively means that both blocks will receive the same rate increases.

There is no federal statutory requirement to maintain a rating relationship applicable for a 1990 Standardized Benefit Plan(s) to a 2010 Standardized Benefit Plan with the same Plan letter. It is anticipated that, all other factors being equal (e.g., lifetime target loss ratio, underwriting, etc.), the initial rates for a 2010 SB Plan will be equal to those for a comparable 1990 SB Plan. If so, the subsequent rate adjustments will be uniform between plan generations throughout the lifetime of the policies. If the initial rates are not equal, then the goal over time is for the premiums for a 1990 SB Plan to become identical to those of the same plan/type 2010 SB Plan. Any variations from this goal are subject to the regulation(s) of the state(s) in which the rates are filed.

In reviewing a change in methodology, a state must ensure that the new methodology:

1) Does not adversely affect existing insureds.
2) Is actuarially equivalent to the existing structure based upon reasonable demographic assumptions that exclude the effect of aging or selection.

The intent of these requirements is to protect insureds in closed blocks of business. If the experience of the eliminated rating structure were not included with the new rating structure, insureds could be “closed” out of coverage, with potential enormous future rate increases.
If an issuer changes rating methodology, the rate revision filing must include a demonstration that the relative ratio for the two methodologies is equivalent. Each rate revision filing and annual rate filing thereafter must include a certification that the relative ratio for the two (or more) methodologies has not changed.

**Area Factors**

Is a change in area factors a change in rating methodology?

No. If changing area factors was a change in rating methodologies, the revised rates could only be applied to new insureds, and the relationship between the two schedules would have to be maintained. However, different geographic areas may experience different trends in health care costs. Issuers should be able to reflect different trend rates to all insureds in different areas within a state, as they are able to reflect different trends between states. In reviewing a requested change, a regulator should ensure that the resulting rate relativities by area are reasonable as demonstrated by credible experience, industry data or CMS data. Note that it may be appropriate to take the effect of large claims into consideration. Also, the requested change should not close off issues in a particular geographic area, either explicitly or in effect.

**COMPENSATION ISSUES**

**Compensation Arrangements**

Section 16B of the model regulation requires that the commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year. Does this mean the same dollar amount or the same rate?

An issuer may demonstrate compliance with Section 15 of the model regulation through a commission schedule that is leveled by either amount or percentage rate. When an issuer anticipates increasing rates in its rate filing, a flat percentage rate renewal would result in an actual increase in commission as a dollar amount. This is not prohibited by the model regulation. (See GENERAL RATING ISSUES, Rating Methodology Options of this section for additional information concerning policies having multiple rating methodologies.)

**Replacement Compensation**

Section 16C of the model regulation requires an issuer to pay the renewal level of compensation for replacement business. How does this work if an issuer pays renewal commissions at a level dollar amount?

If an issuer pays renewal commissions as a level dollar amount, the commission payable for business that has been replaced will depend on the original year of issue. If an issuer is replacing its own business, the original issue year of the replaced policy must be used for purposes of determining commission amounts. If another issuer is being replaced, the commission must be no more than the commission in the second year for a policy issued one year prior.

Until October 31, 1994, the model legislation and federal law permitted first-year commissions if “benefits of the new policy or certificate are clearly and substantially greater than the replaced policy.” For replacements after this date, only renewal commissions are payable.

**GROUP ISSUES**

**Group-Specific Rates**

If an issuer offers a group Medicare supplement policy, may the rates for each group policyholder be experience-rated?

Nothing in the model regulation explicitly prohibits group rating practices. However, it should be noted that in 1993, the NAIC’s Medicare Supplement and Other Limited Benefit Plans (B) Task Force sent a letter to CMS stating, “The task force believes that the prohibition of experience rating is in the best interest of the consumer and is most consistent with NAIC models. … This interpretation is consistent with federal statutes and regulations, including OBRA-90.”
Some carriers might file a group rate manual with rates that vary by certain demographic variables, which are composited for purposes of a group’s rates. For example, for a specific group, carriers might use unisex rates that are equivalent to the filed rates based on the distribution by sex of the group. As long as the rates charged to the group are equivalent to the filed rates based on the group’s demographics, the prohibition against experience rating would not be violated.

Conversion Requirements and Rates

Group Medicare supplement insurance is required to offer certificateholders certain conversion rights. Can an issuer charge a much higher rate for the conversion policy, or should there be a limit to the price differential between the group policy and the conversion policy?

There are two circumstances under which a conversion may occur, and the required conversion rights differ for each. In both cases, an individual policy with benefits comparable to those in the group policy must be available. It is assumed that the 2010 Standardized Benefit Plan of the same Plan letter is “comparable” to the 1990 Standardized Benefit Plan. For 1990 Standardized Benefit Plans that are being discontinued, the following are deemed “comparable” for conversion purposes:

- 1990 SB Plan E is comparable to 2010 SB Plan D.
- 1990 SB Plan H is comparable to 2010 SB Plan D.
- 1990 SB Plan I is comparable to 2010 SB Plan G.
- 1990 SB Plan J is comparable to 2010 SB Plan F.
- 1990 SB Plan J (high deductible) is comparable to 2010 SB Plan F (high deductible).

(a) If a standardized group policy is terminated and is not replaced, the issuer must offer each certificateholder two choices of coverage: i) an individual policy with comparable benefits, and, ii) the core benefits policy (Package A).

(b) If a pre-standardization group policy is terminated and is not replaced, the issuer must offer each certificateholder two choices of coverage: i) a standardized policy currently offered by the issuer with benefits most comparable to the benefits in the terminated policy, and, ii) the standardized core benefits policy (Package A).

(c) If an individual leaves the group, the same conversion benefits must be offered, or the group policyholder may elect to continue coverage under the group policy.

The purpose of a conversion provision is to provide permanent coverage regardless of the status of the group policy or membership in the group. In order to be a legitimate option, the cost for these conversion policies should be reasonable. Since conversion policies often experience morbidity 50% to 100% higher than the group policies, passing on the actual morbidity cost of the converted certificateholders may result in rates that are much higher than the original group policy. This can create a conversion policy whose cost is not affordable to the insured.

If the insured is allowed to continue coverage under the group contract [see (c) above], the morbidity experience for individuals with continued coverage should be combined with the rest of the group experience for the purpose of rate revisions and refunds. There would not be separate, higher rates charged.

If the insured is converted to an individual policy form (either with similar benefits or another standardized benefit plan), the experience for individuals exercising conversion should be combined with the rest of the individuals having that policy form for the purpose of rate revisions and refunds. If the pool of individuals covered under that policy form are composed primarily of non-conversions, conversion rates should be kept reasonable by subsidies from the overall population. Furthermore, rates should bear a reasonable relationship to the original group rates through this subsidization. Differences will be due to the different loss ratio standards for individual and group forms, a different experience base, and, potentially, a different benefit plan if the individual so elected.

If the pool of individuals covered under that policy form is composed substantially of conversions, it is possible that rates for that form may become unaffordable. An example of this would be where the issuer actively markets only group policies. The model regulation provides no direct means of controlling the rate relationships between the group policy and individual conversions in this situation. The grouping of policies at the form level for experience rating purposes limits the level of subsidy available from other forms. However, the rate relationship between conversions and group policies can be reviewed for reasonableness at the initial rate filing (since the issuer is required to have an individual policy available with similar benefits). Thereafter, it may be possible to maintain this relationship in situations where there are few converted policies (and
therefore the experience alone is not credible) by reviewing the group’s experience and rate relationships when determining the conversion policy’s rates.

If both the group contract and the conversion policy are rated based on issue-age, the premium rate charged to the converted individual should be based on the original issue-age under the group contract and should not be based on the attained age at time of conversion.

**Conversion Policies**

*Issuers who only market group coverage must have individual policies available that meet the conversion requirements. If there are no conversions for a period of time, doesn’t the model regulation deem that conversion policy an inactive policy form?*

Section 15D(1) of the model regulation states that a policy form is considered inactive “unless the issuer has actively offered it for sale in the previous 12 months.” Even if there were no actual conversions that took place, a plan developed purely for conversions should be considered as “actively offered for sale.” That is, it is being used for the purpose for which it was intended and should not be considered a discontinued form.

**REFUND ISSUES**

**Refund**

*What are the criteria for determining when refunds or premium credits must be given?*

The model regulation provides for refunds or premium credits to be given if the cumulative actual experience loss ratio is less than the benchmark ratio. For standardized policies, the experience begins with inception. To achieve optimal credibility, the experience for 1990 SB Plans and 2010 SB Plans with the same Plan letter must be combined.

For pre-standardized policies, the experience begins with the SSAA-94 effective date (see Appendix E for additional explanations concerning effective dates). Both of these ratios exclude the business issued in the most recent calendar year. The calculated experience loss ratio is adjusted for credibility based on the life years. There is also a *de minimus* test to avoid small refunds/credits.

The filing is made for each type within any plan on a state-by-state basis. For example, an issuer licensed in 10 states with three standardized plans, one pre-standardized plan and both individual and group forms must complete eight forms for each state, or a total of 80 forms.

**Filing Timing**

*When must the refund/credit worksheets be filed with the state regulators?*

These forms must be filed by May 31 for the prior year’s experience.

**Credibility**

*Is a refund filing required if the experience is not credible?*

The refund form must be completed (through line 10) even if the experience is not credible (i.e., less than 500 life years exposed) because it may ultimately become credible, and subsequent reports build upon data from prior reports.

**Payment**

*If necessary, when must the refunds/credits be delivered?*
Issuers have until September 30 to give refunds/credits on the prior year’s experience. Interest on the amount must be given from December 31 of the reporting year until the date of the refund/credit. The rate of interest is specified by the Secretary of the U.S. Department of Health and Human Services at a rate not less than the average rate of interest for 13-week Treasury notes. This rate will be established by CMS by regulation.

**Recipients**

**If the filing indicates that a refund/credit is required, which policyholders receive the refund/credit?**

Section 1882(r)(2)(B) of the Social Security Act as amended by OBRA-90 states that all policyholders in that state/planner-type cell on December 31 of the year being reported should receive a refund/credit payment. The Social Security Act does not address whether refund/credit amounts need to be the same if the 1990 Plans are combined with the 2010 Plans, and the experience for some subset (of the combined 1990 SB Plan and 2010 SB Plan pool) was distinctly favorable and justifies a larger proportion of the amount of refund required. CMS has stated that the requirement for a payment applies to policyholders who have been in force less than one year, even though their experience was not included in the experience calculation.

**Refund State**

**If a policyholder moves between states, in which state should the experience for the policy be assigned for the refund filing?**

The experience for the policy should be filed in the state of original issue, not the state of current residence.

For pre-standardized policies, the insurer may use the individual’s state of residence at the time of the SSAA-94 effective date as the state of origin for reporting purposes, or the insurer may choose to report based on the state of original issue. This is a one-time option and may not be changed once a state has been identified, regardless of whether the individual moves to another state at a later time. However, the premiums actually charged the individual should be based on the state of residence.

**Escheat**

**What should be done if the policyholder cannot be located for the refund?**

The model regulation does not specify what should be done under these circumstances. It is reasonable to assume that whatever rules the state normally uses for money due policyholders who cannot be located should apply also in this case.

**Premium Credit**

**What are valid approaches for granting premium credits?**

The model regulation provides for premium credits as an alternative to cash refunds. It does not specify valid methodologies. A description of the refund/credit approach is required as part of the filing. You should review this carefully to determine if you have any concerns. This review should ensure that provision is made for policies which have terminated between December 31 and the date the refund/credit is made.

**Data**

**What data must be available to complete the refund filing?**

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7 CMS (formerly the Health Care Financing Administration) has published the basis to be used for calculating the interest rate in the Federal Register, Vol. 59, No. 100 dated May 25, 1994. At the time of the update of this manual, this is still the methodology to be used; however, for later dates please verify with CMS that this methodology still applies.
The worksheet is shown in the appendix to the model regulation. It requires the following types of information to be captured by the issuer (all data by issue state for each plan/type):

- Incurred claims by issue year
- Earned premium by issue year
- Number of lives exposed by issue year
- Amount of earned premium in the calendar year of issue for policies issued in each year preceding the reporting year
- Annualized premium in force at December 31 by issue year
- Refunds/credits granted each year (excluding interest)

**Life Years Exposed**

**What is meant by “life years exposed”?**

Life years exposed is used to determine the credibility of the block of business. It is a measure of the number of policyholders covered by the plan/type on a cumulative basis. As an example, if 600 policies are issued on July 1 and are still in force on December 31, 300 life years were exposed during that calendar year. One way to capture this data is to sum the number of policyholders covered each month and divide by 12. An adjustment would be necessary if the policy covered more than one life.

**Experience Loss Ratio**

**How is the experience loss ratio calculated?**

The experience loss ratio is calculated as (a)/(b), where:

- \((a) = \) the cumulative incurred claims for the plan/type excluding the business issued in the year being reported.
- \((b) = \) the cumulative earned premiums for the plan/type excluding the business issued in the year being reported less the cumulative refunds/credits (excluding interest).

The worksheets refer to this calculation as Ratio 2.

**Benchmark Ratios**

**How is the benchmark loss ratio calculated?**

There are two separate worksheets included in the appendix to the model regulation that are used to calculate the benchmark ratio, referred to as Ratio 1. One is used for Individual, Individual SELECT, and Pre-standardized Individual. The other is used for Group, Group SELECT, and Pre-standardized Group. The factors in columns (c), (e), (g) and (i) are the same for all filings of the same type. These factors are estimates of persistency and loss ratios based on a set of assumptions. They are applied to the earned premium reported in each prior calendar year on policies issued in that calendar year. The reporting calendar year value is excluded in column (b).

The worksheet illustrates the estimated experience in the first three years separately from subsequent years. This was done to illustrate that the target loss ratio (65% individual and 75% group) was met by the third year. Columns (c) through (f) show estimated experience in the first three policy years, and columns (g) through (j) show estimated experience in subsequent years. An example of the derivation of the factors is displayed in Appendix C.

**Pre-Standardized Plans**

**Are refunds/credits required on pre-standardized Medicare supplement plans?**

Yes. Passage of SSAA-94 now provides that if the pre-standardized policies do not meet certain loss ratio requirements, then refunds or premium credits must be given to the policyholders. Similar rules apply to these pre-standardized plans as they do to standardized plans, except that pre-standardized plans are aggregated into only two types within each state: 1) individual including group policies subject to individual loss ratios if permitted by the state, and 2) group policies subject to group loss ratios. (See Appendix E for additional explanations concerning refunds for pre-standardized policies.)
SECTION III: ANNUAL FILING OF PREMIUM RATES AND LOSS RATIO PROJECTIONS

INTRODUCTION

The model regulation requires that all new product premium rates and requests for rate revisions be approved by the states in accordance with the filing requirements and procedures prescribed by the commissioner (Sections 15A and B). The model regulation also requires the annual filing of premium rates that include demonstrations of compliance with loss ratio standards (Section 14C).

Forms Subject to Annual Filing

The annual rate and loss ratio filing requirement applies to all Medicare supplement forms. This filing must be made for each Medicare supplement form, regardless of whether a rate revision will be requested. The experience of all 1990 standard plans shall be pooled with the experience of all 2010 standard plans of the same letter and type designation for all rating purposes. It is anticipated that filings for all forms in a pool will be submitted as one filing or as concurrent filings.

Distinction from Rate Revision Filing

Although it is likely that many issuers will combine their requests for rate revisions with their experience filings (in fact, this may be required by some states), it is useful to draw a distinction between the purpose of a rate revision request and the annual loss ratio demonstration. The annual rate and loss ratio filing fulfills two purposes. The first is to demonstrate compliance with loss ratio standards. The second is to obtain approval for the proposed rates for the upcoming year. These rates may or may not be the same as the current year rates. If the rates are not the same, the filing elements of a rate revision filing must be met.

Section III addresses the filing requirements for the annual rate and loss ratio filing and may be a subset of a combined rate filing. The additional information needed if a rate revision is requested is provided in Section IV (Section IV also addresses the information to be provided for a new policy filing). If a rate revision is requested, the revised rate must be used in the loss ratio projections discussed in this section.

Loss Ratio Standards

The model regulation discusses five loss ratio standards that must be met, if applicable:

1. A Medicare supplement policy form or certificate form shall not be issued unless the form can be expected to return to policyholders aggregate benefits that are greater than or equal to the applicable percentage of aggregate premiums. This loss ratio requirement must be demonstrated for new form filings.

2. For all policies or certificates in force less than three years, the expected third-year loss ratio is greater than or equal to the applicable percentage (Section 13C). A new form must demonstrate expected values that meet this standard.

3. The accumulated value of experienced claims plus the present value of expected future claims is greater than or equal to the applicable percentage times the sum of the accumulated value of experienced premiums and the present value of expected future premiums. For standardized policies, the accumulated experience premiums begin with inception (Section 14A(2)). For pre-standardized policies, the accumulated experience premiums begin with the effective date of the state’s revised regulation (Section 14A(4)).

4. Over the entire future period for which the rates are computed, the ratio of the present value of claims to the present value of premiums is greater than or equal to the applicable percentage (Sections 14A(2) and 14A(4)). For rate structures that include some prefunding, the future loss ratio standard should be revised as appropriate, to properly reflect the prefunding.
5. For pre-standardized policies, the lifetime accumulated value of experience claims plus the present value of expected future claims is greater than or equal to the originally filed loss ratio times the sum of the lifetime accumulated value of experience premiums and the present value of expected future premiums (Section 14A(4)).

(NOTE: In accumulating experience for the above loss ratios, a carrier may use a date prior to the SSAA-94 date for any state if, for administrative convenience, the carrier uses a common date for a group of states—none of which actually has an earlier SSAA-94 effective date.)

**Applicable Ratios**

The applicable loss ratios are: 75% for group policies and 65% for individual policies. Mass-market group policies are required to meet a 65% loss ratio; however, many states accepted the suggestion in the model regulation drafting note and require a 75% loss ratio. Policies sold prior to November 5, 1991, must also meet these loss ratios, as well as continuing to meet the originally filed loss ratio. This includes all pre-standardized plans (see Appendix E for additional explanations concerning pre-standardized loss ratio requirements).

**Timing and Approval**

This filing must be made annually, but the model regulation does not specify whether this filing must be done on a calendar-year basis or some other annual basis. Each filing must be filed for approval by the state, according to each state’s filing requirements and procedures. The purpose of this filing is to monitor compliance with minimum loss ratio requirements. If these standards are not met, the state should disapprove the filing, and the issuer should demonstrate what actions it intends to take in order to comply with the requirements. Latitude may be given for small blocks of business that by themselves do not meet all loss ratio requirements based on their non-credible experience.

**FILING REQUIREMENTS**

The model regulation requires that demonstrations of loss ratio compliance be prepared “in accordance with actuarial standards of practice.” Therefore, the filing must be certified by a qualified actuary and would be subject to the actuarial standards of practice developed by the Actuarial Standards Board. The term “qualified actuary” as used in this regulation means an actuary who is a member of the American Academy of Actuaries.

Experience reporting for demonstration of loss ratio compliance and rate revisions shall be consistent with state requirements. To the extent consistent with state requirements, separate filings should be prepared for each policy form offered by the issuer (e.g., if an issuer offers both a direct response and agent-sold Plan A policy under different policy forms, the experience of each should be provided separately). Experience reporting on pre-standardized policy forms that are consistently combined to increase credibility may also be approved.

The model regulation specifically requires issuers to provide rates and rate schedules and to file the ratios of incurred losses to earned premiums by policy duration. The specific information that should be included in the filing is described below and summarized in Appendix B.

**Purpose of the Filing**

There should be a statement that the filing has been prepared to demonstrate loss ratio compliance and to request approval for the rates. If a rate revision is also requested, this should be clearly indicated.

**General Description**

A general description of the policy and benefits should be provided, including:

- Issuer name
- Form number
- Type of policy (i.e., individual, group, individual SELECT, group SELECT, pre-standardized individual, pre-standardized group)
- Benefit description
- Renewal provision
— Marketing approach
— Underwriting method
— Preexisting condition exclusion
— Issue-age limits (including availability to individuals eligible for Medicare due to a disability)
— Premium basis (e.g., attained age or issue age)
— Name, actuarial credentials, address, and phone number of actuary rendering the certification
— Target lifetime loss ratio for which the insurer is pricing

**Rate Sheets and Rating Factors**

The rates appropriate for the state—including any additional rating factors such as area factors, smoker/non-smoker factors, standard/substandard factors, etc.—must be filed. The assumed period for which the rates apply must also be noted.

Companies should document the approach used to deal with the situation where the state of residence is no longer the state of issue.

**Rate History**

The history of rate changes in the last five years applicable to policyholders for the form in the state and the implementation dates of these changes should be shown. If rate revisions were not applied uniformly across all rating factors, this should also be noted. Also, the effective date and timing of the rate revision should be described (e.g., effective January 1, upon policy renewal or anniversary).

**In-Force Counts**

The number of policies for the state and nationwide in-force for the policy form should be included (both current counts and historical counts since inception). Where historical counts for pre-standardized policies have not been requested, the data should start with the SSAA-94 effective date. For use in comparing data with that reported for refunds, current counts and historical counts can be replaced with life years exposed.

**Historical Incurred Claims by Duration**

Incurred claims should be shown for each prior calendar year (and for the most recent partial year, if available). These incurred claims should be split either by policy duration (e.g., the experience in each calendar year relating to policies in their first year of duration, second year of duration, etc.) or on a calendar year of issue basis (e.g., the experience in each calendar year grouped by the year in which the policies were originally issued). This data must be provided for the experience of the policies issued in the state for which the filing is submitted. In addition, if the projected state experience is based on national experience, the national data must also be provided.

Incurred claims must be restated based on the claims paid plus change in the unpaid claim reserve. Use of actual runoff of claims should be indicated. Changes in active life reserves or claims expenses should not be included in incurred claims.

**Historical Earned Premium by Duration**

Earned premium by calendar year should be illustrated, split either by policy duration or calendar year of issue within each calendar year. The basis of reporting durational earned premium should be consistent with that used to provide incurred claims. State data should be provided in all cases. National data may also be appropriate as noted above for the incurred claims.

Earned premium for calendar years after 1991 must include modal loadings and policy fees. An adjustment for premium refunds should also be made. The change in active life reserves should not be subtracted from the earned premium.

**Experience and Loss Ratio Projection**

Future experience (premiums, claims and loss ratios) must be projected. The filing must clearly state the assumptions used to prepare such projections, including:
— Definition of loss ratio.
— Base period of projection and whether based on state or national experience.
— Lapse rates.
— Trend and rationale for trend.
— Method for incorporating attained-age changes and wearing-off of selection.
— Assumptions regarding future premium rate revisions.
— Interest rates for discounting and accumulating.

One implication of the availability of two options of Plans F and J is that the respective experience (including potentially different percentage premium increases) for a policy form must be combined in the demonstration of loss ratio compliance. Otherwise, the basis for loss ratios and refunds will not be based on consistent experience.

**Premium Adjustment for Medicare Supplement forms with Prescription Drug Benefits Issued Prior to January 1, 2006**

Beginning January 1, 2006, there were three subsets of individuals covered under Medicare supplement plans that covered prescription drugs (this includes plans H, I, J, high-deductible J, pre-standardized plans with drug benefits, and the prescription drug plans in Minnesota, Wisconsin and Massachusetts):

- Those who do not enroll in Part D of Medicare, but keep their existing policy with the prescription drug benefits.
- Those who do enroll in Part D of Medicare and retain their policy with the prescription drug benefits removed.
- Those who purchase Plans H, I, J, high deductible J, or prescription drug plans in Minnesota, Wisconsin or Massachusetts after December 31, 2005, and before June 1, 2010, without prescription drug benefits. (There may be no individuals in this category if states do not require these plans to be offered, since federal law does not require issuers to make these plans available.)

Experience for all subsets of insureds covered under each standardized plan must be combined for purposes of demonstrating compliance with the loss ratio standards. For purposes of determining premium rates, issuers should separate experience for prescription drug benefits from the experience for non-prescription drug benefits. Premiums for non-prescription drug benefits should be determined based on the non-prescription drug benefit experience of all insureds with the plan. Premiums for prescription drug benefits should be based on the prescription drug experience of those who kept their policy with prescription drug benefits.

Issuers should submit the experience and assumptions used in determining premium rate adjustments separately for prescription drug coverage and non-prescription drug coverage. An issuer may use reasonable approximations to separate prescription drug claim experience from other claims experience, if such experience is not obtainable for incurral dates prior to January 1, 2006.

**Non-credible Experience and Closed Blocks**

If an issuer’s statewide experience is not credible for purposes of projecting expected future experience, the projection should be based on a larger block. In some cases, particularly in-force business and comparable standardized plans, combining the experience of several plans within the state may be appropriate. In other cases, the projection should be made based on national experience. State historical experience should be provided in all filings, even if nationwide experience is used to demonstrate compliance with the loss ratio requirements and to develop premium adjustments.

If state and national experience for a plan is not credible, judgment is needed to determine reasonable premiums and premium adjustments. Examples of data sources and methods for determining the premiums for such plans include the following:

- Pooling with other comparable Medicare supplement plans.
- Benefit relativities between plans.
- Any potential refunds that may be required for a plan.
- Medicare data.
- Intercompany studies.

States should use latitude in requiring future premium adjustments when the combined historical and projected experience is below the applicable percentage for non-credible plans, particularly in early durations or for closed blocks of business.
**Loss Ratio Demonstration**

Currently targeted loss ratios should not be lower than the originally filed anticipated loss ratios unless explicit approval has been granted by the commissioner. For policy forms with in-force in durations of three years or less, loss ratio standard 2 must be met. For all existing policy forms, loss ratios 3 and 4 must be met. For pre-standardized policy forms, loss ratio 5 must additionally be met. That is:

- **Loss ratio standard 1** – The lifetime minimum loss ratio required by federal law and applied by state laws and regulations.

- **Loss ratio standard 2** – Policies in force less than three years will generate their applicable lifetime loss ratio in the third year.

- **Loss ratio standard 3** – The sum of accumulated past incurred claims and the present value of projected future claims must equal or exceed the applicable ratio times the sum of accumulated past earned premiums and projected future earned premiums. For standardized policies, the accumulated experience begins with inception (Section 14A(2)). For pre-standardized policies, the accumulated experience begins with the SSAA-94 effective date (Section 14A(4)).

- **Loss ratio standard 4** – The ratio of the present value of future claims to the present value of future premium equals or exceeds the applicable ratio.

- **Loss ratio standard 5** – For pre-standardized policies, the sum of the lifetime accumulated past incurred claims and the present value of projected future claims must equal or exceed the originally filed loss ratio times the sum of the lifetime accumulated past earned premiums and projected future earned premiums.

As noted previously, it may be necessary to modify loss ratio standard 4 to properly reflect any prefunding in the rate structure. The anticipated loss ratio when the policy was filed should also be stated.

**Actuarial Certification**

The actuarial certification should state that, to the best of the actuary’s knowledge and judgment, the following items are true with respect to the filing:

- The assumptions present the actuary’s best judgment as to the expected value for each assumption and are consistent with the issuer’s business plan at the time of the filing.
- The anticipated lifetime loss ratio, future loss ratios, and third-year loss ratio all exceed the applicable ratio.
- The filed rates maintain the proper relationship between policies that had different rating methodologies.
- The filing was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board.

**A SAMPLE OF HOW AN ISSUER CAN DEMONSTRATE LOSS RATIO COMPLIANCE**

An example of how an issuer can demonstrate loss ratio compliance for a standardized policy is shown below:

1. Present policy year durational loss ratios.

2. Develop calendar year expected loss ratios (by issue year) based on the assumed issue month and the policy year expected loss ratio.

3. Present historical earned premium and incurred claims by issue year and experience year.

4. Project the future experience using trend. Projected premium increases beyond any currently filed increase should be comparable to the trend assumptions used in projecting incurred claims (see checklist item 4). Verify that the expected third policy year loss ratio is at least the applicable percentage and that calendar year loss ratios are calculated consistently with the policy year ratios.
5. Calculate the accumulated and present values. If the ratio of claims to premiums exceeds the applicable loss ratio, then loss ratio standard 3 is met.

6. Calculate the ratio of the present value of future claims to the present value of future premiums. If this exceeds the applicable percentage, then loss ratio standard 4 is met. (As noted previously, if the rate structure includes prefunding, loss ratio standard 4 should be revised to reflect this.)

7. Based upon the projected premium by calendar issue year for the prior three issue years, calculate the claims that would be required to meet the expected calendar year loss ratios for the second and third years following the calendar year of issue. Compare this total to the projected claims for these calendar issue years developed in step 4.

8. Verify that the historical experience in the second and third years following the calendar year of issue has exceeded the calendar equivalents of the policy year applicable percentages. If the expected claims in step 7 meet or exceed levels necessary to comply with the third-year loss ratio requirement and historical experience has met this test (step 8), then loss ratio standard 2 is met.

Please note that the foregoing is only a sample of how compliance can be demonstrated. This sample should not be considered to be a limit on other appropriate actuarial methodologies.

HOW DOES A REGULATOR KNOW IF ASSUMPTIONS ARE REASONABLE?

Many of the critical assumptions for a Medicare supplement policy—such as the trend rate, investment income rate, and lapse rates—will vary over time and among issuers. Therefore, it is not possible to present reasonable ranges in this manual. Each state will have its own process for compiling critical assumptions for purposes of developing its own database that can then be used to compare new filings. It is not expected that historical values for these assumptions will change materially with the advent of the 2010 Standardized Benefit Plans. A summary assumption form that would be useful for this purpose is displayed in Appendix A.

Relative Costs by Age

The relative cost by age is also subject to differences among carriers and changes over time. However, it is likely to be somewhat more stable than the other factors. The relative cost by attained age (in five-year age groups), as may have been applicable in the 1990s for the basic kinds of Medicare supplement plans, may be found in Section VIII.

Attained-age rates, in particular, should be reviewed to ensure that the slope by age is not too steep. If this were to occur, older insureds would be subsidizing younger insureds. The shape of the attained age premium curve should be comparable to the shape of the ultimate claim cost curve. Differences from the slope could be expected. However, if an issuer’s slope is much steeper than that shown, the reason for the steepness should be investigated.

Relative Costs by Benefit

Rate relativities may not match benefit relativities for the different Medicare supplement plans due to differences in actual claims experience by plan. This is because premium refunds are based on claims experience by plan, so issuers need to consider this experience in developing premium rates. However, benefit relativities should be considered in determining rate relativities, particularly for plans without credible experience.

REGULATORY CHECKLIST

The following items should be considered when reviewing these policy forms:

1. Has all the information outlined above been provided?
2. Can rates be compared to those of other plans sold by the insurer to establish reasonableness?

The logic of the Medicare supplement loss ratio standards, as well as the refund requirement, requires that a plan’s rates be based on its own credible experience. Experience may be combined for plans with similar benefits to enhance credibility (see also #7).

3. Does the policy comply with minimum loss ratio standards?

The filing must demonstrate that all relevant loss ratio standards are met.

4. Is trend assumed in the loss ratio projection?

The filing requirements provide for disclosure of how the loss ratio is calculated, and the projected experience should include trend adjustments for premiums and claims. Except for short-term (no more than 24 months), immediate lower premium trend assumptions that are consistent with filed rates (and presumably are intended to keep loss ratios in compliance), the projected trend assumptions for premiums and claims should follow these rules:

a. For an attained-age rated policy, the increase in premiums should be at least as large as the increase in claims.

b. For an issue-age rated policy, the trend in claims may exceed the increase in premiums by no more than the average assumed increase in claim costs for one additional attained age plus any underwriting wear-off at early ages.

The elements of the premium and claim trend rates (inflation, aging, etc.) should be reviewed in conjunction with the methodology used to determine their respective trend rates to ensure that certain factors, such as aging, are properly counted (i.e., not excluded or double counted).

Trend assumptions should be reasonable compared to past experience or other sources. For the high-deductible variations of Plans F and J, it should be expected that different trend assumptions will be used and the result is that rate increases for the normal variations will not be the same percentage as the high-deductible variations.

5. Are the interest rates used to discount cash flows reasonable?

Interest must be considered in calculating the anticipated lifetime and future loss ratios, otherwise loss ratios will be overstated. The interest rates should be reasonable; a minimum level would be appropriate valuation interest rates.

6. Are the lapse rates used for the loss ratio projection reasonable?

The issuer should state the basis of lapse rates and whether or not they consider mortality. If mortality is not considered separately, the ultimate lapse rate used should equal or exceed mortality rates.

7. How has the filing addressed non-credible experience?

To the extent that a plan lacks credible experience, issuers should provide an explanation of and justification for any premium adjustments (see the section Non-credible Experience and Closed Blocks).

8. Is the premium adjustment for removal of prescription drug benefits reasonable?

Claims costs for non-prescription drug benefits of plans with prescription drug coverage stripped out may have historically been higher than claims cost for the same benefits of plans without prescription drug coverage. Therefore, the premiums for plans with prescription drug coverage stripped out may be higher than premiums for similar plans.
Claims experience after December 31, 2005, for the plans with prescription drug coverage will depend on the plan selection choices made by insureds covered under those plans. These plans may have been closed to new business prior to June 1, 2010, so they may have experienced greater anti-selection effects than previously. However, insureds may move to other plans, which could result in adverse experience for the other plans. Such movement may also result in improved experience for the remaining insureds in the plans with prescription drug coverage.

Claims projections should be based on historical experience of the plans to the extent it is statistically credible. The issuer should provide an explanation of and justification for any premium adjustments when a plan does not have credible experience.

Regulators should recognize the potential effects of pooling different plans on future refund requirements, as the refund formula is based separately on experience for each of the standardized plans.
SECTION IV: FILINGS OF PROPOSED RATES

EXTRA REQUIREMENTS FOR A RATE FILING

While many issuers may prepare a joint filing of rate revisions with demonstration of loss ratio compliance, these are theoretically separate issues. The annual premium rate and loss ratio filing requires that issuers demonstrate compliance with minimum loss ratio standards. For a new policy form or a rate revision request, the issuer must provide additional data to demonstrate that the requested rates are reasonable, equitable, adequate, and in compliance with standards. The experience of all 1990 standard plans shall be pooled with the experience of all 2010 standard plans of the same letter and type designation for all rating purposes. It is anticipated that filings for all forms in a pool will be submitted as one filing or as concurrent filings.

In filing its initial rates for a 2010 SB Plan, the company should describe the relationship of those rates to the filed renewal rates for the comparable 1990 SB Plan. It is anticipated that, all other factors being equal (e.g., lifetime target loss ratio, underwriting, etc.), the initial rates for a 2010 SB Plan will be equal to those for a comparable 1990 SB Plan. If so, the subsequent rate adjustments will be uniform between plan generations throughout the lifetime of the policies. If the initial rates are not equal, then the goal over time is for the premiums for a 1990 SB Plan to become identical to those of the same plan/type 2010 SB Plan. Any variations from this goal are subject to the regulation(s) of the state(s) in which the rates are filed. The rate increase for specific forms within a pool may be adjusted, on a revenue neutral basis, to avoid violation of federal lifetime loss ratio standards for specific forms within the pool.

Similarly, premium rates for Plans D and G (based on experience prior to 2020) may need to have a different level of change than other Plans for 2020 and thereafter. Under MACRA, Plans D and G starting in 2020 will be subject to the guaranteed issue right for newly eligible individuals under Section 12 of the model regulation. This may require a reasonable assumption for higher incurred claims than would result from just medical inflation. If the open enrollment and guaranteed issue components are expected to be a substantial part of the new business, then the prior experience for these plans may need adjustment to still be an appropriate assumption for rate revisions.

Reasonable

The filing must demonstrate that the proposed premium rates are correctly derived from reasonable assumptions and that the resulting anticipated loss ratios are correctly derived from these assumptions and rates.

Equitable

The proposed rates should be equitable among policyholders with the same policy form. If an issuer is changing rating methodologies, the new methodology must be actuarially equivalent to the old.

Adequate

Rates should be adequate to provide for the benefits in accordance with the rating methodology used and reasonable assumptions regarding claim costs by duration. Rates based strictly on early duration favorable experience would generally not be considered adequate.

In Compliance With Standards

The loss ratios required by the model regulation are outlined in Section III. A new policy filing must demonstrate that these standards are met. A rate revision filing must demonstrate that the standards are met, including a higher lifetime loss ratio if the originally filed loss ratio exceeded the minimum. In addition, both filings must indicate compliance with commission limits and other requirements (such as limits on multiple forms per plan/type or changes in rating methodology).

Each state must adopt filing procedures to implement these standards. To assist state regulators, this section of the manual presents guidelines for each type of rate filing, an outline of the filing requirements, and a checklist for regulators of items and issues to consider when evaluating these filings.

Consistency in Format

Information provided in a new product rate filing should be presented in a format consistent with the requirements of the rate revision filings and annual premium rate and loss ratio filings so that consistency among filings can be checked.
**Consolidated Policy Filings**

States may wish to allow groupings of pre-standardized policy forms for rate filings to avoid the consequences of many small closed blocks. If they do, they have to publish it in their regulations and have it approved by CMS (see drafting note to Section 14(A)(4) of the NAIC model regulation).

**NEW PRODUCT RATE FILING**

Actuaries preparing regulatory filings for rates must comply with general actuarial guidelines for professional conduct and actuarial standards of practice developed by the Actuarial Standards Board. You should expect a competently prepared actuarial filing to contain the following information. Appendix B contains a summary of the items described below.

**Purpose of the Filing**

The filings will often contain a statement such as, “The purpose of this rate filing is to demonstrate that the anticipated loss ratio of the product meets the minimum requirements of your state. This rate filing is not intended to be used for other purposes.” The information included in the rate filing must “demonstrate”—not just “certify”—that the filing is in compliance.

**General Description**

A general description of the policy and benefits should include the same items outlined in Section III for the annual rate filing, plus:

- The date the form being submitted was approved by the issuer’s domiciliary state (if it was filed in that state).
- An indication of whether the proposed rates are for a type of plan (i.e., individual, individual SELECT, group, or group SELECT) for which the issuer already has a form. (If so, the issuer should provide the total number of forms within the type, the difference between these forms, the reason for the new form, and when the plan was last sold, if it was previously sold). The issuer should note whether the filing is related to new 2010 SB Plans intended to replace existing 1990 SB Plans.
- The method of group conversion if the policy is a group policy. The individual form number for conversions should also be provided.

**Methodology and Assumptions Used to Determine the Rates**

This methodology section should include:

- The general rate methodology used to calculate the rates.
- The degree to which provisions for inflation trends, aging, and the wearing-off of the effects of selection have been provided for in the pricing.
- The timing and magnitude of future rate revisions that are anticipated in the filing.
- The commission schedule.
- The commission level and methodology for policyholders who are replacing other coverage.
- Actuarial assumptions, including:
  - lapse rates, including the basis for choosing lapse rates.
  - morbidity assumptions, including the source of the assumptions and the effects of selection year by year.
  - interest rate used to discount cash flows.
  - expense assumptions by general expense application categories (e.g., percent of premium, cost per policy, percent of claims).

**Rate Sheets and Rating Factors**

The proposed rates for the state must be provided. This should include all rating factors such as area, smoker/non-smoker, standard/substandard, etc. There should also be a clear description of which rates will apply at Medigap open enrollment and the expected period of time for which the rates will apply.
**Loss Ratio Projections**

The same information as described in Section III for the loss ratio projection must be provided (with the exception of a definition of the base period).

**Loss Ratio Demonstration**

Loss ratio standards 1 and 2 must be demonstrated. The anticipated loss ratios should be provided, including:

- The average durational loss ratio expectation for at least the first 10 years.
- The anticipated loss ratio by age or age band and other rating factors if the loss ratios by factor are expected to differ.

**Actuarial Certification**

The actuarial certification should cover the same items outlined in Section III (excluding the item pertaining to a change in rating methodology), plus statements that:

- The filing is in compliance with applicable laws and regulations in the state.
- The rates are reasonable in relationship to the benefits.

**NEW FORM REGULATORY CHECKLIST**

Except for question (7), the regulatory checklist outlined in Section III applies for new policy form filings as well. In addition, the following items should be considered during the review:

1. **Can the proposed rates support the anticipated expenses at the anticipated loss ratio?**

   For example, it would be difficult for a policy with a 30% renewal commission rate to meet an expected 65% loss ratio. If expenses seem out of line, restatement of expenses on a level percentage of premium basis using the same methodology as the loss ratio calculation can be requested.

2. **Are the proposed rates adequate?**

   The issue of rate adequacy is important to consider, as consumers who buy policies that are underrated during their Medigap open enrollment period may be faced with large rate increases when open enrollment is no longer an option. When evaluating adequacy, the regulator may consider whether the rates make sense compared to competition, with appropriate adjustments for differences in loss ratio, underwriting, etc. If you suspect that rates are inadequate, you could request that the issuer compare the rates for the proposed plan with rates charged for existing, credible blocks of business with suitable adjustments for benefits.

3. **Do the proposed commission rates comply with standards?**

   Commission rates must comply with the following:

   - First-year commissions less than or equal to twice the renewal commissions (years 2-6).
   - Rates for Medigap open enrollment at age 65 must be no less than the ages 66 through 69 commission.
   - Duration years 2 through 6 must be level.

   Also, the commission rate calculation for replacement situations must clearly be stated.
RATE REVISION FILING

The model regulation requires that all rate revisions be filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner. The model regulation leaves the methodology up to the commissioner regarding the information to be provided.

When requesting a rate revision, the issuer should demonstrate that the requested rates are consistent with the loss ratios originally anticipated for the policy. The issuer should also demonstrate continued compliance with loss ratio standards after the implementation of the proposed rate revision.

It is likely that many issuers will incorporate their rate revision requests into their annual premium rate and loss ratio filing. If an issuer chooses not to do this and files for a rate revision at a later date, the issuer must demonstrate in a manner consistent with the annual premium rate and loss ratio filing that the appropriate loss ratio standards will continue to be met.

FILING REQUIREMENTS

Since premium rates can differ by policy form within type of policy (e.g., medically underwritten Plan A premiums can differ from guaranteed issue Plan A premiums), a premium rate revision request should be submitted separately for each policy form. The filing guidelines described here allow each filing to be evaluated on its own, without access to information from previous filings. Refer to Appendix B for a summary of the recommended data to include in the filing.

Purpose of the Filing

There should be a statement that the purpose of the filing is to request a rate revision and demonstrate compliance with loss ratio standards.

General Description

A general description of the policy and the benefits should include the items outlined in Section III, plus:

--- The date the rate request submitted was approved by the issuer’s domiciliary state (if applicable).
--- Disclosure of whether or not the policy form is open or closed.

Scope and Reason for Rate Request

The reason for the rate revision must be clearly described. The scope of the rate revision, whether it applies to all rates uniformly or differs by rating attribute (area, etc.) should be clearly indicated. Also, the effective date and timing of the rate revision should be described (e.g., effective January 1 upon policy renewal or anniversary).

Methodology and Assumptions Used to Determine the Rates

The description of the methodology, and assumptions used to determine the rates, should include the same items as a new policy filing (excluding expenses other than commissions).

The rate methodology should properly reflect the prefunding of future incurred claims inherent in the rating methodology. The filing should include explicit statements that make clear the extent of the prefunding.

The model regulation directs the commissioner to prescribe the filing requirements and procedures that will be used to approve rates (Sections 14C, 15A, and 15B of the model regulation). One important element in determining the appropriateness of a requested rate revision is to determine the degree of recognition of any prefunding inherent in the prior rate that should be incorporated into the analysis of future loss ratios. Given the complexity and controversial nature of this issue, groups interested in this issue—such as the NAIC Life and Health Actuarial Task Force—should study methods for recognizing this prefunding.
Demonstration of Equivalence for Change in Rating Methodology

If an issuer is proposing a change in the rating methodology (e.g., change in attained-age relationships, introduction of new rating factor), the issuer must clearly describe the change. The two rating methodologies must produce equivalent expected results as of the estimated effective date of the change, although the commissioner may approve changes in rate differentials that are in the public interest. Future rate revisions must maintain this percentage relativity.

Rate Sheets and Rating Factors

The current rate schedule and the proposed rate schedule for the state must be attached, including all rating factors such as area, smoker/non-smoker, standard/substandard, etc. The expected period of time for which the rates will apply must also be stated.

Companies should document the approach that is used to deal with the situation where the state of residence is no longer the state of issue.

Rate History

The history of rate changes in the last five years (with implementation dates) for the form in the state should be included. If rate revisions were not applied uniformly across all rating factors, this should also be noted. Also, the effective date and timing of the rate revision should be described (e.g., effective January 1 upon policy renewal or anniversary).

In-Force Policy Counts

The number of policies for the state and nationwide in-force for the policy form should be included (both current counts and historical counts since inception). Where historical counts for pre-standardized policies have not been requested, the data should start with the SSAA-94 effective date. For use in comparing data with that reported for refunds, current counts and historical counts can be replaced with life years exposed.

Historical Incurred Claims

Historical incurred claims by duration must be included. These should be included for each historical calendar year on either a policy-duration basis or a calendar-year-of-issue basis. The incurred claims should not include claims expenses or active life reserves. State experience should always be provided. If the proposed rates are based on national experience, the national data must also be provided. State and national data should be reported consistently on either a policy-duration or calendar-duration basis. Claims should be reported on a direct basis only, and should not reflect the adjustments for assumed or ceded reinsurance arrangements except assumption reinsurance.

Historical Earned Premiums

Historical earned premium by duration must be provided either on a policy-duration or calendar-year-of-issue basis. This must be provided on a basis consistent with the reporting of incurred claims. An adjustment should also be shown for premium refunds. The earned premium should include all modal loadings and policy fees. The change in active life reserves should not be subtracted from the earned premium. State experience should always be provided. If the proposed rates are based on national experience, the national data must also be provided. Premiums should be reported on a direct basis only, and should not reflect the adjustments for assumed or ceded reinsurance arrangements except assumption reinsurance.

Experience and Loss Ratio Projection

The information provided for the experience and loss ratio projection should be the same as outlined in Section III. Also, this projection should be made both with and without the proposed rate revision.

Loss Ratio Demonstration

The loss ratio demonstration is similar to that described in Section III, except that the demonstration must show that the originally filed loss ratios are met.
**Actuarial Certification**

The actuarial certification should cover the same items outlined in Section III, plus statements that:

- The filing is in compliance with applicable laws and regulations in the state.
- The rates are reasonable in relationship to the benefits.

**RATE REVISION REGULATORY CHECKLIST**

The items in the regulatory checklist for the annual loss ratio filing (Section III) are also applicable for rate filings. Additional items for consideration are the following:

1. **Are the proposed rates adequate?**

   The issue of rate adequacy is important to consider, as consumers who buy policies that are underrated may be faced with large rate increases. When evaluating adequacy, the regulator may consider whether the rates make sense compared to competition, with appropriate adjustments for differences in loss ratio, underwriting, etc. If you suspect that rates are inadequate, you could request that the issuer compare the rates for the proposed plan with rates charged for existing, credible blocks of business with suitable adjustments for benefits.

2. **Do the proposed commission rates comply with standards?**

   Commission rates must comply with the following:

   - First year commissions less than or equal to twice the renewal commissions (years 2-6).
   - Rates for Medigap open enrollment at age 65 must be no less than the ages 66 through 69 commission.
   - Duration years 2 through 6 must be level.

   Also, the commission rate calculation for replacement situations must clearly be stated.

3. **Does the rate methodology properly reflect any prefunding inherent in the rating methodology?**

   Some rating structures (e.g., issue-age rates) are intended to prefund for increases solely due to aging. The proposed rate methodology should reflect this.

4. **Does the filing propose a change in rating methodology?**

   If the filing requests a change in rating methodology, you must confirm that the new rating structure applies only to new issues and that the proposed rating structure is actuarially equivalent to the current rating structure.
SECTION V: REFUND CALCULATION FORM

INTRODUCTION

An integral part of OBRA-90 and the model regulation is the requirement to file annually a comparison of the cumulative loss ratio to benchmark targets to determine if the loss ratio requirements are met. If the actual loss ratio is below the benchmark loss ratio, the issuer is required to give refunds or premium credits. The premium refund is determined so that the ratio of cumulative incurred claims to cumulative premiums (including modal loadings but excluding policy reserves) net of refunds equals the benchmark. This calculation is made on a cumulative basis, but excludes the experience of policies issued in the reporting year.

The experience refund form calculation includes an adjustment for credibility through a tolerance factor for small blocks of experience. The refund calculation form should be completed even if the form does not have credible experience (i.e., less than 500 life years). If the refund is less than 0.5% of the annualized premium in force at December 31, the refund is deferred.

The specific requirements are discussed in the remainder of this section.

Filing Date

The refund calculation must be completed for each type by May 31 following the end of the reporting year.

Distribution Date

The issuer then has until September 30 to make the refund or credit. Interest must be credited from December 31 until the date of the refund or premium credit. The interest rate is specified by the Secretary of the U.S. Department of Health and Human Services (but it will not be less than the average rate of interest for 13-week Treasury notes).3

Business Covered

Refund calculations must be completed for all Medicare supplement policies. The standardized plans issued on or after the OBRA-90 effective date must be reported separately for each unique plan/type combination. Experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan in both the 1990 and 2010 plans shall be combined for the refund or credit calculation.

The experience of policies issued during the reporting year is excluded from the actual-to-expected comparison (but would be captured retroactively in the next reporting year).

Beginning with the SSAA-94 effective date, the experience for all Medicare supplement policies issued prior to the OBRA-90 effective date are aggregated under one of the two pre-standardized policy types—group or individual—as if they had been issued on the SSAA-94 effective date. Since the experience in the year of “issue” is excluded, these policies would not be included in the first reporting year (see Appendix E for additional explanations).

Assigned State

If an insured moves from one state to another, the experience of a policy remains with the state in which it was issued, although the rates may change to reflect costs and utilization in the new state (see Section II: ISSUES AND COMMENTS, GENERAL RATING ISSUES, Rate Revisions for additional details).

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3 CMS (formerly Health Care Financing Administration) has published the basis to be used for calculating the interest rate in the Federal Register, Vol. 59, No. 100, dated May 25, 1994. At the time of the update of this manual, this is still the methodology to be used; however, for later dates please verify with CMS that this methodology still applies.
For pre-standardized policies, the insurer may use the individual’s state of residence at the time of the SSAA-94 effective date as the state of origin for reporting purposes, or the insurer may choose to report on the state of original issue. This is a one-time option and may not be changed once a state has been identified, regardless of whether the individual moves to another state at a later time. However, the premiums actually charged the individual should be based on the state of residence.

CALCULATIONS

Individual and Group Benchmark Worksheets

The appendix to the model regulation contains two worksheets that are to be used to calculate the benchmark loss ratios. The individual benchmark worksheet was developed assuming that the expected lifetime loss ratio is 65% and that this is achieved by the third policy year. The group benchmark worksheet was developed with the factors adjusted to a loss ratio of 75%. Policies issued as a result of mass media advertising in a state that allows the use of individual loss ratios for these policies should be included on the individual benchmark worksheet. The factors contained in these worksheets are also based on assumptions regarding the effects of selection, trend and policy terminations, which produce values that are less than those anticipated for most issuers. Consequently, the resulting values should be considered “floor” assumptions and not necessarily expected values for a particular issuer. The assumptions underlying these factors are outlined in Appendix C of this manual.

Refund Calculation Form

The appendix to the model regulation also contains a Medicare Supplement Refund Calculation Form. The Form:

- Presents the actual incurred loss ratio.
- Applies a credibility adjustment (tolerance).
- Compares the result to the benchmark loss ratio calculated by the worksheet.
- Determines the amount of refund/premium credit, if any.
- Contains a certification of the truth and accuracy of the refund calculation.

The mechanics of completing the worksheets and the Form are described in this section.

Benchmark Loss Ratio

The example in Appendix D of this manual contains copies of the benchmark loss ratio worksheets. The calculation of the benchmark is a straightforward calculation in the worksheets. The worksheets look more complicated than they really are because the calculations were split into pieces that separately illustrate the expected experience in the first two policy years and the later policy years. The factors used to develop the composite benchmark ratio are fixed. The only item required to complete the worksheet is the earned premium in each calendar year of issue.

The worksheet is computed by entering the amount of earned premium in the calendar year of issue for policies issued in each year preceding the reporting year. These are entered in column (b), beginning with the year preceding the reporting year and working backward.

Multiplying the issue-year earned premiums by the factors in columns (c) and (g) give the benchmark cumulative earned premiums to date in the first two policy durations [column (d)] and in the third and later durations [column (h)]. These amounts are totaled to compute the benchmark earned premium, which forms the denominator of the benchmark loss ratio.

Multiplying the cumulative earned premiums in columns (d) and (h) by the factors in columns (e) and (i) produces the benchmark cumulative incurred claims for the first two policy durations [column (f)] and the third and later durations [column (j)]. These amounts are totaled to compute the benchmark incurred claims, which form the numerator in the benchmark loss ratio calculation.

The benchmark loss ratio calculation looks only at the earned premium in the year of issue, not the earned premium in subsequent durations. The calculation assumes a standard set of assumptions (lapse, trend, etc.). Therefore, actual earned premiums will differ from benchmark amounts because of differences in assumptions.
Expected earned premiums are used in place of actual earned premiums so that high experience lapse rates would not distort the calculations. The expected cumulative incurred claims for the cumulative earned premium are calculated through appropriate factors. Column (o) is not used, but provides the base policy year factors used to develop the cumulative factors.

The benchmark loss ratio is then calculated as the ratio of the benchmark incurred claims to the expected earned premium (both excluding issues in the most recent policy year).

**Experience Loss Ratio**

Lines (1) through (3) of the Form develop the actual cumulative loss ratio. Refer to the example in Appendix D of this manual for a sample form. Line (1) presents the experience in the reporting year and deducts the experience for policies issued in that year. Line (2) presents all cumulative experience through the year preceding the reporting year. Line (3) is the sum of lines (1c) and (2). The premiums entered in these lines should include total earned premium, including modal loadings and policy fees. The incurred claims entered in these lines should not include active life reserves or claims expenses. The incurred claims should be the current best estimates based on claim runoff data and an amount to estimate the remaining amount to be paid.

**Cumulative Refund Credits**

Lines (4) through (6) calculate the cumulative refunds/premium credits, which are to be netted against the earned premium reported in line (3). The amount of refunds/premium credits in the year preceding the reporting year is entered in line (4). The amount from all earlier reporting years is entered in line (5). Line (6) is the sum of lines (4) and (5). Note that the amounts entered here do not include the interest that was credited to the refunds.

**Ratio 1**

The benchmark loss ratio that was computed by the worksheet is entered in line (7). The Form refers to this as Ratio 1.

**Ratios 2 and 3**

Line (8) calculates the actual experience loss ratio as the ratio of incurred claims to earned premium net of refunds (both incurred claims and earned premiums exclude the most recent policy year). This amount is referred to as Ratio 2. A tolerance adjustment is added to Ratio 2 that is based on the credibility as represented by the number of life years exposed on a cumulative basis. The tolerance-adjusted ratio is referred to as Ratio 3 and is shown on line (11).

**Credibility**

In the comparison of the experience loss ratio to the benchmark, there is a credibility adjustment. This adjustment is based on cumulative exposures. Line (9) of the Form indicates the number of life years exposed. This is the sum of the average number of lives covered each year through the reporting year (excluding policies issued in the reporting year). This is not the same thing as the number of policyholders in force at December 31 of the reporting year, nor even the sum of the policyholders in force at the end of all prior years. For pre-standardized policies, exposure begins with the SSAA-94 effective date in the state.

If the number of life years exposed is less than 500, the rest of the Form does not need to be completed. There would not be any refund/premium credit required regardless of the relationship between the benchmark loss ratio and the actual experience loss ratio. When the Form is completed in each subsequent year, the number of life years exposed will increase and might eventually reach the minimum credibility level of 500 life years.

The credibility table included in the Form is mandatory. Issuers may not apply their own credibility factors.

**Refund Calculation**

There is a test following line (11) of the Form to determine if a refund is required. Lines (12) and (13) of the Form calculate the amount of premium refund, if any.
Refund Test

If the experience loss ratio adjusted for credibility (Ratio 3) is equal to or greater than the benchmark loss ratio (Ratio 1), no refund is required.

Refund Amount

If the experience loss ratio adjusted for credibility (Ratio 3) is less than the benchmark loss ratio (Ratio 1), a refund is required. The refund amount is the total amount that the premium must be reduced (by refund) so that the experience loss ratio based upon the net premium balances with the benchmark and tolerance factors. The refund amount is increased with interest from December 31 to the payment date.

De Minimus Test

The final step in the process is the de minimus test, which is used to avoid small refunds. It is not in the policyholder’s best interest to require very small refunds because the cost of issuing the refund/premium credit would outweigh any benefit gained. The test used is that the total amount of the refund must be at least as great as .005 times the annualized premium in force (including modal loadings and policy fees) at December 31 of the reporting year. If the calculated refund is less than this amount, no refund is required for that reporting year. If experience continues to be favorable, the de minimus test would eventually fail and the refund would be paid.

WHO GETS REFUND/CREDIT

Section 1882(r)(2)(B) of the Social Security Act as amended by OBRA-90 provides for the refund or premium credit, if any, to be paid to the policyholders in force on December 31 of the reporting year. CMS has stated that policies issued in the reporting year are also eligible for the refund/credit even though they were excluded from the calculation of the total amount to be refunded.

Pre-Standardized Plans

Pre-standardized policies in force on the SSAA-94 effective date are grouped together by type and treated as if they were issued on the SSAA-94 effective date. It is unlikely that they will generate a refund, as the benchmark calculation will assume they are in the early years (with expected low loss ratios) when the experience will be in advanced years. It was not practical to do anything different, but the refund calculation is required for these policies.

REGULATOR’S CHECKLIST

When the filing is received, the regulator should be satisfied that the worksheets and refund forms have been completed accurately. Some of the checks that should be made are listed below:

Number of Forms

1. Was the number of forms filed at least as high as in previous years?

   The number of refund forms will depend on the number of Plans a particular company offers. In most cases, the implementation of the 2010 SB Plans will create an increase in the number of refund forms because of the addition of two new Plan letters (M and N). The fact that certain 1990 SB Plans are not continued to be offered for sale does not mean that there is no refund form for that Plan letter.

Correct Date

2. Is the correct date being used to segment the new standardized plans?
This should be measured from the OBRA-90 effective date in your state. If 1990 Standardized Benefit Plans were issued prior to the OBRA-90 effective date, they are included with the pre-standardized in-force block with a SSAA-94 effective date for refunds, except when a carrier has already included these policies in their 1995 refund calculations (and prior calculations). That practice should be continued.

The effective date of the new 2010 SB Plans M and N should be June 1, 2010, or later, regardless of when the state’s regulation was changed.

**Individual vs. Group Worksheets**

3. **Is the correct worksheet used to calculate the benchmark loss ratios?**

All individual policies must use the individual worksheet (with a 65% loss ratio expectation), and all group policies should use the group worksheet (with a 75% loss ratio expectation). The form for mass-marketed group policies will depend upon your state’s regulation. You should also check that the factors have not been modified (i.e., they cannot be based on issuer assumptions; the factors are fixed for everyone). You should also check that the calculated benchmarks are correctly transferred to the appropriate Refund Calculation Form.

**Earned Premium**

4. **Is the earned premium in the issue year in column (b) of the benchmark worksheets consistent with prior filings?**

The amounts shown in column (b) should be shifted down each reporting year. Also, the amount shown in line (1b) of the Refund Calculation Form in the prior reporting year is the amount that should be shown in Year 1 of the benchmark worksheet for the current reporting year. In the first reporting year, you may want to see if the amounts shown appear to be consistent with the annual rate/experience filing.

**Consistency of Experience**

5. **Is the reported experience consistent with prior filings?**

The cumulative experience in the Refund Calculation Form should be consistent with prior years. The earned premium amount in line (2) should equal the sum of lines (1b) and (3) from the prior reporting year. This relationship will not necessarily hold for incurred claims because the claim experience is restated, but there should be a close relationship. In addition, the experience should be consistent with the annual rate/experience filing. Note, however, that the rate/experience filings are completed at the form level, and the experience for multiple forms may need to be added to develop the amount at the type level.

**Prior Refunds**

6. **Is the amount of prior refunds consistent with prior filings?**

The amount on line (4) of the Refund Calculation Form should equal the amount from line (13) in the prior reporting year. The amount shown in line (5) should equal the amount from line (6) of the prior reporting year. Check that the amounts shown do not include the interest that was paid.

**Life Years Exposed**

7. **Does the amount shown for life years exposed appear to be reasonable?**

This number should increase with successive reporting years. One reasonableness test that could be performed is based on the number of policies in force at the end of the prior year. The increase should be approximately equal to the number of policies covered at the end of the prior year after adjusting for an assumed level of lapses and new issues. Note that the Refund Calculation Form does not include this information directly. It should be available from the annual rate filing (but you may need to add several forms to develop the amount at the type level). If you are not satisfied that this amount has been correctly determined, you should ask for additional information.
Tolerance Factor

8. Has the tolerance been correctly determined?

Check that the tolerance amount on line (10) of the Refund Calculation Form is correct based on the life years exposed. The credibility table included on the form must be used; issuers may not use their own credibility table.

De Minimus Test

9. Was the de minimus test made correctly?

If a refund is not paid because the amount is considered to be de minimus, the worksheet should show the calculation. You should confirm that the premium used for the test is annualized premium in force at December 31 of the reporting year (including modal loadings and policy fees).

Distribution Methodology

10. If a refund is required, are you satisfied with the distribution methodology described?

The Refund Calculation Form requires the method of distribution to be included with the filing. This description must include the rate of interest to be credited and the amount of time for which the interest is to be applied. The rate of interest credited must be no less than 1) that specified by the Secretary of the U.S. Department of Health and Human Services, and 2) the average rate of interest for 13-week Treasury notes. If no interest rate has been specified by regulatory authorities, the issuer should use its best judgment as to the average rate. The methodology must result in a completed transaction by September 30. Note that this deadline applies to a premium credit methodology also. For this reason, premium vouchers should not be used, as there is no guarantee as to when they would be used. Likewise, premium adjustments could not be used for modal premiums coming due after September 30.

Potential Forms

You should also review how the refund/premium credits are allocated to the individual policyholders. Some potential methodologies are:

- Equal amount or percentage based on the premium in the reporting year. This may be the most reasonable approach.
- Equal percentage based on the length of time the policy is in force. This may be a reasonable approach if the refund has been delayed due to the de minimus test or low credibility.
- Unequal amounts/percentages. If this type of approach is used, justification for the unequal distribution must be provided. For example, was there one policy form within the type that contributed more to generating the refund?

It is recommended that the refund formula be consistent within a policy form, but variations of the formula may be justifiable between forms. However, it is not anticipated that the refund/credit would ever be completely eliminated for any subset of policyholders.

Certification

11. Has the certification been completed?

This section of the Refund Calculation Form must be completed showing an individual’s name and title, not the issuer’s name.
SECTION VI: OTHER FILING REQUIREMENTS

Each issuer must file the following experience reports on an annual basis. These reports are required by the model regulation and by federal statute. They include:

Annual Statement Experience Exhibit

The Medicare Supplement Insurance Experience Exhibit

This exhibit is contained in the Annual Statement and filed with the statement by March 1 each year. It contains information relative to loss ratios by policy form and state of issue. The form also includes information to satisfy the requirements of 42 USC 1395 ss (b) (1) E. This section of the federal code requires each state to periodically (but at least annually) provide the Secretary of the U.S. Department of Health and Human Services with a list containing the name and address of each issuer of Medicare supplement insurance in their state, including the name and number of such policies (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided). This information is collected directly by the NAIC, compiled, and mailed to the states for comments and verification. The NAIC submits the report, including the states’ comments and corrections, to CMS on behalf of the states.

Duplicative Policies

The Form for Reporting Duplicative Medicare Supplement Policies

Section 22 of the NAIC model regulation requires issuers to report on or before March 1 each year the policy and certificate number and date of issue of any policyholder who has more than one Medicare supplement policy. This information should be used by insurance departments to determine compliance with the non-duplication provisions found in Section 21B of the NAIC model regulation.
SECTION VII: MEDICARE SELECT

INTRODUCTION

The OBRA-90 amendments gave CMS authorization to designate 15 states that could approve Medicare SELECT policies. Federal legislation passed in 1995 extended the Medicare SELECT program to any of the 50 states that adopt the SELECT program, and to be effective until 1998. This was changed to permanent status in 1998.

Any benefit plan that conditions the payment of benefits on which providers are used may only be offered under the SELECT program. Therefore, typical HMO or PPO plans could not be offered as supplemental coverage to Medicare Parts A and B after the effective date of OBRA-90. The following types of coverage are available as alternatives to Medicare Parts A and B but are not subject to regulation as Medicare supplement coverage:

- Medicare risk contracts under Medicare Part C
- Medicare cost contracts
- Employer or union plans

SELECT BENEFIT PLANS

The SELECT program provides a means of offering different delivery systems. SELECT policies do not offer additional benefits compared to non-SELECT policies. The usual standardized benefit plans apply for SELECT products. The benefit plan is defined by the benefits paid when network providers are used. That is, the in-network benefits must follow one of the standardized plans outlined in the model regulation. The benefits that apply when non-network providers are used may be less than the network benefits.

For example, if Plan G is offered, the in-network benefits cover “core” services, the Part A deductible, skilled nursing coinsurance for stays 21 to 100, 100% of any Part B balance billing, and 80% of medically necessary foreign travel. The out-of-network benefits could cover any part of these costs. For example, the Part A deductible and Part B balance billing costs may not be paid if non-network providers are used. Alternatively, a SELECT policy may not cover any services if non-network providers are used.

Required Offers of Coverage

Section 10L of the model regulation states that at the time of initial purchase, a SELECT issuer must make available to each applicant for a SELECT policy or certificate the opportunity to purchase any non-SELECT Medicare supplement policy or certificate otherwise offered by the issuer. Clearly, if the issuer provides both SELECT and non-SELECT products, then the non-SELECT plans offered by the issuer must be made available to SELECT applicants at the time of initial purchase. If the SELECT issuer does not otherwise offer non-SELECT Medicare supplement coverage, such as an HMO, it would not be required to offer non-SELECT Medicare supplement coverage to SELECT applicants at the time of initial purchase.

Section 10M of the model regulation states that at the request of the individual insured under a SELECT plan, the SELECT issuer shall make available to the individual the opportunity to purchase a non-SELECT Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits. The issuer is prohibited from requiring evidence of insurability if the request is made within six months after the effective date of the SELECT plan. If the SELECT issuer does not otherwise offer non-SELECT Medicare supplement coverage, such as an HMO, it would not be required to provide non-SELECT Medicare supplement coverage to SELECT insureds. A SELECT policy may not offer a plan to newly eligible individuals that covers any part of the Medicare Part B deductible.
Since some SELECT issuers do not otherwise offer non-SELECT Medicare supplement coverage, it is very important that, in those cases, the SELECT applicants be made clearly aware of the coverage limitations of these plans. For example, if a SELECT insured is afforded coverage through an HMO and the HMO does not offer non-SELECT Medicare supplement coverage, the insured should know that if he or she moves out of the HMO’s service area or wants to change providers to one that is not a panel provider, the SELECT coverage will not be available to the insured. However, Medicare coverage would still continue.

Section 10I of the model regulation requires such disclosures, and SELECT states should strongly require such disclosures.

REQUIREMENTS

The requirements a SELECT product must meet are:

**Plan of Operation**

- File a plan of operation. This plan covers such topics as access, quality assurance, and disclosure of policy restrictions and coverage options. In addition, proposed changes to the plan of operation must be filed prior to implementing the changes.

**Network List**

- File updated lists of network providers quarterly.

**Non-SELECT Option**

- Allow an applicant any non-SELECT policy that the issuer offers. Also, allow an insured, upon request made after at least six months of coverage, the opportunity to change to any non-SELECT plan the issuer offers that has comparable or lesser benefits without evidence of insurability. Note that the issuer may not offer any non-SELECT policy; this is not interpreted to be a violation of the model regulation requirements.

**Continuation of Coverage**

- Provide for continuation of coverage if the SELECT program is discontinued. If the issuer’s license with the state allows a non-SELECT policy to be offered, the issuer must meet this requirement. However, some states do not allow HMOs to offer indemnity types of benefits. Prior to approval of a carrier to offer a SELECT program, provisions must be in the plan of operation to allow for the continuation of coverage if the SELECT program is not renewed federally, either with the HMO or outside the HMO (with another carrier, for example).

**New Form Filing**

- File anticipated loss ratios and rate development for a new policy form. This requirement is the same as for non-SELECT plans.

**Annual Filing**

- File rates and experience annually. This requirement is the same as for non-SELECT plans.

**Rate Increase Filing**

- File for rate increases. This requirement is the same as for non-SELECT plans.

**Refund Filing**

- File the rate refund form. This requirement is the same as for non-SELECT plans.

Special data considerations for these filings are discussed for the remainder of this section.
DATA CONSIDERATIONS

SELECT policies are distinguished from non-SELECT policies only in that they provide for reduced benefits if non-network providers are used. Therefore, the same types of data and information should be available for both types of policies. This may present a departure from traditional data captured by an HMO.

New Form Filing

For example, the rate filing for a new policy form must demonstrate that the anticipated loss ratio over the life of the policy and the expected loss ratio in the third policy year both meet the minimum required. This means that data must be presented on a policy duration basis, not the capitation premium development used by an HMO. If underwriting is performed, the assumed selection factors and lapse rates must be identified in order to make the demonstrations required.

Annual Filing/Rate Revision Filing

Requests for rate revisions and the annual rate/experience filing will also require data to be presented in a manner other than the traditional capitation methodology. As noted in Sections III and IV, historical experience by policy year or calendar year of issue is required for these filings.

Refund Filing

The refund filing will require that data by issue year be available to complete both the benchmark ratio and experience ratio calculations.

Incurred Claims Definitions

Loss ratios in the model regulation are defined to be the ratio of incurred claims experience or incurred health care expenses to earned premium. Section 5D of the model regulation defines health care expenses as those expenses associated with the delivery of health care services and expressly excludes the following costs: home office and overhead, advertising, commissions, taxes, capital, administrative, and claims processing.

It is recognized that some HMO expenses are valid health care expenses, but are not readily allocated to an issue-year basis. Examples are capitations, withholds, and physician incentive payments based on non-physician services (e.g., hospital utilization).

Capitations

A capitation could be allocated on the same basis as it is paid to specific policies that have been previously assigned to a calendar year of issue. This approach would not give any recognition to any anticipated durational difference in claims (i.e., it will not recognize any selection impact). An issuer may wish to identify in advance a more refined method of allocation that would recognize expected selection. Any method used should be consistent from year to year.

Withholds and Other Incentive Payments

Withhold and other incentive payments are paid based on each physician’s experience. It is generally not possible to allocate the amount paid to a specific member or, therefore, issue year. For these types of payments, an acceptable method of allocation would be a pro rata amount based on the total amount of withhold or incentive to total incurred claims or capitation. In order to assess if a more refined methodology could be possible, a complete description of how the withhold or incentive payment is made should be requested.
SECTION VIII: HISTORICAL MATERIAL

The following material was a part of prior versions of the Compliance Manual. It may have some limited relevance when reviewing the prior operations of a block of Medicare supplement business. As such, it has been retained by moving it from the location noted to this Historical Section so that the material is not lost.

Relocated from Section I

OVERVIEW AND PURPOSE OF THE MANUAL

#6: Requirements under the Medicare Modernization Act of 2003

In 2004 the Model Regulation was revised to reflect requirements of the MMA applicable to beneficiaries who enroll in Part D (the new Medicare prescription drug program) of Medicare. Changes to the Model include:

- Stripping all prescription drug benefits from any Medicare supplement plan with an insured that enrolls in Part D after December 31, 2005.
- Prohibiting Medicare supplement issuers from offering prescription drug benefits to new enrollees after December 31, 2005. (This includes plans H, I, J, high-deductible J, and the prescription drug plans in Minnesota, Wisconsin, and Massachusetts.)
- Creating two new Medicare supplement plans, “K” and “L.”

If an individual is covered under a Medicare supplement plan with prescription drug benefits and does not enroll in Part D, the issuer must continue to renew the plan with the prescription drug benefits.

If an individual is covered under a Medicare supplement plan with prescription drug benefits and does enroll in Part D, the issuer must give the insured two options:

1. Lapsing the existing policy and purchasing Plan A, B, C, F, K or L on a guaranteed issue basis.
2. Keeping the existing policy and eliminating the drug benefits effective with the date their drug coverage starts under Part D.

If option 2 is selected, the issuer must adjust the premium of the stripped-out plan appropriately to reflect the reduced benefits (see section III of this manual). Note that if the insured does not notify the issuer in advance, the issuer is required to refund the portion of premiums paid for prescription drug benefits from the effective date of Part D coverage for the insured. The refund may be reduced by claims already paid on prescription drug benefits incurred after the effective date of Part D coverage, but not below zero.

Relocated from Section II

EFFECTIVE DATE ISSUES

Is there any flexibility in the effective dates? [pertaining to effective dates of 1990 Plans versus pre-standardization plan]

Generally, no. However, administrative flexibility is allowed to carriers in two instances where the policyholders will benefit.

If a carrier wishes to use a common SSAA-94 effective date for a group of states (all of which have a SSAA-94 date equal to or later than the one chosen by the carrier for administrative simplicity) in the accumulation of experience for loss ratios and/or refunds, this should be acceptable.
Relocated from Section III

HOW DOES A REGULATOR KNOW IF ASSUMPTIONS ARE REASONABLE?

Relative Costs by Age [These were originally developed in 1992 and updated in 1996 but have not been updated thereafter. Thus, they have historical relevance but may not be appropriate for current use.]

The relative cost by age is also subject to differences among carriers and changes over time. However, it is likely to be somewhat more stable than the other factors. The relative cost by attained age (in five-year age groups) is shown for the basic kinds of Medicare supplement plans in the following table.

These tables are intended to be illustrative and are for comparison purposes.

<table>
<thead>
<tr>
<th>Medicare Supplement</th>
<th>Claim Costs by Attained Age</th>
<th>(Relative to Age Group 75-79)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital</td>
<td>Part B</td>
</tr>
<tr>
<td>65-69</td>
<td>0.76</td>
<td>0.68</td>
</tr>
<tr>
<td>70-74</td>
<td>0.90</td>
<td>0.91</td>
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<tr>
<td>75-79</td>
<td>1.00</td>
<td>1.00</td>
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</tr>
<tr>
<td>85+</td>
<td>1.36</td>
<td>1.05</td>
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</tbody>
</table>

Note that the relative slope of the costs varies dramatically by kind of benefit. Therefore, the rate relativities by age for a standardized plan will depend upon which benefits are included. This is illustrated in the following table.

<table>
<thead>
<tr>
<th>Relative Attained Age Cost</th>
<th>(by Standardized Plan)</th>
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<tr>
<td></td>
<td>Plan A</td>
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<tr>
<td>65-69</td>
<td>0.69</td>
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<tr>
<td>70-74</td>
<td>0.91</td>
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<td>75-79</td>
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<td>80-84</td>
<td>1.06</td>
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<td>85+</td>
<td>1.08</td>
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## APPENDIX A

**Medicare Supplement Assumption Summary**

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<th>Company Name</th>
<th>Plan(s)</th>
<th>Form Number</th>
<th>Rating Period</th>
<th>Issue or Attained</th>
<th>Loss Ratio Std (65% or 75%)</th>
<th>Trend Rate</th>
<th>Investment Income Rate</th>
<th>Commission Schedule</th>
<th>Lapse Rates</th>
<th>Average Annual Premium</th>
<th>Durational Loss Ratios</th>
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<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 2</td>
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<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 7</td>
<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 7</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 8</td>
<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 8</td>
</tr>
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<td>Year 9</td>
<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 9</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 10</td>
<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 10</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 11</td>
<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 11</td>
</tr>
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<td>Year 7 +</td>
<td>Year 13</td>
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<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 14</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Year 15</td>
<td>Year 1</td>
<td>Year 7 +</td>
<td>Year 15</td>
</tr>
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</table>

**APPENDIX B**

Summary of Information to Include in Annual Rate and Loss Ratio Filing, New Policy Filing, and Rate Revision Filing

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Rate/Loss Ratio Filing</th>
<th>New Policy Filing</th>
<th>Rate Revision Filing</th>
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<tbody>
<tr>
<td>Purpose of Filing (a)</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>General Description</td>
<td></td>
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<tr>
<td>Issuer Name</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<td>X</td>
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</tr>
<tr>
<td>Underwriting Method</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pre-existing Condition Excl.</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Issue-Age Limits</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Premium Basis</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Actuary’s Name, etc.</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Domicile State Approval</td>
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<td>X</td>
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<tr>
<td>Multiple Forms by plan/type?</td>
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<td></td>
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<td>Group Conversion (Method/Form)</td>
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<tr>
<td>Rate Methodology/Assumptions</td>
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</tr>
<tr>
<td>General Method</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Priced w/ Rate Increases?</td>
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<td>X</td>
<td>X</td>
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<td>Replacement Commissions</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Lapse Assumption</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Morbidity Assumption</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Interest Assumption</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Expense Assumptions</td>
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<tr>
<td>Equivalence of Change in Rating Methodology</td>
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<td></td>
<td>X</td>
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<tr>
<td>Scope/Reason for Request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Increase</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Variations by Cell</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timing</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rates and Rating Factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Proposed</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Period Rates Apply</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
| Average Annual Premium (incl. mix by cell)       |                               |                   | X                   | X (c)
<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Rate/Loss Ratio Filing</th>
<th>New Policy Filing</th>
<th>Rate Revision Filing</th>
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</thead>
<tbody>
<tr>
<td>Rate History (5 yrs.) (amount and timing)</td>
<td>X</td>
<td></td>
<td>X</td>
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<td>In-Force Counts</td>
<td></td>
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</tr>
<tr>
<td>Since Inception</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>State and National</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Historical Incurred Claims</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Iss. Yr and Cal. Yr (d)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>State Basis</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>National Basis (e)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Historical Earned Premium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Iss. Yr and Cal. Yr (d)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>State Basis</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>National Basis (e)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Loss Ratio Projection</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Definition</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
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<td>Base Period</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lapse Assumption</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Claim Trend Assumption</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Att.-Age/Selec. Adjustments</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Future Rate Increases?</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Interest Assumption</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>With and w/o rate change</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss Ratio Demonstration (f)</td>
<td>X (Min./Filed)</td>
<td>X (Min.)</td>
<td>X (Filed)</td>
</tr>
<tr>
<td>Actuarial Certification</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Notes to Appendix B:

(a) Each filing serves a different purpose. The annual rate and loss ratio filing must file the rates for approval and demonstrate loss ratio compliance with the minimum standards in the regulation. A new policy filing must describe the rate development and demonstrate compliance with minimum loss ratios. A rate revision filing must describe how and why the rate revision is requested and demonstrate compliance with the originally filed loss ratios.

(b) The rate revision filing must also indicate whether the policy is a closed block of business.

(c) This should be shown both before and after the rate revision.

(d) Alternatively, the data could be presented by calendar year of issue and calendar experience.

(e) The national data need only be provided if the projections and/or rates are derived from national experience.

(f) The loss ratio demonstration varies for each filing. The new form filing and annual filing must both demonstrate compliance with the minimum standards. Since the annual filing also covers approval of rates, it should also indicate the anticipated loss ratio when the policy form was filed. The rate revision filing must demonstrate compliance with the anticipated loss ratio when the policy form was filed. The new form filing must also illustrate the expected loss ratio for at least the first 10 years and indicate any variations by age.
APPENDIX C
Refund Calculation Factor Development

Assumptions
1. Loss ratios achieved over 15 years.
2. Policies are issued July 1 of the issue year.
3. 10% trend in premiums and claims.
4. Loss ratios by policy year: 40%, 55%, 65%, 67%, 69%, 71%, 73%, 75%, 76% for three years, and 77% for the remainder.
5. Lapse rates for each year: 30%, 25%, 20% for three years and 17% thereafter. Lapses are assumed to occur at the end of the year.

Methodology
The earned premium factor is applied to the first calendar year earned premium (1/2 policy year) to derive the appropriate cumulative expected earned premium based upon the above assumptions. The benchmark incurred claims are derived by applying the assumed loss ratios by duration, and the cumulative loss ratio is the ratio of the sums.

Sample Factor Calculation (Year 3)
For example, for each dollar of earned premium in the issue year, the expected cumulative earned premium factor (4.175) and the cumulative loss ratio (.493) in the third calendar year are calculated as follows:

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Benchmark Earned Premium</th>
<th>Loss Ratio</th>
<th>Benchmark Incurred Claims</th>
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</thead>
<tbody>
<tr>
<td>1 (1/2 year assumed)</td>
<td>1.000</td>
<td>.40</td>
<td>.4000</td>
</tr>
<tr>
<td>+ 2, 1st Half</td>
<td>+ 1.000</td>
<td>.40</td>
<td>.4000</td>
</tr>
<tr>
<td>+ 2, 2nd Half</td>
<td>+ 1.100 \times \text{persistency rate} \times .7</td>
<td>+ .770</td>
<td>.55</td>
</tr>
<tr>
<td>+ 3, 1st Half</td>
<td>+ 1.100 \times \text{persistency rate} \times .7</td>
<td>+ .770</td>
<td>.55</td>
</tr>
<tr>
<td>+ 3, 2nd Half</td>
<td>+ 1.210 \times \text{persistency rate} \times .7 \times .75</td>
<td>+ .635</td>
<td>.65</td>
</tr>
<tr>
<td>Total</td>
<td>4.175</td>
<td>2.0598</td>
<td></td>
</tr>
</tbody>
</table>

Cumulative Loss Ratio Factor (Year 3) .493
APPENDIX D
Refund Filing Example

ASSUMPTIONS

This example assumes that the information in this manual is being adhered to as shown. Both the data that the issuer has and the completion of the benchmark worksheets and Refund Calculation Forms are provided. The assumptions underlying this example are:

Company ABC is licensed in two states (A and B). The new Medicare regulation became effective on July 1, 1992, in State A and on May 1, 1992, in State B. Besides a block of pre-standardized business, Company ABC began issuing standard plans A and F on May 1, 1992. Plans A and F are marketed to individuals on both an agency basis and direct response basis. No business has been issued in Plan A through direct response.

Each year, Company ABC would file three refund forms in each state: In-Force, Plan A, and Plan F (all individual).

Reporting Year 1992

Table 1 presents Company ABC’s experience data at the end of 1992. Since this is the year in which the refund provision of the new regulation became effective, no refund filing is required (all first-year business is excluded from the refund calculation).

Reporting Year 1993

Table 2 presents Company ABC’s experience data at the end of 1993. Note that the incurred claims estimates for 1992 are different from Table 1. This is because the incurred claims should be restated based on claim runoff plus an amount for claims not yet paid.

Table 3 represents the benchmark worksheets and Refund Calculation Forms that should be filed in State A. There are two pages for each of the three “plans” being filed (In-Force, Plan A, and Plan F). Table 3.1 is the benchmark worksheet, and Table 3.2 is the Refund Calculation Form.

For simplicity of presentation, the filings in State B are not included here. The primary difference from State A is the earlier effective date, which would result in the issues from May 1, 1992, through June 30, 1992, being included with the standardized forms instead of the in-force block.

Note that no refund is required for the in-force block, as Ratio 2 exceeds Ratio 1. No refund is required for Plan A, as Ratio 3 exceeds Ratio 1. A refund is required for Plan F (and it exceeds the de minimus test).

Reporting Year 1994

Table 4 presents Company ABC’s experience data at the end of 1994. Again, note that incurred claims have been restated.

Table 5 presents the benchmark worksheets (Tables 5.1) and Refund Calculation Forms (Tables 5.2) that should be filed in State A.

No refund is required for the in-force block, as Ratio 2 exceeds Ratio 1. No refund is required for Plan A, as Ratio 3 exceeds Ratio 1. A refund is again required on Plan F (note that this may not have occurred if the annual rate filing had resulted in a premium reduction).
TABLE 1
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1992

<table>
<thead>
<tr>
<th>Policy Group</th>
<th>Issue Dates</th>
<th>Description</th>
<th>Cal. Yr. Exper. – State A</th>
<th>Cal. Yr. Exper. – State B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1992</td>
<td>1992</td>
</tr>
<tr>
<td>Pre-Standardized</td>
<td></td>
<td>Earned Premium</td>
<td>5,013,720</td>
<td>7,520,580</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incurred Claims</td>
<td>3,504,890</td>
<td>5,257,335</td>
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<tr>
<td></td>
<td></td>
<td>Life Yrs Exposed</td>
<td>5,530</td>
<td>8,295</td>
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<td></td>
<td></td>
<td>Annzd. Prem. IF</td>
<td>4,726,000</td>
<td>7,089,000</td>
</tr>
<tr>
<td>Plan A (Indiv)</td>
<td>5/1/92 –</td>
<td>Earned Premium</td>
<td>70,000</td>
<td>105,000</td>
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<tr>
<td></td>
<td>6/30/92*</td>
<td>Incurred Claims</td>
<td>24,500</td>
<td>36,750</td>
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<tr>
<td></td>
<td></td>
<td>Life Yrs Exposed</td>
<td>100</td>
<td>150</td>
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<tr>
<td></td>
<td></td>
<td>Annzd. Prem. IF</td>
<td>140,000</td>
<td>210,000</td>
</tr>
<tr>
<td></td>
<td>7/1/92 –</td>
<td>Earned Premium</td>
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<td>12/31/92</td>
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<td>73,875</td>
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<td>Life Yrs Exposed</td>
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<td>300</td>
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<td></td>
<td></td>
<td>Annzd. Prem. IF</td>
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<td>422,100</td>
</tr>
<tr>
<td>Total**</td>
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<td>Earned Premium</td>
<td>141,000</td>
<td>316,500</td>
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<tr>
<td></td>
<td></td>
<td>Incurred Claims</td>
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<td>110,625</td>
</tr>
<tr>
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<td></td>
<td>Life Yrs Exposed</td>
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<td>450</td>
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<td>Annzd. Prem. IF</td>
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<tr>
<td></td>
<td></td>
<td>Incurred Claims</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Life Yrs Exposed</td>
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<td>0</td>
</tr>
<tr>
<td></td>
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<td>Annzd. Prem. IF</td>
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</tr>
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<td>5/1/92 –</td>
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<td>210,000</td>
</tr>
<tr>
<td></td>
<td>6/30/92*</td>
<td>Incurred Claims</td>
<td>49,000</td>
<td>73,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Life Yrs Exposed</td>
<td>200</td>
<td>300</td>
</tr>
<tr>
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<td>Annzd. Prem. IF</td>
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<td>Earned Premium</td>
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<td>423,000</td>
</tr>
<tr>
<td></td>
<td>12/31/92</td>
<td>Incurred Claims</td>
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<td>147,750</td>
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<td>Life Yrs Exposed</td>
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<td>600</td>
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<td></td>
<td>Annzd. Prem. IF</td>
<td>562,800</td>
<td>844,200</td>
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<tr>
<td>Total**</td>
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<td>Earned Premium</td>
<td>282,000</td>
<td>633,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incurred Claims</td>
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<td>221,250</td>
</tr>
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<td>900</td>
</tr>
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<td></td>
<td></td>
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<td>1,264,200</td>
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<td>Earned Premium</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Incurred Claims</td>
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</tr>
<tr>
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<td></td>
<td>Life Yrs Exposed</td>
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</tr>
<tr>
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<td>Annzd. Prem. IF</td>
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<td>0</td>
</tr>
</tbody>
</table>

Plan F (Indiv. Dir. Resp.) 5/1/92 – 6/30/92
|                      | Earned Premium | 245,000                  | 367,500                  |
|                      | Incurred Claims | 85,750                   | 128,625                  |
|                      | Life Yrs Exposed | 350                      | 525                      |
|                      | Annzd. Prem. IF  | 490,000                  | 735,000                  |
TABLE 1
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1992

<table>
<thead>
<tr>
<th>Policy Group</th>
<th>Issue Dates</th>
<th>Description</th>
<th>Cal. Yr. Exper. – State A</th>
<th>Cal. Yr. Exper. – State B</th>
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<tbody>
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*These issues are included with the pre-standardized block for State A and with the standardized plans for State B.

**Excludes 5/92–6/92 issues for State A, as those issues are included with the pre-standardized policies.
<table>
<thead>
<tr>
<th>Policy Group</th>
<th>Issue Dates</th>
<th>Description</th>
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<th>Cal. Yr. Exper. – State B</th>
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*These issues are included with the pre-standardized block for State A and with the standardized plans for State B.

**Excludes 5/92–6/92 issues for State A, as those issues are included with the pre-standardized policies.
## TABLE 3.1 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1993

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<th>Year</th>
<th>Earned Premium</th>
<th>Factor</th>
<th>(b)x(c)</th>
<th>Cumulative Loss Ratio</th>
<th>(d)x(e)</th>
<th>Factor</th>
<th>(b)(x)(g)</th>
<th>Cumulative Loss Ratio</th>
<th>Policy Yr Loss Ratio</th>
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Benchmark Ratio Since Inception 0.442
TABLE 3.2 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1993

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<th>In-Force</th>
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<tr>
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<td>Person Completing This Exhibit:</td>
<td>John Doe</td>
<td></td>
<td></td>
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<tr>
<td>Title:</td>
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<tr>
<td>Telephone Number:</td>
<td>(123) 456-0000</td>
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1. Current Year’s Experience
   a. Total (all policy years) 5,137,659 3,534,423
   b. Current year’s issues 0 0
   c. Net (1a – 1b) 5,137,659 3,534,423

2. Past Year’s Experience (all policy years)
   5,468,720 3,829,585

3. Total Experience (1c + 2)
   10,606,379 7,364,008

4. Refunds Last Year (excluding interest) 0

5. Previous Since Inception (excluding interest) 0

6. Refunds Since Inception (excluding interest) 0

7. Benchmark Ratio Since Inception (Ratio 1) 0.442

8. Experienced Ratio Since Inception (Ratio 2)
   (Line 3, Col. b)/(Line 3, Col. a – Line 6) 0.694

9. Life Years Exposed Since Inception
   If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.
   11,709

10. Tolerance Permitted (from credibility table)

11. Adjustment to Incurred Claims for Credibility
    (Ratio 3 = Ratio 2 + Tolerance)
    If Line 11 > Line 7, a refund/credit is not required.

12. Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11

13. Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))
    De minimus Amount
    (.005 x Annualized Prem. IF at 12/31)

Medicare Supplement Credibility Table

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<tr>
<td>5,000 – 9,999</td>
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</table>

If less than 500, no credibility

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature Name (type) ____________________________
Title ______ Date ________

TABLE 3.1 Plan A
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1993

<table>
<thead>
<tr>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
<th>(d)</th>
<th>(e)</th>
<th>(f)</th>
<th>(g)</th>
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<td>8.493</td>
<td>0.493</td>
<td>8.493</td>
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<td>0.77</td>
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Benchmark Ratio Since Inception 0.442
TABLE 3.2 Plan A
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1993

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<th>TYPE: Individual</th>
<th>SMSBP(p): Plan A</th>
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<tr>
<td>For the State of: State A</td>
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<tr>
<td>Company Name: Company ABC</td>
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</tr>
<tr>
<td>NAIC Group Code: 0001 NAIC Co. Code: 0001</td>
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<tr>
<td>Address: 123 Anystreet, Kansas City, MO</td>
<td></td>
</tr>
<tr>
<td>Person Completing This Exhibit: John Doe</td>
<td></td>
</tr>
<tr>
<td>Title: Chief Actuary Telephone Number: (123) 456-0000</td>
<td></td>
</tr>
</tbody>
</table>

(a) Earned Premium  (b) Incurred Claims

1. Current Year’s Experience
   a. Total (all policy years) 666,530 250,589
   b. Current year’s issues 415,520 151,704
   c. Net (1a – 1b) 251,010 98,885

2. Past Year’s Experience (all policy years) 141,000 46,788

3. Total Experience (1c + 2) 392,010 145,673

4. Refunds Last Year (excluding interest) 0

5. Previous Since Inception (excluding interest) 0

6. Refunds Since Inception (excluding interest) 0

7. Benchmark Ratio Since Inception (Ratio 1) 0.442

8. Experienced Ratio Since Inception (Ratio 2)
   (Line 3, Col. b)/(Line 3, Col. a – Line 6) 0.372

9. Life Years Exposed Since Inception
   If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.
   Life Years Exposed Since Inception 542

10. Tolerance Permitted (from credibility table) 0.150

11. Adjustment to Incurred Claims for Credibility
    (Ratio 3 = Ratio 2 + Tolerance) 0.522
    If Line 11 > Line 7, a refund/credit
    is not required.

12. Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11

13. Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7)) The refund is only paid if it exceeds the De minimus Amount. The distribution methodology must be filed also.
    De minimus Amount (.005 x Annualized Prem. IF at 12/31)

<table>
<thead>
<tr>
<th>Medicare Supplement Credibility Table</th>
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<tr>
<td>Life Yrs Exposed Since Inception</td>
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<td>5,000 – 9,999</td>
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<td>2,500 – 4,999</td>
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<td>500 – 999</td>
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<tr>
<td>If less than 500, no credibility</td>
</tr>
</tbody>
</table>

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature __________________________________________

Name (type) _________________________________________

Title _______________________________________________

Date _______________________________________________
TABLE 3.1 Plan F
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR 1993

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<th>(e)</th>
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<td>Cumulative Loss Ratio</td>
<td>(d)x(c)</td>
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Benchmark Ratio Since Inception 0.442
TABLE 3.2 Plan F  
COMPANY ABC  
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

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<tr>
<th>TABLE 3.2 Plan F</th>
<th>COMPANY ABC</th>
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| MEDICARE SUPPLEMENT REFUND CALCULATION FORM |
| FOR CALENDAR YEAR 1993 |

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<th>Person Completing This Exhibit:</th>
<th>John Doe</th>
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<thead>
<tr>
<th>Title:</th>
<th>Chief Actuary</th>
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</table>

<table>
<thead>
<tr>
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<th>(123) 456-0000</th>
</tr>
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</table>

1. Current Year’s Experience
   a. Total (all policy years) 3,243,040 1,277,260
   b. Current year’s issues 1,868,880 754,260
   c. Net (1a - 1b) 1,374,160 523,000

2. Past Year’s Experience (all policy years) 775,500 248,713

3. Total Experience (1c + 2) 2,149,660 771,713

4. Refunds Last Year (excluding interest) 0

5. Previous Since Inception (excluding interest) 0

6. Refunds Since Inception (excluding interest) 0

7. Benchmark Ratio Since Inception (Ratio 1) 0.442

8. Experienced Ratio Since Inception (Ratio 2)
   (Line 3, Col. b)/(Line 3, Col. a – Line 6) 0.359

9. Life Years Exposed Since Inception
   If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.
   2,990

10. Tolerance Permitted (from credibility table) 0.075

11. Adjustment to Incurred Claims for Credibility
    (Ratio 3 = Ratio 2 + Tolerance) 0.434
    If Line 11 > Line 7, a refund/credit is not required.

12. Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11 932,952

13. Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7)) 38,908
    The refund is only paid if it exceeds the De minimus Amount. The distribution methodology must be filed also.
    De minimus Amount 6,048

De minimus Amount (.005 x Annualized Prem. IF at 12/31)

Medicare Supplement Credibility Table

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<tr>
<td>500 – 999</td>
<td>15.0%</td>
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</table>

If less than 500, no credibility

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature __________________________

Name (type) __________________________

Title __________________________

Date __________________________

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<th>Issue Dates</th>
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<th>Cal. Yr. Exper. – State B</th>
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*These issues are included with the pre-standardized block for State A and with the standardized plans for State B.

**Excludes 5/92-6/92 issues for State A, as those issues are included with the pre-standardized policies.
## TABLE 5.1 In-Force
### COMPANY ABC
### BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR 1994**

<table>
<thead>
<tr>
<th>Year</th>
<th>Earned Premium</th>
<th>Factor</th>
<th>(b)x(c)</th>
<th>Cumulative Loss Ratio</th>
<th>(d)x(e)</th>
<th>Factor</th>
<th>(b)x(g)</th>
<th>Cumulative Loss Ratio</th>
<th>(h)x(i)</th>
<th>Policy Yr Loss Ratio</th>
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Benchmark Ratio Since Inception 0.493
TABLE 5.2 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1994

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<th>In-Force</th>
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<td>Company ABC</td>
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<td>NAIC Group Code</td>
<td>0001</td>
<td>NAIC Co. Code: 0001</td>
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<tr>
<td>Address</td>
<td>123 Anystreet, Kansas City, MO</td>
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<td></td>
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<tr>
<td>Person Completing This Exhibit</td>
<td>John Doe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Chief Actuary</td>
<td>Telephone Number: (123) 456-0000</td>
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</tr>
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1. Current Year’s Experience
   a. Total (all policy years) 5,086,282 3,411,753
   b. Current year’s issues 0 0
   c. Net (1a – 1b) 5,086,282 3,411,753

2. Past Year’s Experience (all policy years) 10,606,379 7,275,799

3. Total Experience (1c + 2) 15,692,662 10,687,552

4. Refunds Last Year (excluding interest) 0

5. Previous Since Inception (excluding interest) 0

6. Refunds Since Inception (excluding interest) 0

7. Benchmark Ratio Since Inception (Ratio 1) 0.493

8. Experienced Ratio Since Inception (Ratio 2) 0.681
   (Line 3, Col. b)/(Line 3, Col. a – Line 6)

9. Life Years Exposed Since Inception 16,685
   If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.

10. Tolerance Permitted (from credibility table)

11. Adjustment to Incurred Claims for Credibility
    (Ratio 3 = Ratio 2 + Tolerance)
   If Line 11 > Line 7, a refund/credit is not required.

12. Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11

13. Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))

De minimus Amount
(.005 x Annualized Prem. IF at 12/31)

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<tr>
<td>10,000+</td>
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<tr>
<td>5,000 – 9,999</td>
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<td>1,000 – 2,499</td>
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<tr>
<td>500 – 999</td>
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</tbody>
</table>

If less than 500, no credibility

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature ____________________________
Name (type) ____________________________
Title ____________________________
Date ____________________________
TABLE 5.1 Plan A  
COMPANY ABC  
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

REPORTING FORM FOR THE CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION  
FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR 1994

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<td>Company Name:</td>
<td>Company ABC</td>
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<td>0001</td>
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<td>NAIC Co. Code:</td>
<td>0001</td>
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<td>Address:</td>
<td>123 Anystreet, Kansas City, MO</td>
</tr>
<tr>
<td>Person Completing This Exhibit:</td>
<td>John Doe</td>
</tr>
<tr>
<td>Title:</td>
<td>Chief Actuary</td>
</tr>
<tr>
<td>Telephone Number:</td>
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<th>(b) Factor</th>
<th>(c) (b)x(c)</th>
<th>(d) Cumulative Loss Ratio</th>
<th>(e) (d)x(c)</th>
<th>(f) Factor</th>
<th>(g) (f)x(g)</th>
<th>(h) Cumulative Loss Ratio</th>
<th>(i) (h)x(i)</th>
<th>(j) Policy Yr Loss Ratio</th>
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Total: 1,739,665 798,955 0 0

Benchmark Ratio Since Inception 0.459
## TABLE 5.2 Plan A

COMPANY ABC

BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1994

<table>
<thead>
<tr>
<th>TYPE: Individual</th>
<th>SMSBP(p): Plan A</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the State of:</td>
<td>State A</td>
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<tr>
<td>Company Name:</td>
<td>Company ABC</td>
</tr>
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<td>NAIC Group Code:</td>
<td>0001</td>
</tr>
<tr>
<td>NAIC Co. Code:</td>
<td>0001</td>
</tr>
<tr>
<td>Address:</td>
<td>123 Anystreet, Kansas City, MO</td>
</tr>
<tr>
<td>Person Completing This Exhibit:</td>
<td>John Doe</td>
</tr>
<tr>
<td>Title:</td>
<td>Chief Actuary</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>(123) 456-0000</td>
</tr>
</tbody>
</table>

1. **Current Year’s Experience**
   - a. Total (all policy years) 1,501,709
   - b. Current year’s issues 511,921
   - c. Net (1a – 1b) 989,788

2. **Past Year’s Experience** (all policy years) 807,530

3. **Total Experience** (1c + 2) 1,797,318

4. **Refunds Last Year** (excluding interest) 0

5. **Previous Since Inception** (excluding interest) 0

6. **Refunds Since Inception** (excluding interest) 0

7. **Benchmark Ratio Since Inception (Ratio 1)** 0.459

8. **Experienced Ratio Since Inception (Ratio 2)** 0.384

9. **Life Years Exposed Since Inception** 2.280

   If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.

10. **Tolerance Permitted** (from credibility table) 0.100

11. **Adjustment to Incurred Claims for Credibility** (Ratio 3 = Ratio 2 + Tolerance) 0.484

   If Line 11 > Line 7, a refund/credit is not required.

12. **Adjusted Incurred Claims** (Line 3, Col. a – Line 6) x Line 11

13. **Refund** (Line 3, Col. a – Line 6 – (Line 12/Line 7))

   **De minimus Amount** (.005 x Annualized Prem. IF at 12/31)

<table>
<thead>
<tr>
<th>Medicare Supplement Credibility Table</th>
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<tr>
<td>Life Yrs Exposed Since Inception</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>10,000+</td>
</tr>
<tr>
<td>5,000 – 9,999</td>
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<tr>
<td>2,500 – 4,999</td>
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<td>1,000 – 2,499</td>
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<tr>
<td>500 – 999</td>
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<tr>
<td>If less than 500, no credibility</td>
</tr>
</tbody>
</table>

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature ____________________________

Name (type) ____________________________

Title ____________________________

Date ____________________________
TABLE 5.1 Plan F
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1994

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<th>Factor</th>
<th>(b)x(c)</th>
<th>Cumulative Loss Ratio</th>
<th>(d)x(e)</th>
<th>Factor</th>
<th>(h)x(g)</th>
<th>Cumulative Loss Ratio</th>
<th>(i)x(j)</th>
<th>Policy Yr Loss Ratio</th>
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</table>

Benchmark Ratio Since Inception 0.462
### TABLE 5.2 Plan F

**COMPANY ABC**

**BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)**

**EXECUTIVE (EX) COMMITTEE AND PLINARY 4/9/19**

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR 1994**

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<td>NAIC Group Code:</td>
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<tr>
<td>NAIC Co. Code:</td>
<td>0001</td>
</tr>
<tr>
<td>Address:</td>
<td>123 Anystreet, Kansas City, MO</td>
</tr>
<tr>
<td>Person Completing This Exhibit:</td>
<td>John Doe</td>
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<tr>
<td>Title:</td>
<td>Chief Actuary</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>(123) 456-0000</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>(a) Earned Premium</th>
<th>(b) Incurred Claims</th>
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<tbody>
<tr>
<td>1. Current Year’s Experience</td>
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</tr>
<tr>
<td>a. Total (all policy years)</td>
<td>7,002,288</td>
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<tr>
<td>b. Current year’s issues</td>
<td>2,302,520</td>
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<tr>
<td>c. Net (1a – 1b)</td>
<td>4,699,768</td>
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<tr>
<td>2. Past Year’s Experience (all policy years)</td>
<td>4,018,540</td>
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<tr>
<td>3. Total Experience (1c + 2)</td>
<td>8,718,308</td>
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<tr>
<td>4. Refunds Last Year (excluding interest)</td>
<td>38,908</td>
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<tr>
<td>5. Previous Since Inception (excluding interest)</td>
<td>0</td>
</tr>
<tr>
<td>6. Refunds Since Inception (excluding interest)</td>
<td>38,908</td>
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<tr>
<td>7. Benchmark Ratio Since Inception (Ratio 1)</td>
<td>0.462</td>
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<tr>
<td>8. Experienced Ratio Since Inception (Ratio 2)</td>
<td>0.372</td>
</tr>
<tr>
<td>(Line 3, Col. b)/(Line 3, Col. a – Line 6)</td>
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<tr>
<td>9. Life Years Exposed Since Inception</td>
<td>9,321</td>
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<tr>
<td>If (Line 8 &lt; Line 7) AND (Line 9 &gt; 500), proceed; else stop.</td>
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<tr>
<td>10. Tolerance Permitted (from credibility table)</td>
<td>0.050</td>
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<td>11. Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)</td>
<td>0.422</td>
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<td>If Line 11 &gt; Line 7, a refund/credit is not required.</td>
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<td>12. Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11</td>
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<td>13. Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))</td>
<td>751,463</td>
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*De minimus Amount* (.005 x Annualized Prem. IF at 12/31)

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<tr>
<th>Medicare Supplement Credibility Table</th>
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<tr>
<td><strong>Life Yrs Exposed</strong></td>
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<td>2,500 – 4,999</td>
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<tr>
<td>1,000 – 2,499</td>
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<tr>
<td>500 – 999</td>
</tr>
</tbody>
</table>

If less than 500, no credibility

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature ____________________________

Name (type) __________________________

Title ________________________________

Date ________________________________
APPENDIX E
Effective Dates and Loss Ratio Time Periods

When Congress passed OBRA-90, the law included a number of effective dates. The most common effective date for various provisions was the date each state made the NAIC model regulation effective (hereafter referred to as the OBRA-90 effective date). The calendar date of this effective date is different in each state. After the OBRA-90 effective date for any particular state, only standardized policies could be issued. Some companies in anticipation of the forthcoming standardized policy requirements began issuing policies prior to the OBRA-90 effective date that would qualify as standardized policies after the OBRA-90 effective date. Other companies continued to issue policies until the OBRA-90 effective date that would not qualify under the standardized criteria. This inconsistency becomes an important issue when considering the loss ratio and the refund requirements.

OBRA-90 also had a November 5, 1991, effective date for application of the new loss ratio and refund requirements. This November 5, 1991, date was independent of the OBRA-90 effective date and applied to any policy issued after November 5, 1991, pre-standardized or standardized, in any state. This made for some inconsistent reporting. States recognized the application of the loss ratio minimums and refund requirements on policies issued after their OBRA-90 effective date, but policies issued after November 5, 1991, and before that state’s OBRA-90 effective date fell into a “semi-regulated” category. These policies were semi-regulated because they were subject to the loss ratio and the refund requirements of the federal regulation, but they were not subject to the standardization requirements. In theory, the experience for these policies was supposed to have been reported separately. In practice, however, the experience on these semi-regulated policies was sometimes combined with the standardized experience if the policies would have qualified as standard policies. In other cases, the experience on these semi-regulated policies was ignored because it was too small to be credible or treated as pre-standardized. These problems were recognized and addressed in the technical corrections of SSAA-94. With the adoption of SSAA-94, the November 5, 1991, date was retroactively removed. Instead, the effective date for application of the loss ratio and refund requirements was changed to be the OBRA-90 effective date for each state. Reporting the experience for loss ratio and refund requirements still remains an issue. Technically, after the SSAA-94 effective date, the experience for these semi-regulated policies should be combined with pre-standardized group or pre-standardized individual policies. (SSAA-94 defined two type levels for combining pre-standardized plans for refund purposes—group pre-standardized and individual pre-standardized.) For semi-regulated policies that had already been included with the standardized reporting, it did not seem practical to change experience already reported. This issue is addressed in the compliance manual in Section II: ISSUES AND COMMENTS, EFFECTIVE DATE ISSUES, under the question “Is there any flexibility in the effective dates?”

SSAA-94 additionally required the pre-standardized policies to be subject to loss ratio and refund requirements similar to those required for standardized policies. One major difference for pre-standardized policies is that the time period to satisfy the refund and 65%-75% loss ratio requirements does not begin at inception as it does for standardized policy forms. Rather, the time period begins at the SSAA-94 effective date, and pre-standardized policies are treated in the benchmark calculation similar to newly issued policies (beginning with duration 0) even though the policies have actually been in force for some time. These new loss ratio/refund standards are in addition to a lifetime loss ratio requirement. This last requirement is that the lifetime (since inception) loss ratio must meet or exceed the originally filed lifetime loss ratio for that policy.

MIPPA has a single effective date for the change from 1990 SB Plans to 2010 SB Plans. As such, the date a state adopts the 2008 revisions to the MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT will not be a problem so long as the effective date of the change is June 1, 2010.

MACRA has a single effective date for the changes to which Medicare eligible may be offered Plans C and F and when Plans D and G replace Plans C and F for open enrollment, etc. for newly eligible individuals on or after January 1, 2020. Also, Plan G (high deductible) is first available on January 1, 2020, or such later date the state adopts the 2016 revisions to the MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT.
Formed in 1871, the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and five U.S. territories. The NAIC has three offices: Executive Office, Washington, D.C.; Central Office, Kansas City, Mo.; and Securities Valuation Office, New York City.

The NAIC serves the needs of consumers and the industry, with an overriding objective of supporting state insurance regulators as they protect consumers and maintain the financial stability of the insurance marketplace.

For more information, visit [www.naic.org](http://www.naic.org).
Shopper’s Guide to LONG-TERM CARE INSURANCE
About the NAIC …

The National Association of Insurance Commissioners (NAIC) is the oldest association of state government officials. Its members are the chief insurance regulators in all 50 states, the District of Columbia, and five U.S. territories. State regulators’ primary responsibility is to protect insurance consumers’ interests, and the NAIC helps regulators do this in several different ways. This Shopper’s Guide is one example of the NAIC’s work to help states educate and protect consumers.

Another way the NAIC helps state regulators is by giving them a forum to develop uniform public policy when that’s appropriate. It does this through a series of model laws, regulations, and guidelines developed for the states’ use. States may choose to adopt the models intact or change them to meet the needs of their marketplace and consumers. As you read through this Shopper’s Guide, you’ll find several references to NAIC model laws or regulations related to long-term care insurance. Check with your state insurance department to find out if your state has enacted these NAIC models.

National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Phone: (816) 842-3600
Fax: (816) 783-8175

www.naic.org
Revised 2018
About This Shopper’s Guide

The decision to buy long-term care insurance is a very important financial decision that shouldn’t be rushed. The National Association of Insurance Commissioners (NAIC) wrote this Shopper’s Guide to help you understand long-term care and the insurance options that can help you pay for long-term care services. Some states produce their own shopper’s guide with state specific information.

Take a moment to review the table of contents below for an overview of this guide. Take your time and read the guide carefully. If you see a term you don’t understand, look in the glossary starting on page 24. (Terms in **bold** in the text are in the glossary.)

If you decide to shop for a long-term care insurance policy, start by evaluating and comparing long-term care policies. You may already have a policy or may be shopping for a first-time policy. If you decide to shop for a long-term care insurance policy, whether it’s a new policy or a replacement policy, start by completing a personal assessment to gauge your need for long-term care insurance, getting information about the long-term care services and facilities you might use and how much they charge.

Use the Personal Assessment starting on page 29 to write down information about the facilities and services in your area and to compare long-term care insurance policies.

If you have questions, call your state insurance department or another consumer assistance agency for state specific information. See the list of state insurance departments, agencies on aging, and **state health insurance assistance programs** that can assist you in obtaining state specific information starting on page 44.
### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
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<tbody>
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<td>What Is Long-Term Care?</td>
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<td>How Much Does Long-Term Care Cost?</td>
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<td>Nursing Home Costs</td>
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<td>Assisted Living Facility Costs</td>
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<td>Home Care Costs</td>
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What Is Long-Term Care?

This kind of care is different from medical care, because it generally helps you to live as you live now instead of improving or correcting medical problems. People often think of long-term care as strictly nursing home care. Long-term care services actually may include help with activities of daily living, home care, respite care, hospice care, or adult day care. This care maybe given in your own home, an adult day care facility, assisted living facility, nursing home, or in a hospice facility.

NOTE: Medicare generally doesn’t pay for personal care services when you aren’t also receiving Medicare-covered skilled care services. Medicare has its own definition of skilled care. Refer to the booklet, Medicare & You1, to learn more about how Medicare defines skilled care.

Personal Assessment

It’s important to identify your reason(s) for buying a policy. This influences many of the choices you’ll make in selecting coverage. A person with few resources, a modest income, and a goal of staying off Medicaid, approaches a purchase one way. A person with a larger amount of assets and income may approach it differently. Please review the Personal Assessment document starting on page 29 to help you determine whether a long-term care insurance policy right for you and your family.

How Much Does Long-Term Care Cost?

Long-term care can be expensive. The cost depends on the amount and type of care you need and where you get it. Below are some average annual costs for care in a nursing home, an assisted living facility, and your own home. Long-term care may cost more or less where you live.

Nursing Home Costs

In 2018, the national average cost of nursing home care was about $89,297 per year (for a semi-private room).2 This cost doesn’t include items such as therapies and medications, which could greatly increase the cost.

Assisted Living Facility Costs

In 2018, assisted living facilities reported charging $4,000 a month (for a one-bedroom unit) on average, or $48,000 each year, including rent and most other fees.3 Residents may pay more for additional care.

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1 https://www.medicare.gov/pub/medicare-you-handbook
Home Care Costs

In 2018, the cost of basic home care averaged $22.00 per hour for a home health aide in the U.S. That’s $34,320 per year for a home health aide who visits six hours per day, five days a week. Skilled care from a nurse in your home is typically more expensive. Annual costs for home care depend on the number of days a week the caregiver visits, the type of care required, and the length of each visit. Home care can be unaffordable for many if round-the-clock care is required. These costs are different across the country. Your state insurance department or the insurance counseling program in your state may know the costs for your area. (See the list of state insurance departments, agencies on aging, and state health insurance assistance programs starting on page 44.)

How Might You Pay For Long-Term Care?

People pay for long-term care in different ways. These include individuals’ or their families’ personal resources, including savings, investments or other assets such as a home, long-term care insurance, and some help from Medicaid for those who qualify. Medicare, Medicare supplement insurance, or your employee or retiree health insurance usually will not pay for long-term care.

Personal Resources

Individuals and their families usually use some of their own money to pay for part or all of their long-term care costs. Many use savings and investments. Some sell assets, such as their homes, to pay for their long-term care needs.

Medicare

Medicare does NOT cover long-term care. However, Medicare Part A does cover skilled nursing facility care, nursing home care (as long as custodial care isn’t the only care you need), hospice care, and limited home care. You should NOT count on Medicare to pay your long-term care costs. Please see www.medicare.gov/coverage/long-term-care.html for more information about Medicare.

Medicare Supplement Insurance

Medicare supplement insurance (Medigap) is private insurance that helps pay for some of the gaps in Medicare coverage, such as hospital deductibles and physician charges greater than Medicare approves. Medigap usually doesn’t pay for long-term care. Please see www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html for more information about Medigap.

Medicaid

Medicaid is the government-funded program that pays for nursing home care only for individuals who are low income and have spent most of their assets. Medicaid pays for nearly a third of all nursing home care in the U.S., but many

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people who need long-term care never qualify for Medicaid assistance. Medicaid also pays for some home- and community-based services. To get Medicaid help, you must meet federal and state guidelines for income and assets. Many people start paying for nursing home care out of their own money and “spend down” their income and assets until they’re eligible for Medicaid. Medicaid then may pay part or all of their nursing home costs. You may have to use up most of your assets paying for your long-term care before Medicaid is able to help. You may be able to keep some assets and income for a spouse who stays at home. Also, you may be able to keep some of your assets if your long-term care insurance is approved by a state as a long-term care insurance partnership policy. (See section on “Long Term Care Insurance Partnership Policies” on page 7.)

State laws differ about how much income and assets you can keep and still be eligible for Medicaid. (Some assets, such as your home, may not keep you from being eligible for Medicaid.) However, federal law requires your state to recover from your estate the costs of the Medicaid benefits you receive, subject to certain rules. Contact your state Medicaid office, state office on aging, or department of social services to learn about the rules in your state. The health insurance assistance program in your state also may have some Medicaid information. (See the list of state insurance departments, agencies on aging, and state health insurance assistance programs starting on page 44.)

### Will I Need or Use Long-Term Care?

If you have a major illness or injury, such as a stroke, heart attack, or broken hip, and need assistance with activities of daily living, such as bathing or dressing, you may need long-term care. If you do need care, you may need nursing home or home care for only a short time. Or, you may need these services for many months, years, or the rest of your life.

It’s hard to know if and when you’ll need long-term care, but the statistics that follow may help:

- Life expectancy after age 65 is about 19.4 years (20.6 years for females and 18 years for males). The longer people live, the greater the chance they’ll need help due to chronic conditions.
- About 11 million Americans of all ages require long-term care, but only 1.4 million live in nursing homes.
- About 70% of people who reach age 65 are expected to need some form of long-term care at least once in their lifetime.
- About 35% of people who reach age 65 are expected to enter a nursing home at least once in their lifetime. Of those who are in a nursing home, the average stay is a year.
- From 2015 to 2055, the number of people aged 85 and older will almost triple from over 6 million to over 18 million. This growth is certain to lead to an increase in the number of people who need long-term care.

### What is Long-Term Care Insurance?

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Long-term care insurance is one way you may pay for long-term care. This type of insurance will pay or reimburse you for some or all of your long-term care costs. It was introduced in the 1980s as nursing home insurance but now often covers services in other facilities. The rest of this Shopper’s Guide gives you information about long-term care insurance.

A federal law, the Health Insurance Portability and Accountability Act of 1996, or HIPAA, gives some federal income tax advantages to people who buy certain long-term care insurance policies. These policies are called tax-qualified long-term care insurance policies or simply qualified policies. The tax advantages of these policies are outlined on page 8. There may be other tax advantages in your state. You should check with your state insurance department or insurance counseling program for information about tax-qualified policies. (See the list of state insurance departments, agencies on aging, and state health insurance assistance programs starting on page 44.) Check with your tax advisor to learn if the tax advantages make sense for you.

Do I Need To Buy Long-Term Care Insurance?

Whether you should buy a long-term care insurance policy depends on your age, health, overall retirement goals, income, and assets. Examine the Personal Assessment and Long-Term Care Policy Checklist starting on page 29 to help you determine whether buying long-term care insurance is right for your situation.

However, carefully consider whether buying a policy makes financial sense if you can’t afford the premium or aren’t sure you can pay the premium, including any increases, for the rest of your life.

If you already have health problems that could lead to long-term care (for example, Alzheimer’s disease or Parkinson’s disease), you probably won’t be able to buy a policy. Insurance companies have medical underwriting standards to keep the cost of long-term care insurance affordable. If companies didn’t have these standards, most people wouldn’t buy insurance until they needed long-term care.

In some states, a regulation requires the insurance company and agent to go through a personal worksheet with you (See the Long-Term Care Insurance Personal Worksheet on page 40) to decide if long-term care insurance is right for you. It also asks you questions about your income and your savings and investments to help with your decision. Some states require you to fill out the worksheet and send it to the insurance company. Even if you aren’t required to fill out the worksheet, it might help you decide if long-term care insurance is right for you.

Remember, not everyone should buy a long-term care insurance policy nor rely solely on long-term care insurance. Paying for long term care can be done by combining different sources together, such as assets, income, and Long-Term Care Insurance. For some, a policy is affordable and worth the cost. For others, it may be unaffordable. You should not buy long-term care insurance if the only way you can afford to pay for it is to not pay other important bills. Look closely at your needs and resources. Talk with family members, a friend, and a trusted and knowledgeable financial professional to decide if long-term care insurance is right for you.

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• You can’t afford the premiums.
• You don’t have many assets.
• Your only source of income is a Social Security benefit or Supplemental Security Income (SSI).
• You often have trouble paying for utilities, food, medicine, or other important needs.
• You are on Medicaid.

You may want to consider buying long-term care insurance if:

• You have many assets and/or a good income.
• You don’t want to use most or all of your assets and income to pay for long-term care.
• You afford to pay the insurance premiums, including possible premium increases.
• You don’t want to burden family or friends.
• You want to be able to choose where you receive care.

If, after careful thought, you decide that long-term care insurance is right for you, check out the company and the agent, if one is involved, before you buy a policy. If you have questions about licensing, contact your state insurance department. (See the list of state insurance departments, agencies on aging, and state health insurance assistance programs starting on page 44.)

What Types of Policies or Contracts Can I Buy that Provide Long-Term Care Benefits or Coverage?

Private insurance companies sell long-term care insurance policies. You can buy an individual policy from an agent or through the mail. Or, you can buy coverage under a group plan through an employer or through membership in an association. The federal government and several state governments offer long-term care insurance coverage to their employees, retirees, and their families. These programs are voluntary, and participants pay the premiums. You also can get long-term care benefits through some life insurance policies.

Individual Policies

One of your options is a long-term care insurance policy. Insurance agents sell many of these policies, but companies also sell policies through the mail or by telephone. Individual policies can be very different from one company to the next. Also, policies from the same company may be different from each other. Shop among policies, companies, and agents to get the coverage that best fits your needs.

Life Insurance Policies and Annuity Contracts

A Life Insurance Policy or Annuity Contract You Already Have

If you have a cash value life insurance policy, you can take some of the cash value to pay for long-term care expenses. But first, ask how a withdrawal might affect your death benefits and talk with your tax advisor or consultant. Or, if you no longer need the policy, you could cancel (or surrender) it and take all of the cash value. But think about how that would affect your beneficiaries.
If you have an annuity, you may be able to take some of the annuity’s value to pay for long-term care expenses. Most annuities require you to pay a surrender charge to withdraw some of the value. Some companies will waive that charge if the withdrawal is to pay for long-term care.

A Hybrid/Combination Life Insurance Policy or Annuity Contract That Have Provisions That Could Be Used for Long-Term Care

An increasing number of life insurance policies and some annuity contracts now offer an add-on rider that you could use to pay long-term care expenses. This type of rider gives you more coverage if you need long-term care. You usually pay an extra premium for a rider.

A life insurance policy that uses an accelerated death benefit (sometimes called a living benefit) could be used to pay for long-term care expenses also may be called a “life/long-term care,” “hybrid,” “linked benefits,” or “combo” policy. It may be an individual or a group life insurance policy. This benefit lets you access some or all of the policy’s death benefit while you’re alive. You must meet certain conditions to use the rider to pay for long-term care expenses. Usually, the benefit triggers are being unable to perform a certain number of activities of daily living or being cognitively impaired.

The company may pay benefits in one of two ways. One way is a reimbursement based on your long-term care expenses. Or, the company may pay a set amount each month (an indemnity benefit). The amount is either set in the rider or the owner chooses it. In either case, there may be minimum and maximum amounts paid each month based on the policy benefit.

A life insurance policy with an accelerated benefit rider for long-term care must follow all of the laws and regulations that apply to long-term care policies. Many of these riders may be tax-qualified. Consult with your tax advisor or tax consultant.

Long-term care benefits paid as an accelerated death benefit likely will reduce the death benefit the policy will pay after you die. For example, suppose your policy has a $100,000 death benefit and you use $60,000 for long-term care. Then your beneficiary would get a $40,000 death benefit, not $100,000. Some policies may offer a small death benefit even if all of the original death benefit amount is used for long-term care expenses.

Also, many life insurance policies and annuity contracts offer benefits beyond acceleration of the death benefit. These are often called extension of benefits riders. They provide more benefits for a set period of time after you’ve used up a policy’s cash value and/or death benefit or your annuity’s value. These policies offer both accelerated death benefits and an extension of benefits rider. The benefits may increase by a set inflation percentage.

As with all insurance products, premiums are higher for policies with more benefits. So, the premium for a traditional stand-alone long-term care policy could be much less than the premium for a hybrid/combo policy, all else being equal.

Policies from Your Employer

Your employer may offer a group long-term care insurance plan or individual policies at a group discount. The employer group plan may be similar to an individual policy you could buy. One advantage of an employer group plan for active employees is you may not have to meet as many medical requirements to get a policy, or the medical screening process may be more relaxed. Many employers also let retirees, spouses, parents, and parents-in-law apply for this coverage. Relatives usually must pass the company’s medical screening to qualify for coverage and must pay the premium.
If you leave your job, or are fired, or your employer cancels the group plan, insurance companies must let you keep your coverage. Your premiums and benefits may change, however.

If an employer offers long-term care insurance, think about it carefully. An employer group plan may give you options you can’t find if you buy a policy on your own.

**Policies from Federal or State Government**

Federal and U.S. Postal Service employees and annuitants, members and retired members of the uniformed services, and qualified relatives of any of these are eligible to apply for long-term care insurance coverage under the Federal Long-Term Care Insurance Program. A company completes underwriting and issues the insurance and the federal government doesn’t pay any of the premiums. The group rates under this program may or may not be lower than individual rates, and the benefits also may be different. If you (or a member of your family) are a state or public employee or retiree, you may be able to buy long-term care insurance under a state government program.

**Association Policies**

Many associations let insurance companies and agents offer long-term care insurance to their members. These policies are like other long-term care insurance policies and typically require medical underwriting. Like employer group plans, association policies usually give their members a choice of benefits. If you are joining an association just to buy insurance, consider the cost of membership in the total cost of coverage. In addition, understand your options and rights if coverage should end.

**Policies Sponsored by Continuing Care Retirement Communities**

Continuing Care Retirement Communities (CCRC) may offer or require you to buy long-term care insurance. A CCRC is a retirement complex that offers a broad range of services and levels of care. You must be a resident or on the waiting list of a CCRC to qualify. You also must meet the insurance company’s medical requirements to buy its long-term care insurance policy. The coverage is similar to other group or individual policies.

**Long-Term Care Insurance Partnership Policies**

There are long-term care insurance partnership policies that help you manage the financial impact of spending down your assets to meet Medicaid eligibility standards. When you buy a partnership policy, you’re protected from the normal Medicaid requirement to spend down your income and assets to become eligible. Note these vary by state.

In most states, you don’t have to use up all of your partnership policy benefits to qualify for Medicaid. In most states, you can qualify for Medicaid and keep income and assets equal to the amount of claims your partnership policy paid.

Partnership policies must be federally tax-qualified plans. They also must include certain consumer protections. They must include inflation protection benefits so benefits keep up with increasing long-term care costs over time. Partnership policies are required to include inflation protection only for those who are 75 or younger when they buy the policy. The requirements are:
- Compound annual inflation protection for those younger than age 61.
- Some level of inflation protection for those ages 61 to 75.

NOTE: This inflation protection requirement varies in the following states: California, Connecticut, Indiana and New York.

How will you know if you have a partnership policy? The insurance company will either give you that information in writing with your policy or send you a letter. Either way, it’s very important to keep this notice.

Please keep in mind that partnership policies have specific requirements. They aren’t offered in every state. Check with your state insurance department or insurance assistance program to learn if these policies are available in your state. Many states with long-term care partnership policies have information about them on their web sites. Use this link to locate your state’s insurance department website: www.naic.org/state_web_map.htm. Also, the U.S. Department of Health and Human Services maintains a website at https://longtermcare.acl.gov/costs-how-to-pay/what-is-long-term-care-insurance/where-to-look-for-long-term-care-insurance.html with information about long-term care insurance and partnership policies.

Tax-Qualified Policies
You may have a choice between a federally “tax-qualified” long-term care insurance policy and one that is “non-tax-qualified.” The differences between the two types of policies are important. A tax-qualified policy, or a qualified policy, offers certain federal income tax advantages. If you itemize your income tax deductions, you may be able to deduct part or all of the premium you pay for a qualified policy. Consult with your tax advisor or tax consultant how this may apply to you.

Federally Tax-Qualified Policies
- Can deduct annual premiums, subject to a cap
- Benefits received generally aren’t counted as income

Federally Non-Tax Qualified Policies
- Annual premiums can’t be deducted
- Benefits received generally are counted as income

Long-term care insurance policies sold on or after January 1, 1997, as tax-qualified must meet certain federal standards. To be qualified, policies must be labeled as tax-qualified, be guaranteed renewable (as defined under the Internal Revenue Code), include a number of consumer protections, and cover only qualified long-term care services. If you bought a long-term care insurance policy before January 1, 1997, that policy is probably qualified. HIPAA allowed these policies to be “grandfathered,” or considered qualified, even though they may not meet all of the standards that new policies must meet to be qualified. The tax advantages are the same whether the policy was sold before or after 1997. You should carefully
consider the advantages and disadvantages of trading a grandfathered policy for a new policy. In most cases, it’s to your advantage to keep your old policy.

Qualified long-term care services usually are those from long-term care providers. You must be chronically ill. Your care must follow a plan that a licensed health care practitioner prescribes. You’re considered chronically ill if it’s expected that you’ll be unable to do at least two activities of daily living without substantial assistance from another person for at least 90 days. Another way you may be considered chronically ill is if you need substantial supervision to protect your health and safety because you have a cognitive impairment. A policy issued to you before January 1, 1997 doesn’t have to define chronically ill this way. (See information about benefit triggers on page 12.)

Some life insurance and annuity policies with long-term care benefits may be tax-qualified. However, be sure to check with your personal tax advisor or tax consultant to learn how much of the premium can be deducted as a medical expense. Tax-qualified life insurance and annuity policies with long-term care benefits must meet the same federal standards as other tax-qualified policies, including the requirement that you must be chronically ill to receive benefits.

There are deferred annuities which provide long-term care benefits by providing an enhanced long-term care value greater than the cash value when used for qualifying care. Some annuities are tax-qualified and have tax advantages that are not provided to annuities which simply allow you to withdraw some of the cash value without paying a surrender penalty. You should consult with your tax advisor or tax consultant for more information.

### How Long-Term Care Benefits Are Paid?

Long-term care insurance policies generally pay benefits by different methods of payment.

Once it is determined that you are eligible to receive LTC benefits, long-term care insurance policies generally pay benefits using one of three different methods:

- The expense-incurred method pays you or your provider the lesser of either the expense or dollar limit of your policy,
- The indemnity method pays benefits based on a set dollar amount that is paid directly to you regardless of your cost, and
- The disability method pays you the full daily benefit regardless of whether you are receiving long term care services.

Most policies purchased today pay benefits according to the expense-incurred method.

### Shared Care

You may be able to buy long-term care insurance that covers more than just one person, often called shared care. The maximum lifetime benefit usually applies to both individuals. If either covered individual collects benefits, that amount is subtracted from the maximum lifetime benefit. For example, suppose two people have shared care that has a $150,000
maximum lifetime benefit and one person uses $25,000 in benefits. Then $125,000 would be left to pay benefits for either person or both. Some coverages have provisions to protect each individual from the other person using up all the benefits. In one variation, neither individual can access the other person’s coverage. Instead there is a “third pool” which both individuals can share.

What Services Are Covered

It’s important that you understand what services your long-term care insurance policy covers and how it covers the many types of services you might need to use. Policies may cover the following:

- Nursing home care
- Home care
- Respite care
- Hospice care
- Personal care in your home
- Services in assisted living facilities
- Services in adult day care centers
- Services in other community facilities

Policies may cover home care in several ways. Those who may provide care may be limited by your policy or state requirements. For instance, services may need to be provided from a licensed provider or agency. Other policies may pay for services from home care aides to help with personal care who may not be licensed or aren’t from licensed agencies.

You may find a policy that pays for homemaker services or chore worker services. This type of benefit, though not available in all policies, would pay for someone to come to your home to cook meals and run errands. Generally, adding home care benefits to a policy increases the cost of the policy.

Note: Most policies do not pay benefits to family members who provide care and may not apply any care they provide to your elimination or waiting period. Check the exclusions or definition section of your policy.

Where Services Are Covered

You should know what types of facilities your long-term care policy covers. If you’re not in the right type of facility (described in your policy), the insurance company can refuse to pay for your care. There may be other options for elder care in the future. Your policy might not cover those, but you always should check with your insurance company before making plans for your care.

Some policies may pay for care in any state-licensed facility. Others only pay for care in some state-licensed facilities, such as a licensed nursing facility. Still others list the types of facilities where services won’t be covered, which may include state-licensed facilities. (For example, some places that care for elderly people are referred to as homes for the aged, rest
homes, or personal care homes, and often aren’t covered by long-term care policies.) Some policies may list specific points about the kinds of facilities they’ll cover. Some say the facilities must care for a certain number of patients or give a certain kind of care.

When you shop for a long-term care policy, carefully compare the types of services and facilities the policy covers. Also know that many states, companies, and policies define assisted living facilities differently. Before you move or retire to another state, ask if your policy covers the types of services and facilities available in your new state. Also, if your policy lists kinds of facilities, check if your policy requires the facility to have a license or certification from a government agency.

NOTE: If you do NOT live in the kind of facility named in your policy, the insurance company may not pay for the services you require.

What Services Aren’t Covered (Exclusions and Limitations)

Most long-term care insurance policies usually don’t pay benefits for:

- A mental or nervous disorder or disease, other than Alzheimer’s disease or other dementia.
- Alcohol or drug addiction.
- Illness or injury caused by an act of war.
- Treatment in a government facility or that the government has already paid for.
- Attempted suicide or intentionally self-inflicted injuries.

NOTE: Many policies don’t cover or limit their coverage for care outside the United States.

How Much Coverage Will I Have?

The policy or certificate may state the amount of coverage in one of several ways. A policy may pay different amounts for different types of long-term care services. Be sure you understand how much coverage you’ll have and how the policy will cover long-term care services you receive.

Maximum Benefit Limit. Most policies limit the total benefit they’ll pay over the life of the policy, but a few don’t. Some policies state the maximum benefit limit in years (one, two, three or more, or even lifetime). Others write the policy maximum benefit limit as a total dollar amount. Policies often use words like “total lifetime benefit,” “maximum lifetime benefit,” or “total plan benefit” to describe their maximum benefit limit. When you look at a policy or certificate, be sure to check the total amount of coverage. In most states, the minimum benefit period is one year. Most nursing home stays are short, but illnesses that go on for several years could mean long nursing home stays. You’ll have to decide if you want protection for very long stays. Policies with longer maximum benefit periods cost more. You usually can learn what the benefit period is by looking through the first few pages of the policy for the schedule page.

Daily/Weekly/Monthly Benefit Limit. Policies normally pay benefits by the day, week, or month. For example, in an expense-incurred plan, a policy might pay a daily nursing home benefit of up to $200 per day, and a weekly home health
care benefit of up to $1,400 per week. Some policies pay one time for single events, such as installing a home medical alert system.

When you buy a policy, insurance companies let you choose a benefit amount for care in a nursing home. If a policy covers home care, the benefit is usually a percentage of the nursing home care benefit – for example, 50% or 75%. But, more policies now pay the same benefit amounts for care at home as in a facility. Often, you can choose the home care benefit amount you want.

It’s important to know how much skilled nursing homes, assisted living facilities, and home health care agencies charge for their services BEFORE you choose the benefit amounts in your long-term care insurance policy. Check the facilities in the area where you think you may be receiving care, whether they’re local, near a grown child, or in a new place where you may retire.

When Will I Be Eligible for Benefits (Benefit Triggers)?

“Benefit triggers” is the term usually used to describe the way insurance companies decide when to pay benefits. This term refers to how the insurance company decides if you’re eligible for benefits. Benefit triggers are an important part of a long-term care insurance policy. Different policies may have different benefit triggers so look at this policy feature carefully as you shop. Look for a section called “Eligibility for the Payment of Benefits” or simply “Eligibility for Benefits” in the policy and outline of coverage. Some states require certain benefit triggers. Also, the benefit triggers for tax-qualified contracts are mostly the same across insurance policies. Check with your state insurance department to find out what your state requires.

NOTE: Companies may use different benefit triggers for home care coverage than for nursing home care, but most don’t. If they do, the benefit trigger for nursing home care is usually harder to meet than the one for home care.

Types of Benefit Triggers

Activities of Daily Living (ADL)

The most common way insurance companies decide when you’re eligible for benefits is that you are expected to be unable to do 2 ADLs without human assistance for 90 days. Most policies use six ADLs: bathing, continence, dressing, eating, toileting, and transferring.

If the policy you’re thinking of buying pays benefits when you can’t do certain ADLs, be sure you understand what that means. Some policies say that someone must be actively engaged into helping you do the activities. That’s known as hands-on assistance. Others say you qualify even if you only need someone nearby to help you if you need it (stand-by assistance). The more clearly a policy describes its requirements, the clearer you or your family will be when you need to file a claim.
Cognitive Impairment. Another benefit trigger is “cognitive impairment.” Coverage of cognitive impairment is especially important if you develop Alzheimer’s disease or other dementia.

Doctor Certification of Medical Necessity. Another benefit trigger is “medical necessity.” Some long-term care insurance policies require that your doctor order- or certify that care is medically necessary. However, tax-qualified policies can’t use this benefit trigger.

NOTE: Medicare still requires a three-day hospital stay to be eligible for Medicare payment of skilled nursing facility benefits. Generally, today’s long-term care policies don’t require pre-hospitalization to be eligible for benefits.

When Benefits Start (Elimination Period)

With many policies, your benefits won’t start the first day you go to a nursing home or start using home care. How many days you have to wait for benefits to start will depend on the elimination period (sometimes called a deductible or a waiting period) you pick when you buy your policy. Typically, a single elimination period applies to any covered service, but the elimination period for home care may be shorter.

The elimination period can be 20, 30, 60, 90, or 100 days before benefits begin. It’s important to remember that you must pay for your own care during the elimination period before benefits can begin. Companies don’t pay for care provided by family members during or after the elimination period. It’s important that you understand how an elimination period is defined and applied in any policy you buy.

There are two ways that companies count an elimination period.

Under a “calendar day” method, every day that you satisfy the benefit triggers count toward the elimination period whether or not you received any services on those days. However, many coverages will not start counting those days until you incur costs. So, it can be important to get commercial services as soon as possible when you need care.

Under the service days method, only the days that you pay for professional care services covered by the policy count toward the elimination period. For example, if you only use paid care for three days a week, it will take longer for your benefits to start than if you use paid care five days a week. So, you would have more out-of-pocket costs before your benefits begin.

You may choose to pay a higher premium for a shorter elimination period. If you choose a longer elimination period, you’ll pay a lower premium.

For example:

- A 30-day waiting period means the insurer will not cover long-term care costs incurred during the first 30 days you would otherwise be eligible.

- A 90-day waiting period means the insurer will not cover long-term care costs incurred during the first 90 days you would otherwise be eligible.

When choosing a waiting period, keep in mind that, by the time you need care, long-term care may be much more costly than today and your maximum daily benefit may have inflated. If you have a financial partner, consider also that you and your partner might both go through waiting periods.
Be sure you know how the policy defines the elimination period. Find out if the insurance company requires another elimination period for a second stay. Some policies only require you to meet the elimination period once in your lifetime. Others require you to satisfy the elimination period with each “episode of care.”

Inflation Protection

Inflation protection can be one of the most important features you can add to a long-term care insurance policy. Inflation protection increases the premium, because it increases the potential benefits. However, unless your benefits increase over time, years from now you may find that they haven’t kept up with increasing long-term care costs. For example, if inflation is 5% a year, a nursing home that costs $150 a day in 2018 will cost $398 a day in 20 years. Obviously, the younger you are when you buy a policy, the more important it is for you to think about adding inflation protection. You usually can buy inflation protection in one of two ways: automatically or by special offer.

Automatic Inflation Protection. With automatic inflation protection, your benefit amounts go up each year, usually with no change in your premium. The maximum daily benefit automatically increases each year by a fixed percentage, usually 3%, for the life of the policy or for a certain period, usually 10 or 20 years.

Policies that increase benefits for inflation automatically “compound” rates. If the increase is compounded, the annual increase will be a larger dollar amount each year and at 3% a year, the $200 daily benefit will be $531 a day by 2050.

The following table shows the effects of inflation on cost of care over a 30-year period, assuming a daily cost of $200 in 2020.

<table>
<thead>
<tr>
<th>Compound Interest</th>
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<tbody>
<tr>
<td>Rate of Inflation</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>3%</td>
</tr>
<tr>
<td>5%</td>
</tr>
<tr>
<td>7%</td>
</tr>
</tbody>
</table>

Special Offer or Non-Automatic Inflation Protection. The second way to buy inflation protection lets you choose to increase your benefits from time to time, such as every two or three years. If you regularly use the special offer option, you usually don’t have to prove you’re in good health. Your premium increases if you increase your benefits. How much it increases depends on your age at the time and how much you increase your benefit. Increasing your benefits every few years may help you afford the cost of increasing your benefits later. If you turn down the option to increase your benefit one year, you may not get the chance again. If you do, you may have to prove good health, or it may cost you more money. If you don’t accept an offer, check your policy to see how that affects future offers. Some policies continue the inflation offers while you receive benefits, but most don’t. Check your policy carefully.
NOTE: Most states’ regulations require companies to offer inflation protection. It’s up to you to decide whether to buy it. If you don’t buy the protection, the company may ask you to sign a statement saying you didn’t want it. Be sure you know what you’re signing.

Third Party Notice
You can name someone the insurance company would be required to contact if your coverage is about to end because your premiums aren’t paid. Without this notice, people with cognitive impairments who forget to pay the premium might lose their coverage when they need it the most.

You can choose a relative, friend, or a professional (e.g., a lawyer or accountant) as your third party. After the company contacts the person you choose, he or she would have some time to arrange to pay the overdue premium. Some states require insurance companies to give you the chance to name a contact and to update your list of contacts from time to time.

Other Long-Term Care Insurance Policy Options I Might Choose
You can probably choose other policy features, but some insurers don’t offer all of them. Each may increase your policy’s cost.

Waiver of Premium. Premium waiver lets you stop paying the premium once you’re eligible and the insurance company starts to pay benefits. Many long-term care insurance policies automatically include this feature, but some may only offer it as an optional benefit. Some companies waive the premium as soon as they make the first benefit payment. Others wait until you’ve received benefits for 60 to 90 days.

Premium Refund at Death. When you die, this benefit pays to your estate any premiums you paid, generally reduced by any benefits the company paid. Some provisions refund premiums only if the policyholder dies before a certain age, usually 65 or 75 and some refund only upon the second death of a couple.

Downgrades. While it may not always appear in the contract, most insurers let you reduce your coverage if you have trouble paying the premium. When you downgrade your policy, it covers less and/or has lower benefits and you’ll pay a lower premium. Downgrading may let you keep your policy instead of dropping it.

What If I Can't Afford the Premiums After I Buy the Policy?
Nonforfeiture Benefits. If, for whatever reason, you drop your coverage and your policy has a nonforfeiture benefit, you’ll get some value for the money you’ve paid into the policy. Without this type of benefit, you get nothing, even if you paid premiums for 10 or 20 years before you dropped the policy. A nonforfeiture benefit can add roughly 10% to 100% (and sometimes more) to a policy’s cost. How much it adds depends on such things as your age at the time you bought the policy, the type of nonforfeiture benefit, and whether the policy has inflation protection.

Some states require insurance companies to offer long-term care insurance policies with a nonforfeiture benefit. If so, you may be given benefit choices, including a reduced paid-up policy, shortened benefit period policy, and an extended term policy. With any of these, when you stop paying your premiums, the company gives you a paid-up policy. Depending
on the option you choose, your paid-up policy could either have the same benefit period but with a lower daily benefit (reduced paid-up policy) or the same daily benefit but with a shorter benefit period (shortened benefit period policy or extended term policy) than your original policy. Regardless, the level of benefits depends on how long you paid premiums and how much you’ve paid in premiums. Since the policy is paid-up, you won’t owe any more premiums. If the nonforfeiture benefit is extended term and you don’t use the benefits in a certain period of time, your coverage ends. There’s no time limit to use the benefits if the nonforfeiture benefit is a reduced paid-up policy.

Other insurers may offer a “return of premium” nonforfeiture benefit. They pay back all or part of the premiums that you paid in if you drop your policy after a certain number of years. This type of nonforfeiture benefit usually costs the most. You have the option to add a nonforfeiture benefit if you’re buying a tax-qualified policy. The return of premium, the reduced paid-up policy, and the shortened benefit period nonforfeiture benefits could be choices when you buy a tax-qualified policy.

**Contingent Nonforfeiture.** In some states, if you don’t accept the offer of a nonforfeiture benefit, a company is required to offer you a contingent benefit if the policy lapses. This means that when your premiums increase to a certain amount (based on a table of increases), the company must give you a way to keep your policy without paying the higher premium. For example, suppose you bought a policy at age 70 and didn’t accept the insurance company’s offer of a nonforfeiture benefit. Also, suppose the policy is required to offer you a contingent benefit upon lapse if the premium increases to 40% or more of the original premium. If you’re offered the contingent benefit upon lapse, you could choose: 1) your current policy with reduced benefits so the premium stays the same; 2) a paid-up policy with a shorter benefit period but no future premiums; or 3) your current policy with the higher premiums.

**Will My Health Affect My Ability to Buy a Policy?**

Companies that sell long-term care insurance medically “underwrite” their coverage. They look at your current and past health before they decide to issue a policy. An employer or another type of group may not use medical underwriting or may have more relaxed underwriting standards. Insurance companies’ underwriting practices affect the premiums they charge you now and in the future. Some companies do what is known as “short-form” underwriting. They only ask you to answer a few questions on the insurance application about your health. For example, they may want to know if you’ve been in a nursing home or received care at home in the last 12 months.

Some companies do more underwriting. They may ask more questions, look at your current medical records, and ask your doctor for a statement about your health. These companies may insure fewer people with health problems. If you have certain conditions that are likely to mean you’ll soon need long-term care (Parkinson’s disease, for example), you probably can’t buy coverage from these companies.

Sometimes companies don’t check your medical record until you file a claim. Then they may try to refuse to pay you benefits because of information they found in your medical record after you filed your claim. This practice is called “post-claims underwriting.” It’s illegal in many states. Companies that thoroughly check your health before selling you a policy aren’t as likely to do post-claims underwriting. No matter how the company underwrites, you must answer certain questions on your application. When you fill out your application, be sure to answer all questions correctly and completely. A company
depends on the information you put on your application. If the information is wrong, an insurance company may decide to **rescind** (or cancel) your policy and return the premiums you’ve paid. A company usually can do this only in the first two years after you bought the policy. Most states require the insurance company to give you a copy of your application when it delivers the policy. Then, you can review your answers again. You should keep this copy of the application with your insurance papers.

**What Happens If I Have Pre-Existing Conditions?**

Most long-term care insurance have no **pre-existing** condition limitation. However, if you purchased through your employer and some evidence of good health was waived, a **pre-existing** exclusion might apply. Generally, a **pre-existing condition** is one for which you got medical advice or treatment or had symptoms within six months before you applied for the policy.

A company that learns about a **pre-existing** condition not disclosed on your application might not pay for long-term care related to that condition and might even **rescind** your coverage. A company usually can do this only within two years after you bought the insurance policy. However, there is usually no time limit if you intentionally don’t tell the company about a **pre-existing** condition on your application.

**Can I Renew My Long-Term Care Insurance Policy?**

Long-term care insurance is **guaranteed renewable**. **Guaranteed renewable** means that you can keep your coverage if you pay your premium on time. This is *not* a guarantee that you can renew at the same premium. Your premium may go up over time as your company pays more claims and more expensive claims.

Insurance companies can increase the premiums on **guaranteed renewable** insurance but only if they increase the premiums on all policies that are the same in that state. Any such premium increase must be filed and/or approved by the state insurance department. An insurance company can’t single out an individual for a premium increase, no matter whether you have filed a claim, or your health has gotten worse. If you buy coverage under a group policy and later leave the group, you may be able to keep your group coverage or convert it to an individual policy, but you may pay more. You can ask your plan sponsor or review your **Certificate of Coverage** whether you have this option.

**How Much Do Long-Term Care Insurance Policies Cost?**

A long-term care insurance policy can be expensive. Be sure you can pay the premiums and still afford your other health insurance and other expenses.

Premiums vary based on a variety of factors. These factors include your age and health when you buy a policy and the level of coverage, **benefits**, and options you choose. The older you are when you buy long-term care insurance, the higher your premiums will be, as it’s more likely you’ll need long-term care services. (See “Will I Need or Use Long-Term Care” on
If you buy at a younger age, your premiums will be lower, but you’ll pay premiums for a longer period of time. According to recent studies, the average buyer is age 59.

If you buy a policy with a large daily benefit, a longer maximum benefit period, or a home health care benefit, it will cost more. Inflation protection and nonforfeiture benefits mean much higher premiums for long-term care insurance. Both inflation protection and nonforfeiture benefits can significantly increase your premium.

The table that follows shows examples of how much premiums can vary depending on your age and coverage options. It shows the average annual premiums for basic long-term care insurance ($200 daily benefit amount; four-year, six-year, and lifetime coverage; and a 20-day elimination period) with and without a 5% compound inflation protection option and with no nonforfeiture benefit option.

*Remember, your actual premium may be very different.*

The following table does not account for basic long-term care insurance that is part of a life insurance or annuity policy.

**Average Annual Premium for Basic Long-Term Insurance, $200 Daily Benefit**

<table>
<thead>
<tr>
<th>Age When Buy</th>
<th>With Inflation Protection 5% Compounded Per Year</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With 4 Years of Benefits</td>
<td>6 Years of Benefits</td>
<td>Lifetime Benefits</td>
</tr>
<tr>
<td>50</td>
<td>$4,349</td>
<td>$5,083</td>
<td>$7,347</td>
</tr>
<tr>
<td>60</td>
<td>$5,331</td>
<td>$6,269</td>
<td>$8,927</td>
</tr>
<tr>
<td>70</td>
<td>$9,206</td>
<td>$10,549</td>
<td>$15,070</td>
</tr>
<tr>
<td>75</td>
<td>$13,500</td>
<td>$15,157</td>
<td>$20,930</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>With No Inflation Protection—Benefit Stays at $200 per Day</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With 4 Years of Benefits</td>
<td>6 Years of Benefits</td>
<td>Lifetime Benefits</td>
</tr>
<tr>
<td>50</td>
<td>$1,294</td>
<td>$1,514</td>
<td>$1,997</td>
</tr>
<tr>
<td>60</td>
<td>$2,057</td>
<td>$2,426</td>
<td>$3,307</td>
</tr>
<tr>
<td>70</td>
<td>$4,914</td>
<td>$5,834</td>
<td>$7,777</td>
</tr>
<tr>
<td>75</td>
<td>$8,146</td>
<td>$8,291</td>
<td>$12,337</td>
</tr>
</tbody>
</table>

Another issue to keep in mind is that long-term care insurance policies may not cover the full cost of your care. For example, if your policy covers $110 a day in a nursing home, but the total cost of care is $150 a day, you must pay the difference. Remember, medications and therapies increase your total daily costs. Consider the long-term care costs in your state when you choose the amount of coverage to buy.

When you buy a long-term care policy, think about how much your income is. How much can you afford to spend on a long-term care insurance policy now? A rule of thumb is that you may not be able to afford the policy if the premiums will be more than 7% of your income. Also, try to think about what your future income and living expenses are likely to be and how much premium you could pay then. If you don’t expect your income to increase and you can barely afford the premium now, it probably isn’t a good idea to buy a policy.
As you decide what you can afford, consider the effect if the premium goes up in the future. While a company can’t raise premiums because you filed a claim or your health changed, the company can raise the premiums for an entire class of policies. Again, it probably isn’t a good idea to buy a policy if you are not confident that you will be able to afford the premiums on an on-going basis.

NOTE: Don’t be misled by the term “level premium.” You may be told that your long-term care insurance premium is “level.” That doesn’t mean that it will never increase. For almost all long-term care insurance policies, companies can’t guarantee that premiums will never increase. Many states have adopted regulations that don’t let insurance companies use the word “level” to sell guaranteed renewable policies. Companies must tell consumers that premiums may go up. Look for that information on the outline of coverage and the policy’s face page when you shop.

What Options Do I Have to Pay the Premiums on the Policy?

If you decide you can afford to buy a long-term care insurance policy, there are two main ways you can pay your premiums—the continuous payment option and the limited payment option. Not every company offers the limited payment option in every state. Ask your state insurance department what options your state allows. (See the list of state insurance departments, agencies on aging, and state health insurance assistance programs starting on page 44.)

Premiums usually are less with the continuous payment option. Under this option, you pay the premiums on your policy, typically monthly, quarterly, or once or twice a year, until you trigger your benefits. The company can’t cancel the policy unless you don’t pay the premiums.

Some companies offer a limited payment option to pay premiums. Under this option, you pay premiums for a set time period in one of the following ways:

- Single pay. You make one lump-sum payment.
- 10-pay and 20-pay. You pay premiums for either 10 or 20 years, and nothing after that. You might choose this option if your income will be lower in 10 or 20 years.
- Pay-to-65. You pay premiums until you’re age 65 and nothing after that.

With any of these payment options, neither you nor the company can cancel the policy after you make the last premium payment. Limited payment option policies are more expensive than continuous payment policies, because you’re paying a greater portion of your premium with each payment. Unless the contract fixes your premium for the payment period, your premium could increase. Despite the higher cost, some consumers want the guaranteed fixed payment and no-cancel features. Ask your tax advisor for information about the tax treatment of limited payment options.

If I Already Own a Policy, Should I Switch Policies or Upgrade the Coverage I Have Now?

Before you switch to a new long-term care insurance policy, be sure it’s better than the one you have now. Even if your agent now works for a different company, think carefully before you make any changes. Switching may be right for you
if your old policy requires you to stay in the hospital or to receive other types of care before it pays benefits. Before you decide to change, though, first ask if you can upgrade the coverage on the policy you already have. For example, you might add inflation protection or take off the requirement that you stay in the hospital. It might cost less to improve a policy you have now than to buy a new one. If not, you could replace your current policy with one that gives you more benefits, or even add a second policy. Be sure to talk about any changes in your coverage with a trusted family member or friend. Also, be sure you’re in good health and can qualify for another policy.

If you decide to switch to a new long-term care insurance policy, be sure the company accepts your application and issues the new policy before you cancel the old one. When you cancel a policy in the middle of its term, many companies won’t give back any premiums you’ve paid. If you switch policies, you may not have coverage for pre-existing conditions for a certain period.

What Shopping Tips Should I Keep in Mind?

Here are some points to keep in mind as you shop.

**Ask questions.**

If you have questions about the agent, the insurance company, or the policy, contact your state insurance department or insurance counseling program. (See the list of state insurance departments, agencies on aging and state health insurance assistance programs starting on page 44.) Be sure the company is reputable and licensed to sell long-term care insurance policies in your state.

**Check with several companies and agents.**

It’s wise to contact several companies (and agents) before you buy. Compare benefits, the types of facilities you have to be in to get coverage, the limits on your coverage, what’s not covered, and, of course, the premiums. (Policies that have the same coverage and benefits may not cost the same.) See the Personal Assessment and Long-Term Care Policy Checklist starting on page 29.

**Check out the companies’ premium increase histories.**

Ask companies whether they’ve increased the premiums on the long-term care insurance policies they sell. Ask to see a company’s personal worksheet that includes the company’s premium increase history. See the Long-Term Care Insurance Personal Worksheet on page 40.

Some state insurance departments prepare a consumer guide for long-term care insurance each year. These guides may include an overview of long-term care insurance, a list of companies selling long-term care insurance in your state, the types of benefits and policies you can buy (both as an individual and as a member of a group), and a premium increase history of each company that sells long-term care insurance in that state. Some guides even include examples of different coverage types and combinations and premiums to help you compare policies. Contact your state insurance department or insurance
Take your time and compare outlines of coverage.

Ask for an outline of coverage, which describes the policy’s benefits and points out important features. Compare outlines of coverage for several policies, making sure they are similar (if not the same). In most states the agent must leave an outline of coverage when he or she first contacts you. Never let anyone pressure or scare you into making a quick decision. Don’t buy a policy the first time you see an agent.

Understand the policies.

Be sure you know what the policy covers and what it doesn’t. If you have any questions, call the insurance company before you buy.

If any information confuses you or is different from the information in the company literature, don’t hesitate to call or write the company to ask your questions. Don’t trust any sales presentation or literature that claims you have only one chance to buy a policy.

Some companies sell their policies through agents, while others sell their policies through the mail, skipping agents entirely. No matter how you buy your policy, check with the company if you don’t understand how the policy works.

Talk about the policy with a trusted family member or friend. You also may want to contact your state insurance department or state health insurance assistance program (SHIP). (See the list of state insurance departments, agencies on aging, and state health insurance assistance programs starting on page 44.)

Don’t be misled by advertising.

Most celebrity endorsers are professional actors paid to advertise. They aren’t insurance experts. Medicare doesn’t endorse or sell long-term care insurance policies. Be wary of any advertising that suggests Medicare is involved.

Don’t trust cards you get in the mail that look like official government documents until you check with the government agency identified on the card. Insurance companies or agents trying to find buyers may have sent them. Be careful if anyone asks you questions over the telephone about Medicare or your insurance. They may sell any information you give to long-term care insurance marketers, who might call you, come to your home, or try to sell you insurance by mail.

Be sure you put correct and complete information on your application.

Don’t be misled by long-term care insurance marketers who say your medical history isn’t important—it is! Give correct information. If an agent fills out the application for you, don’t sign it until you’ve read it. Be sure that all of the medical information is accurate and complete. If it isn’t and the company used that information to decide whether to insure you, it could refuse to pay your claims and even cancel your policy.
**Never pay in cash.**

Use a check, an electronic bank draft made payable to the insurance company, or a credit card.

**Be sure to get the name, address, and telephone number of the agent and the company.**

Get a local or toll-free number for both the agent and the company.

**If you don’t get your policy within 60 days, contact the company or agent.**

You have a right to expect prompt delivery of your policy. When you get it, keep it somewhere you can easily find it. Tell a trusted family member or friend where it is.

**Be sure you look at your policy during the free-look period.**

If you decide you don’t want the policy soon after you bought it, you can cancel it and get your money back. You only have a certain number of days after you get the policy to tell the company you don’t want it. How many days you have depends on the “free-look” period. In some states the insurance company must tell you about the free-look period on the cover page of the policy. In most states you have 30 days to cancel, but in some you have less time. Check with your state insurance department (see the list of state insurance departments, agencies on aging and **state health insurance assistance programs** starting on page 44) to find out how long the free-look period is in your state.

If you want to cancel:
- Keep the envelope the policy was mailed in. Or ask the agent for a signed delivery receipt when he or she hands you the policy.
- Send the policy to the insurance company along with a short letter asking for a refund.
- Send both the policy and the letter by certified mail. Keep the mailing receipt.
- Keep a copy of all letters.
- It usually takes four to six weeks to get your refund.

**Read the policy again and be sure it gives you the coverage you want.**

Check the policy to see if the **benefits** and the premiums are what you expected. If you have any questions, call the agent or company right away. Also, reread the application you signed. It’s part of the policy. If it’s not filled out correctly, contact the agent or company right away.

**Think about having the premium automatically taken out of your bank account.**

Automatic withdrawal may mean that you won’t lose your coverage if you forget to pay your premium. If you decide not to renew your policy, be sure you tell the bank to stop the automatic withdrawals.
Check the financial stability of the insurance company.

Insurer ratings can show you how analysts see the financial health of individual insurance companies. Different rating agencies use different rating scales. Be sure to find out how the agency labels its highest ratings and the meaning of the ratings for the companies you’re considering.

You can get ratings from some insurer rating services for free at most public libraries. And now you can get information from these services on the Internet.

Some companies provide credit ratings that shows the financial strength ratings of insurers, such as:
- A.M. Best Company
- Moody’s Investor Service, Inc.
- Weiss Ratings, Inc.

If your insurer is not rated by these companies, you can refer to the link from the U.S. Securities & Exchange Commission (SEC) for a current list of credit rating agencies approved by the SEC: [www.sec.gov/ocr/ocr-current-nrsros.html](http://www.sec.gov/ocr/ocr-current-nrsros.html)

You should always ask your trusted financial advisor or agent for information on the credit rating of your insurer.
GLOSSARY

**Accelerated Death Benefit** - A life insurance policy feature that lets you use some of the policy’s death benefit before you die.

**Activities of Daily Living (ADLs)** - Everyday functions and activities individuals usually do without help. ADLs include bathing, continence, dressing, eating, toileting, and transferring. Many policies use being unable to do a certain number of ADLs (such as two of six) to decide when to pay benefits.

**Adult Day Care** - Care given during the day at a community-based center for adults who need help or supervision during the day, including help with personal care, but who don’t need round-the-clock care.

**Alternate Care** -- Alternate care (or “alternative care”) means that an insurer is willing to consider a type or place of care not specifically referenced in the policy. Most commonly, this provision is intended to allow coverage for a future type of care not available at the time the policy was issued. Generally, the insurer is agreeing only to consider such an alternative and the contract language may require the alternate care to be less expensive.

**Alzheimer’s Disease** - A progressive, degenerative form of cognitive impairment that causes severe intellectual deterioration.

**Assisted Living Facility** - A residential living arrangement that provides personal care and health services for people who need some help with activities of daily living, but don’t need the level of care that nursing homes give. Assisted living facilities can range from small homes to large apartment-style complexes and also can offer different levels of care and services.

**Bathing** - Washing oneself in either a tub or shower. This activity includes getting in or out of the tub or shower.

**Benefits** - The amount the insurance company pays for covered services.

**Benefit Triggers** – The criteria and ways an insurer decides when a policy pays benefits, such as being unable to do two or more activities of daily living, or the need for substantial supervision due to having dementia or Alzheimer’s disease.

**Care Management Services** - A service in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long-term care services (also called care coordination services).

**Cash Value** - The amount of money the insurance company owes you when you terminate a life insurance policy or annuity contract with this feature. The policy states the amount of the cash value.

**Certificate of Coverage** – A certificate you receive or may request from the plan sponsor after buying coverage in a group policy. The certificate is evidence of your coverage under the policy and describes the benefits, coverage, exclusions and limitations of the policy that principally affect you.

**Chronically Ill** - A term used in a tax-qualified long-term care contract to describe a person who needs long-term care either because of a severe cognitive impairment or because s/he can’t do everyday activities of daily living (ADLs) without help.

**Cognitive Impairment** - A loss of short- or long-term memory; difficulty knowing people, places, or the time or season; loss of the ability to make good decisions; or loss of safety awareness.
Community-Based Services - Services designed to help older people stay independent and in their own homes.

Continence – Being able to control bowel and bladder function or, if you can’t, being able to manage needed personal hygiene (such as a catheter or colostomy bag).

Contingent Benefit Upon Lapse -- A requirement in some states that companies are required to offer if premiums increase to a certain amount (based on a table of increases) to enable policyholders to keep their policy without paying the higher premium. If offered, the policyholder could choose: 1) their current policy with reduced benefits so the premium stays the same; 2) a paid-up policy with a shorter benefit period but no future premiums; or 3) their current policy with the higher premiums.

Contingent Nonforfeiture - A reduced benefit provided to some policyholders whose policies terminate, sometimes called a “lapse.” The amount of the reduced benefit is the total premiums you paid for the policy, without interest. Some states require the company to offer contingent nonforfeiture to policyholders whose premiums increase by a certain percentage or more. For example, suppose you bought a policy at age 65 for $2,000 per year, and didn’t buy the optional nonforfeiture benefit. Also suppose that after you paid premiums for ten years, the company raised the rates by 50% or more, and your coverage ends because you don’t pay the higher premiums. If the policy has contingent nonforfeiture, then you’ll be eligible for up to $20,000 (the total amount you paid in premiums) of benefits if you meet the benefit triggers in the future.

Continuing Care Retirement Community (CCRC) - A retirement complex that offers a broad range of services and levels of care.

Continuous Payment Option - A premium payment option that requires you to pay premiums until you’re eligible for benefits. You can pay premiums monthly, quarterly, or once or twice a year. The policy is guaranteed renewable, which means the only reason the company can cancel it is if the premiums aren’t paid when due.

Custodial Care (Personal Care) - Care to help individuals with activities of daily living such as bathing, dressing, and eating. Usually, medical training isn’t needed to give this type of care.

Daily Benefit - The amount the policy will pay for each day of care, often limited to the amount charged for your care.

Death Benefit – The amount paid to a beneficiary upon the death of an insured person.

Deductible – A specified amount of time or dollar amount the insured must satisfy before an insurance company will pay a claim.

Dementia – Another term for significant cognitive impairment.

Disability Method - Method of paying benefits that only requires you to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit, even if you aren’t receiving any long-term care services.

Downgrades – Reduction of coverage you choose if you can’t pay your premiums that could allow you to keep your policy instead of dropping it.

Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating - Feeding yourself by getting food into the body from a receptacle (such as a plate, cup, or table).

Elimination Period (Waiting Period) - A type of deductible; the length of time the individual must pay for covered services before the insurance company begins to make payments. Increasing your policy’s elimination period
reduces the premium, because the insurance company has to pay less benefits. Another term for this is a “waiting period.”

Episode of Care – The care provided by a health care facility or provider for a specific medical condition during a set time period.

Expense-Incurred Method – Once there’s an expense for an eligible service, the insurer pays benefits either to you or your provider. The coverage pays either the amount of the expense or your policy’s dollar limit, whichever is less. Most policies sold today use the expense-incurred method.

Extended Term Benefits – After you stop paying premiums, this coverage provides full benefits for use during a certain period of time. If you don’t collect benefits during that period, the contract ends and you have no coverage.

Extension of Benefits Rider – A rider that may increase your long-term care coverage beyond your policy’s cash value and/or death benefit or your annuity’s value.

Guaranteed Renewable - A policy that an insurance company can’t cancel and must renew, unless the benefits listed in the policy have been completely used or the premiums haven’t been paid. Note: The insurance company may increase premiums for a guaranteed renewable policy but can’t single out your policy for an increase.

Hands-On Assistance - Physical help (minimal, moderate, or maximal) an individual must have to do an activity of daily living.

Health Insurance Portability and Accountability Act (HIPAA) - Federal health insurance legislation passed in 1996 that allows, under some conditions, long-term care insurance policies to be qualified for certain tax benefits.

Home Care - Services in the client’s home. Can include nursing care, personal care, social services, medical care, homemaker services, and occupational, physical, respiratory, or speech therapy.

Hospice Care – Care for a person who isn’t expected to live very long, so the care is designed to reduce pain and discomfort.

Hospice Facility - A health care facility for the terminally ill in which hospice care is provided.

Homemaker Services - Household tasks such as laundry, cleaning, or cooking.

Indemnity Benefit/Method - Method of paying benefits where the benefit is a set dollar amount that isn’t based on the specific service received or the expenses incurred. Once the company decides you’re eligible for benefits because you’re receiving eligible long-term care services, it pays the set amount up to the limit of the policy.

Inflation Protection - A policy option that increases benefits levels to cover expected increases in long-term care services’ costs.

Lapse - Termination of a policy when a renewal premium isn’t paid.

Licensed Health Care Practitioner – A doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law.

Limited Payment Option - A premium payment option in which you pay premiums for a set time period, but the policy covers you for the rest of your life.
Medicaid - A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

Medicare - The federal program that provides hospital and medical insurance to people aged 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited to a short period of time.

Medicare Supplement Insurance (also called Medigap insurance coverage) - A private insurance policy that covers many of the gaps in Medicare coverage.

National Association of Insurance Commissioners (NAIC) - Membership organization of state insurance commissioners. A goal is to promote uniformity of state insurance regulation and legislation.

Nonforfeiture Benefits - A policy feature that keeps some coverage available to you if the policy ends because the premiums weren’t paid.

Nursing Home - A licensed facility that provides nursing care to those who are chronically ill or can’t do one or more activities of daily living.

Outline of Coverage - A summary of the benefits and coverage provided in the policy and the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium.

Paid-up Policy - When you stop paying your premiums, but your insurance policy is considered paid-in-full. You don’t pay any more premiums, and your policy benefits depend on how much you’ve already paid in premiums, not the level of benefits that you first bought.

Partnership Policy - A type of policy that lets you protect (keep) some of your assets if you apply for Medicaid after you use your policy’s benefits. Not all states have these policies.

Personal Care (Custodial Care) - Care to help individuals meet personal needs such as bathing, dressing, and eating. Someone without professional training may provide personal care.

Personal Care Home – A general term for a facility that cares for elderly people. Long-term care insurance policies often don’t cover care here.

Pre-existing Condition – An illness or disability for which you were treated or advised within a time period before you applied for insurance.

Reduced Paid-up Policy - A nonforfeiture option that reduces your daily benefit but keeps the full benefit period on your policy until death. For example, if you bought a policy for three years of coverage with a $150 daily benefit and let the policy lapse, the daily benefit would be reduced to $100 but the benefit period still would be three years. Just how much less your benefit would be depends on how much premium you’ve paid on the policy. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use reduced paid-up benefits at any time after you lapse (until death).

Rescind - When the insurance company voids (cancels) a policy.

Respite Care - Care a third party gives to relieve family caregivers for a few hours to several days and give them an occasional break from daily caregiving responsibilities.
Rider – An additional form that is optional that can be attached to an original life insurance policy, long-term care policy or annuity contract on or after its date of issue that may provide additional benefits over and above the main policy or contract.

Shared Care – A policy covering two people who can access the same benefits until one or both people have used up the benefits.

Shortened Benefit Period Policy – A nonforfeiture option that reduces the benefit period but retains the full daily maximums applicable until death. The period of time for which benefits are paid will be shorter.

Skilled Care - Daily nursing and rehabilitative care that can be done only by, or under the supervision of, skilled medical personnel. This care usually is needed 24 hours a day, must be ordered by a physician, and must follow a plan of care. Individuals usually get skilled care in a nursing home but also may get it in other places.

Spend Down - A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

Stand-by Assistance - Caregiver stays close to watch over the person and to give physical help if needed.

State Health Insurance Assistance Program (SHIP) - Federally funded program to train volunteers to counsel senior citizens about insurance needs. (See the list of state insurance departments, agencies on aging and state health insurance assistance programs starting on page 44)

Substantial Assistance - Hands-on or stand-by help required to do ADLs.

Substantial Supervision – Help from a person who directs and watches over another who has a cognitive impairment.

Tax-Qualified Long-Term Care Insurance Policies (Tax-Qualified Policies or Plans) – Long-term care policies that meet certain standards in federal law and offer certain federal tax advantages.

Third Party Notice - A benefit that lets you name someone whom the insurance company would notify if your coverage is about to end because the premium hasn’t been paid. This can be a relative, friend, or professional such as a lawyer or accountant.

Toileting - Getting to and from the toilet, getting on and off the toilet, and doing related personal hygiene.

Transferring - Moving into and out of a bed, chair, or wheelchair.

Underwriting - Collecting and reviewing information to determine whether to issue an insurance policy.

Waiver of Premium - An insurance policy feature that means an insured who’s receiving benefits no longer has to pay premiums.

Waiting Period – See Elimination Period.
The First Step — A Personal Assessment

Reasons for Wanting Long-Term Care Insurance

It’s important to identify your reason(s) for buying a policy. This influences many of the choices you’ll make in selecting coverage. A person with few resources, a modest income, and a goal of staying off Medicaid, approaches a purchase one way. A person with a larger amount of assets and income may approach it differently.

If your reason is to preserve resources for heirs, you might consider having them help pay the premium. They will benefit from your long-term care insurance purchase. If you don’t have dependents or heirs, you may consider using resources to pay for long-term care rather than buying insurance.

**What are your objectives?**

- Protecting resources or leaving an inheritance
- Not burdening others to pay nursing home bills
- Avoid Medicaid
- Being able to choose the type of care and the place where care is received
- Having peace of mind
- Being independent of others’ support
- Protecting a spouse/domestic partner or dependent(s)
Your Health

Unlike Medicare supplement insurance (Medigap), long-term care insurance is rarely available on a guaranteed basis. You will need to show that you are not a serious health risk before the company will approve your application. Your health is typically not taken into consideration for an annuity.

- **Excellent** - People can easily find coverage if health is excellent.
- **Good** - (minor health problems, one insignificant chronic condition) - People have little trouble finding coverage if health is good.
- **Fair** - (one or more chronic conditions requiring medical supervision and/or hospitalization in the last year) - People with fair health are sometimes accepted for coverage, but they may pay a higher premium.
- **Poor** - (heart disease, pulmonary disease, cancer or other advanced disease) - People in poor health are rarely accepted and should question any attempt to sell them coverage.

Your Age

Age affects the premium you’ll pay. Also, as age increases so does the possibility of developing health conditions that will make it difficult for you to buy insurance. Most companies direct their marketing efforts accordingly.

- **50 to 79** - Within this range, you’ll have many companies and policies from which to choose. Premiums will be more affordable.
- **80 to 84** - A few companies market to this age range. Some companies sell only one year of coverage to those 80 and older.
- **85 and older** - Few companies sell to people older than 84. Very elderly people should carefully consider the wisdom of purchasing long-term care insurance because of its cost.
Your Annual Income

The purchase of long-term care insurance should not cause financial hardship or prevent you from meeting your basic needs. If premiums cannot be paid from current income, long-term care insurance should not be purchased.

You need to consider your ability to pay premiums now and in the future.

- Is your only income Social Security or Supplemental Security Income (SSI)? If it is, this is likely not an appropriate purchase for you.
- Is the long-term care policy premium less than 7% of your income (rule of thumb for affordability)?
- Could you still pay the premium if it was increased by more than 25%?
- If you purchase an annuity or life insurance policy, can you afford the one-time payment or periodic payments?

Cash Value of Assets Excluding Your Primary Residence

The cost of long-term care insurance is significant. If protecting assets is your reason for buying, you should have substantial assets to protect. Your home is protected from Medicaid as long as a spouse/domestic partner lives there. Additional resources also can be protected for a spouse/domestic partner. Check with your state insurance department, agencies on aging, state health insurance assistance programs (SHIP), or another consumer assistance agency for more information, starting on page 44.

These suggested amounts represent individual resources. They would double for a couple.

- Less than $30,000 - Over several years you might spend as much in premium as the value of assets being protected.
- $30,000 - $75,000 - Carefully review your resources to see if the amount you are protecting justifies the premium you’ll pay.
- $75,000 and up - Long-term care insurance may be an appropriate way to save assets for your own security or estate.
Long-Term Care Policy Checklist

Use this checklist when you are shopping for a policy or to evaluate a policy you already have.

<table>
<thead>
<tr>
<th>Types of Long-Term Care (LTC) Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Which type of long-term care coverage is best for you?</strong></td>
</tr>
<tr>
<td>- Individual Policy</td>
</tr>
<tr>
<td>- Employer Group Policy</td>
</tr>
<tr>
<td>- Association Policy</td>
</tr>
<tr>
<td>- <strong>Partnership Policy</strong>*</td>
</tr>
<tr>
<td>*Partnership policies may be available as an individual policy or from an employer or association group.</td>
</tr>
<tr>
<td>- Life Insurance or <strong>Rider</strong></td>
</tr>
<tr>
<td>- Annuity or <strong>Rider</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Company and Agent Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Is the insurance company financially strong?</strong></td>
</tr>
<tr>
<td>- Company name</td>
</tr>
<tr>
<td>- Company address</td>
</tr>
<tr>
<td>- Company telephone number</td>
</tr>
<tr>
<td>- Company website</td>
</tr>
<tr>
<td>- Insurance company rating</td>
</tr>
<tr>
<td>Name of rating agency</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Are you working with an agent?</strong></td>
</tr>
<tr>
<td>- Agent’s name</td>
</tr>
<tr>
<td>- Agent’s address</td>
</tr>
<tr>
<td>- Agent’s telephone number</td>
</tr>
<tr>
<td>- Agent’s email address</td>
</tr>
</tbody>
</table>

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4. What types of services and care are covered?

- **Nursing home** care
- **Assisted living**
  | Policy A | Policy B |
  | Yes | No | Yes | No |
- **Home and Community-based services**
  | | | | |
  | Home skilled services | Yes | No | Yes | No |
  | Home personal services | Yes | No | Yes | No |
  | **Respite care** | Yes | No | Yes | No |
  | **Adult day care** | Yes | No | Yes | No |
  | **Homemaker/chore services** | Yes | No | Yes | No |
  | **Hospice care** | Yes | No | Yes | No |
  | **Family care** | Yes | No | Yes | No |
  | **Informal Care** | Yes | No | Yes | No |
  | **Alternate care** | Yes | No | Yes | No |
  | List other benefits | | | | |

5. Are Benefits Determined on Daily or Monthly Basis?

6. How much does the policy pay per day?

- **Nursing Home**
  | per day | per day |
  | | | | |
  | Same amount for all levels | Yes | No | Yes | No |
- **Assisted living**
  | per day | per day |
  | | | | |
- **Home and community-based services**
  | Daily | Monthly | Daily | Monthly |
  | | | | |
  | Home skilled services | $ | | $ | |
  | Home personal services | $ | | $ | |
  | **Respite care** | $ | | $ | |
  | **Adult day care** | $ | | $ | |
  | **Homemaker/chore services** | $ | | $ | |
  | **Hospice care** | $ | | $ | |
  | **Alternate care** | $ | | $ | |
  | **Family care** | Yes | No | Yes | No |
  | **Informal care** | Yes | No | Yes | No |
### 7. Are benefits adjusted for inflation?

<table>
<thead>
<tr>
<th></th>
<th>Policy A</th>
<th>Policy B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does policy have inflation adjustment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>• Automatic annual increase option</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual percent increase</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Type of increase</td>
<td>Compound</td>
<td>Compound</td>
</tr>
<tr>
<td>Additional premium</td>
<td>$_______</td>
<td>$_______</td>
</tr>
</tbody>
</table>

- **Regular offer to buy more:**
  - Frequency of offer: Annual or every yrs
  - Amount of increase offered
  - Times offer can be declined
  - Age for premium calculation: Current age, issue age

- **With the inflation benefit, what daily benefit would you receive for**
  - **Nursing Home** care at age 75: $ __________
  - at age 80: $ __________
  - at age 85: $ __________
  - **Home care** at age 75: $ __________
  - at age 80: $ __________
  - at age 85: $ __________

Do increases end after a certain period of years or a certain age? Yes No Yes No
If increases do end, when? Age/Year N/A Age/Year N/A
Does the policy maximum increase over time? Yes No Yes No

### 8. How long do benefits last?

- **Policy maximum**: Yrs. _____ or $ _____ Yrs. _____ or $ _____
- **Is there a pool for all benefits?** Yes No Yes No
- **Can benefits shared with spouse/domestic partner?** Yes No Yes No
- **Annual or policy maximums for individual benefits (days or $)**
### How Do You Qualify for Benefits?

#### 9. What level of need is required?

- **Functional incapacity — need help with ADLs**
  - Yes
  - No
  - How many? ______
  - How many? ______

- **Cognitive impairment**
  - Yes
  - No

- **Medical necessity due to illness or injury**
  - Yes
  - No

#### 10. What is a qualified place?

List the types of facilities that are NOT covered by the policy.

#### 11. Who is a qualified person to give care?

- Can a family member be paid?
- Who is a qualified family member?
- Does the policy pay for training?

#### 12. How long is the elimination period or deductible before benefits begin?

- **Nursing home**

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<table>
<thead>
<tr>
<th>Service</th>
<th>Policy A</th>
<th>Policy B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite care</td>
<td></td>
<td></td>
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<tr>
<td>Adult day care</td>
<td></td>
<td></td>
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<tr>
<td>Homemaker/chore services</td>
<td></td>
<td></td>
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<tr>
<td>Hospice care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How is it satisfied?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required only once</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>New one for repeat stay</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Days for different services added together</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>13. Does the policy provide care management/care coordination?</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Could the insurer pay benefits based on a plan of care that neither you nor your doctor approved?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Other Policy Features**

<table>
<thead>
<tr>
<th>Question</th>
<th>Policy A</th>
<th>Policy B</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Does the policy have a waiver of premium?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>If your premium is prepaid but then you require use of your coverage, will you get back some of your premium?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the waiver of premium apply to home care?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
15. **Does the policy have a nonforfeiture benefit?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

- Selected option

<table>
<thead>
<tr>
<th>How long before it’s in effect?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>How does the <strong>benefit</strong> work?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Premium for this <strong>benefit</strong>?</th>
<th>$</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. **If this is a group policy, what conversion options are offered?**

17. **Is the policy federally tax-qualified?**
### Annual Cost

<table>
<thead>
<tr>
<th>18. What does the policy cost per year?</th>
<th>Policy A</th>
<th>Policy B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Basic Policy</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Rider #</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Rider #</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Rider #</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Policy or group membership fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Less any spouse/domestic partner discount</td>
<td>less $</td>
<td>less $</td>
</tr>
<tr>
<td>• Less any other discount</td>
<td>less $</td>
<td>less $</td>
</tr>
<tr>
<td><strong>Total Costs per year:</strong></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Do you lose the spouse/domestic partner discount if one spouse/domestic partner dies?
- Yes
- No

If Buying A Stand-Alone LTC Policy, You Don’t Need to Complete This Section

### Other Approaches to Long-Term Care Insurance

**Life Insurance and Annuities**

<table>
<thead>
<tr>
<th>Question</th>
<th>Policy A</th>
<th>Policy B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this product a good purchase for you at this time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can I add long-term care benefits to an existing policy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does a loan against the policy affect the long-term care benefits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does the policy pay long-term care benefits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who is covered by the policy long-term care benefits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Are benefits payable for long-term care available immediately or is there an elimination period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How is your premium calculated?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Long-Term Care Insurance Personal Worksheet

Drafting Note: Companies shall at a minimum provide all of the information shown below and in the same order. The company may include additional information related to this long-term care insurance coverage in relevant and readable language. Bracketed statements indicate the companies should choose the applicable statement, are allowed flexibility in inserting numerical ranges, etc.

Long-Term Care Insurance Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to give you some important facts about premiums and premium increases and to ask you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

The premium for the coverage you are considering will be [$_______ per [insert payment interval] or a total of [$$_______ per year] [a one-time single premium of $____________].

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.

Drafting Note: Companies will insert payment interval – monthly, quarterly, etc. and the appropriate dollar amount.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

[Noncancellable - The company cannot increase your premiums on this [policy] [certificate] [rider]].

[Guaranteed renewable - The company can increase your premiums on this [policy] [certificate] [rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider]].

Drafting Note: Companies will insert the appropriate policy type and the associated bracketed statement. Premium guarantees shall not be shown on this form.

Premium Increase History

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.]
**Drafting Note:** If the summary of premium increases is extensive, the company may disclose the required premium increase history via an addendum attached to this worksheet. The company may substitute the language below for the last sentence in the paragraph above and include the full summary as an attachment to this worksheet.

“Over the past 3 years, the company has increased premiums by ___%.” “A summary of premium increases in the last 10 years is attached to this worksheet.”

Companies that have increased premiums by 30% or more in the last ten years must include the following statement: “There was a 30% or greater premium increase in ____ [insert year].” “A summary of premium increases in the last 10 years is attached to this worksheet.”

**Questions About Your Income**

You do not have to answer the questions that follow. They are intended to make sure you have thought about how you’ll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

**What resources will you use to pay your premium?**

- Current income from employment
- Current income from investments
- Other current income
- Savings
- Sell investments
- Sell other assets
- Money from my family
- Other ____________

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy] [certificate] [rider] if the premiums will be more than 7% of your income.

Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?

- Yes
- No
- Had not thought about it
- Do not know
- Does not apply

What would you do if the premiums went up, for example, by 50%?

- Pay the higher premium
- Call the company/agent
- Reduce benefits
- Drop the [policy] [certificate] [rider]
- Do not know

**Drafting Note:** The company is not required to use the bracketed question above if the coverage is fully paid up or is noncancellable.

What is your household annual income from all sources? (check one)

- [Less than $10,000]
- $[10,000-19,999]
- $[20,000-29,999]
- $[30,000-50,000]
- [More than $50,000]

**Drafting Note:** The companies may choose the income ranges to put in the brackets to fit its suitability standards.

Do you expect your income to change over the next 10 years? (check one)

- No
- Yes, expect increase
- Yes, expect decrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?

- Yes
- No
- Do not know

Will you buy inflation protection? (check one)

- Yes
- No

*Inflation may increase the cost of long-term care in the future.*

If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?
From my income □ From savings □ From investments □ Sell other assets □ Money from my family □ Other

The national average annual cost of long-term care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. This figure should also be used when calculating the cost of long-term care in the “approximate cost $____ for that period of care” question found below. In the above statement, the second figure will equal 163% of the first figure.

What [elimination period][waiting period][cash deductible] are you considering?
[Number of days ________ in [elimination period][waiting period]
Approximate cost of care for this period: $_________
($xxx per day times number of days in [elimination period] [waiting period], where “xxx” represents the most recent estimate of the national daily average cost of long-term care)]
[Cash Deductible $________]

How do you plan to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)
□ From my income □ From my savings/investments □ My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
□ [Less than $20,000] □ [$20,000-$29,999] □ [$30,000-$49,999] □ [More than $50,000]

Drafting Note: Companies may choose the asset ranges to put in the brackets to fit its suitability standards.

Do you expect the value of your assets to change over the next ten years? (check one)
□ No □ Yes, expect to increase □ Yes, expect to decrease

If you’re buying this [policy] [certificate] [rider] to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

□ The answers to the questions above describe my financial situation.

Or
□ I choose not to complete this information.
(Check one.)

□ I agree that the company and/or its agent (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)

Drafting Note: For direct mail situations, the lead in sentence should be changed to “I agree that I have reviewed this worksheet including the premium….”
I explained to the applicant the importance of answering these questions.

[☐ I explained to the applicant the importance of answering these questions.

Agent’s Printed Name: ____________________________________________]

[In order for us to process your application, please return this signed worksheet to [name of company], along with your application.]
Each state has its own laws and regulations governing all types of insurance. The insurance departments, which are listed in the left column, are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. Centered below each state listing is the telephone number for the insurance counseling programs. Please note that calls to 800 numbers listed here can only be made from within the respective state.

<table>
<thead>
<tr>
<th>INSURANCE DEPARTMENTS</th>
<th>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</th>
<th>AGENCIES ON AGING</th>
</tr>
</thead>
</table>
| Alabama Department of Insurance  
201 Monroe Street, Suite 502  
Montgomery, AL 36104  
(334) 269-3550  
Fax: (334) 241-4192  
www.aldoi.org  | Alabama State Health Insurance Assistance Program  
1-800-243-5463  | Department of Senior Services  
770 Washington Ave. RSA Plaza Suite 570  
Montgomery, AL 36130  
1-800-243-5463  
(334) 242-5743  
Fax: (334) 242-5594 |
| Alaska Division of Insurance  
9th Floor State Office Bldg.  
333 Willoughby Ave. 99801  
P.O. Box 110805  
Juneau, Alaska 99811-0805  
(907) 465-2515  
Fax: (907) 465-3422  
TDD: (907) 465-5437  
www.commerce.state.ak.us/insurance  | Alaska State Health Insurance Assistance Program  
1-800-478-6065 In State Only  
(907) 269-3680  
Fax: (907) 269-2045  
TYY: (800) 770-8973  | Alaska Commission on Aging  
150 Third Street  
P.O. Box 110693  
Juneau, AK 99811-0693  
(907) 465-4879 or (907) 465-3250  
Fax: (907) 465-1398 |
| American Samoa  
A.P. Lutali Executive Office Building  
Pago Pago, American Samoa 96799  
011(684)-633-4116  
Fax: 011-684-633-2269  | AMERICAN SAMOA  | Territorial Administration on Aging  
American Samoa Government  
Pago Pago, American Samoa 96799  
011 (684) 633-1251  
Fax: 1 (684) 633-2533 |
<table>
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</table>
| Arizona Department of Insurance  
2910 North 44th Street, Suite 210  
Phoenix, AZ 85018-7269  
(602) 364-3100  
Fax: (602) 364-3470  
www.id.state.az.us | Arizona State Health Insurance Assistance Program  
1-800-432-4040  
Fax: (602) 542-6575 | Arizona Department of Economic Security  
Division of Aging and Adult Services  
1789 W. Jefferson, No. 950A  
Phoenix, AZ 85007  
(602) 542-4446  
Fax: (602) 277-4984 |
| Arkansas Department of Insurance  
1200 West 3rd Street  
Little Rock, AR 72201-1904  
(501) 371-2600  
1-800-852-5494  
Fax: (501) 371-2818  
www.insurance.arkansas.gov | Arkansas Senior Health Insurance Information Program  
1-800-282-9134 or  
(501) 371-2600  
Fax: (501) 371-2618 | Division of Aging & Adult Services  
Arkansas Dept. of Human Services  
700 Main Street  
P.O. Box 1437, S530  
Little Rock, AR 72203-1437  
(501) 682-2441  
Fax: (501) 682-8155 |
| California Department of Insurance  
Office of the Ombudsman  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814  
(916) 492-3500  
www.insurance.ca.gov | California Health Insurance Counseling & Advocacy Program  
1-800-434-0222  
(916) 419-7500  
Fax: (916) 928-2506  
TDD: 1-800-735-2929 | California Department of Aging  
1300 National Drive, Suite 200  
Sacramento, CA 95834  
(916) 419-7500  
Fax: (916) 928-2267  
TDD: 1-800-735-2929 |
| Colorado Division of Insurance  
1560 Broadway, Suite 850  
Denver, CO 80202  
(303) 894-7499  
1-800-930-3745  
Fax: (303) 894-7455  
http://www.dora.state.co.us/insurance/ | Colorado Senior Health Insurance Assistance Program  
1-888-696-7213  
(303) 894-7552  
Fax: (303) 869-0151  
TTY: (303) 894-7455 | Colorado Division of Aging and Adult Services  
1575 Sherman Street, 10th Floor  
Denver, CO 80203  
(303) 866-2800  
Fax: (303) 866-2696 |
| Commonwealth of the Northern Mariana Islands Department of Commerce  
Caller Box 10007  
Saipan, MP 96950  
011 (670) 644-3000  
Fax: 011 (670) 664-3067  
http://commerce.gov.mp/divisions/insurance | COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS | Mariana Islands  
CNMI Office on Aging  
Commonwealth of the Northern Marina Islands  
P.O. Box 502178  
Saipan, MP 96950-2178  
011 (671) 734-4361  
Fax: 011 (670) 233-1327 |
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<td>Connecticut Department of Insurance</td>
<td>Connecticn Program for Health Insurance Assistance, Outreach, Information &amp; Referral Counseling and Eligibility Screening</td>
<td>Connecticut Aging Services Div. Department of Social Services</td>
</tr>
<tr>
<td>P.O. Box 816</td>
<td>1-800-994-9422 or (860) 424-5023</td>
<td>25 Sigourney St., 10th Street</td>
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<tr>
<td>Hartford, CT 06142-0816</td>
<td>TDD (860) 842-4524</td>
<td>Hartford, CT 06106</td>
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<tr>
<td>(860) 297-3800 or 800-203-3447</td>
<td>Fax: (860) 424-5301</td>
<td>(860) 424-5274 or 866-218-6631</td>
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<td>Fax: 860-566-7410</td>
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<td><a href="http://www.ct.gov/cid">www.ct.gov/cid</a></td>
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<td>Delaware Department of Insurance</td>
<td>Delaware ELDERinfo</td>
<td>Division of Services for Aging &amp; Adults with Physical Disabilities</td>
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<tr>
<td>Rodney Building</td>
<td>1-800-336-9500</td>
<td>Dept. of Health &amp; Social Services</td>
</tr>
<tr>
<td>841 Silver Lake Boulevard</td>
<td>(302) 674-7364</td>
<td>1901 North DuPont Highway</td>
</tr>
<tr>
<td>Dover, DE 19904</td>
<td>Fax: (302) 739-6278</td>
<td>New Castle, DE 19720</td>
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<tr>
<td>(302) 674-7300</td>
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<td>1-800-223-9074</td>
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<td>Fax: 302-739-5280</td>
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<td>Fax: (302) 255-4445</td>
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<td><a href="http://www.delawareinsurance.gov">www.delawareinsurance.gov</a></td>
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<td>TDD: 302-391-3505</td>
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<tr>
<td>Department of Insurance, Securities and</td>
<td>Health Insurance Counseling Project</td>
<td>District of Columbia Office on Aging</td>
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<tr>
<td>Banking</td>
<td>(202) 739-0668</td>
<td>One Judiciary Square</td>
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<tr>
<td>Gov’t of the District of Columbia</td>
<td>Fax: (202) 293-4043</td>
<td>441 4th St., N.W., 9th Floor</td>
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<tr>
<td>810 First Street, N.E. Suite 701</td>
<td>TDD: (202) 973-1079</td>
<td>Washington, DC 20001</td>
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<td>Washington, DC 20002</td>
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<td>(202) 724-5622 or (202) 724-5626</td>
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<tr>
<td>(202) 727-8000</td>
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<td>Florida Office of Insurance Regulation’s Long</td>
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<td>Range Program Plan</td>
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<td>Office of Health Services</td>
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<tr>
<td>200 East Gaines Street</td>
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<td>Federated States of Micronesia</td>
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<td>Tallahassee, FL 32399-0300</td>
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<td>(850) 413-3140</td>
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<td>Fax: 850-488-334</td>
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<td><a href="http://www.florir.com">www.florir.com</a></td>
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<td>SHINE (Serving Health Insurance Needs of</td>
<td>Florida Department of Elder Affairs</td>
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<tr>
<td>Elders)</td>
<td>1-800-963-5337</td>
<td>4040 Esplanade Way</td>
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<td>(850) 414-2000</td>
<td>Tallahassee, FL 32399</td>
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<td>Fax: (850) 414-2150</td>
<td>(850) 963-5337</td>
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<td>TDD: 1-800-955-8771</td>
<td>Fax: (850) 414-2150</td>
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<td>TTY: 800-955-8770</td>
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<tr>
<td>Georgia Department of Insurance</td>
<td>GeorgiaCare</td>
<td>Georgia Division for Aging Services</td>
</tr>
<tr>
<td>2 Martin Luther King Jr. Drive</td>
<td>1-866-552-4464</td>
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<tr>
<td>Floyd Memorial Bldg., 704 West Tower</td>
<td>(404) 657-5258</td>
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<td>Atlanta, GA 30334</td>
<td>Fax: (404) 657-5285</td>
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<td>Guam Dept. of Revenue and Taxation</td>
<td>Guam Medicare Assistance Program</td>
<td>Regulatory Programs Administrator</td>
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<tr>
<td>Banking Insurance Commissioner</td>
<td>(671) 735-7388</td>
<td>Dept. of Revenue and Taxation</td>
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<tr>
<td>P.O. Box 23607</td>
<td>Fax: (671) 735-7416</td>
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<td>GMF Barrigada, Guam 96921</td>
<td>TDD: (671) 735-7415</td>
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<tr>
<td>(1240 Army Drive, Barrigada, Guam, 96913)</td>
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<td>(671) 635-1817</td>
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<td>Hawaii Insurance Division</td>
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<td>P.O. Box 3614</td>
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<tr>
<td>335 Merchant Street, Room 213</td>
<td>Fax: (808) 586-0185</td>
<td>No. 1 Capitol District</td>
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<tr>
<td>Honolulu, HI 96811</td>
<td>TDD: (866) 810-4379</td>
<td>250 South Hotel St., Suite 406</td>
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<tr>
<td>(808) 586-2790 or (808) 586-2790</td>
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<tr>
<td>Idaho Department of Insurance</td>
<td>Senior Health Insurance Benefits Advisors</td>
<td>Idaho Commission on Aging</td>
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<tr>
<td>700 West State Street</td>
<td>1-800-247-4422</td>
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<tr>
<td>P.O. Box 83720</td>
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<td>Boise, ID 83720-0043</td>
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| Illinois Division of Insurance  
320 West Washington St.  
Springfield, IL 62767-0001  
(217) 782-4515  
Fax: (217) 782-5020  
TDD: (217) 524-4872  
www.insurance.illinois.gov | Senior Health Insurance Program  
1-800-548-9034  
(217) 782-0004  
Fax: (217) 557-8457  
TDD: (217) 524-4872 | Illinois Department on Aging  
One Natural Resources Way, Suite 100  
Springfield, IL 62701-1271  
(217) 785-3356  
Fax: (217) 785-4477 |
| Indiana Department of Insurance  
311 W. Washington Street, Suite 300  
Indianapolis, IN 46204  
(317) 232-2385  
Fax: (317) 232-5251  
www.in.gov/doi | State Health Insurance Assistance Program  
1-800-452-4800  
(765) 608-2318  
Fax: (765) 608-2322  
TDD: (866) 846-0139 | Family and Social Services Administration  
Division of Aging  
402 W. Washington St.  
P.O. Box 7083  
Indianapolis, IN 46207-7083  
1-888-673-0002  
Fax: (317) 232-7867 or (317) 233-2182 |
| Iowa Division of Insurance  
601 Locust Street  
Des Moines, IA 50309  
(515) 281-5705  
877-955-1212  
Fax: (515) 281-3059  
www.iid.state.ia.us | Senior Health Insurance Information Program  
1-800-351-4664  
In State Only  
(515) 281-5705  
Fax: (515) 281-3059  
TTD 1-800-735-2942 | Iowa Department on Aging  
Jessie M. Parker Building  
510 East 12th St., Suite 2  
Des Moines, IA 50309-9025  
(515) 725-3333  
1-800-532-3213  
TTY: (515) 725-3333 |
| Kansas Department of Insurance  
420 S.W., 9th Street  
Topeka, KS 66612-1678  
(785) 296-3071  
Fax: (785) 296-7805  
www.ksinsurance.org | Senior Health Insurance Counseling for Kansas  
1-800-860-5260  
(316) 337-7386  
Fax: (785) 296-0256 | Kansas Department on Aging  
New England Building  
503 South Kansas Avenue  
Topeka, KS 66603-3404  
(785) 296-4986  
1-800-860-5260  
Fax: (785) 296-0256  
TTY: (785) 291-3167 |
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<th>INSURANCE DEPARTMENTS</th>
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<tr>
<td>Kentucky Department of Insurance P.O. Box 517 215 West Main Street Frankfort, KY 40601 (502) 564-3630 Fax: (502) 564-6090 <a href="http://insurance.ky.gov">http://insurance.ky.gov</a></td>
<td>State Health Insurance Assistance Program 1-877-293-7447 (502) 564-6930 Fax: (502) 564-4595 TDD: 1-888-642-1137</td>
<td>Kentucky Office of Aging Services Cabinet for Health Services 275 East Main Street, 3E-E Frankfort, KY 40621 (502) 564-6930 Fax: (502) 564-4595</td>
</tr>
<tr>
<td>Louisiana Department of Insurance P.O. Box 94214 Baton Rouge, LA 70804 (225) 342-5900 800-259-5300 Fax: (225) 342-5711 <a href="http://www.ldi.la.gov">www.ldi.la.gov</a></td>
<td>Senior Health Insurance Information Program Both In State Only 1-800-259-5300 (225) 342-5301 Fax: (225) 342-5711</td>
<td>Governor’s Office of Elderly Affairs P.O. Box 61 Baton Rouge, LA 70821 (225) 342-7100 Fax: (225) 342-7133</td>
</tr>
<tr>
<td>Maine Bureau of Insurance Dept. of Professional &amp; Financial Reg. #34 State House Station Augusta, ME 04333-0034 (207) 624-8475 800-300-5000 Fax: (207) 624-8599 <a href="http://www.maine.gov">http://www.maine.gov</a></td>
<td>Maine State Health Insurance Assistance Program In State Only 1-877-353-3771 Fax: (207) 287-9229 TDD: 1-800-606-0215</td>
<td>Maine Bureau of Elder &amp; Adult Services 11 State House Station 32 Blossom Lane Augusta, Maine 04333 (207) 287-9200 Fax: (207) 287-9229</td>
</tr>
<tr>
<td>Maryland Insurance Administration 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 (410) 468-2000 Fax: (410) 468-2020 <a href="http://www.mdinsurance.state.md.us">www.mdinsurance.state.md.us</a></td>
<td>Senior Health Insurance Assistance Program Both in State Only 1-800-243-3425 (410) 767-1100 Fax: (410) 333-7943 TDD: 1-800-637-4113</td>
<td>Maryland Department of Aging State Office Building, Room 1007 301 West Preston Street Baltimore, MD 21201 (410) 767-1100 Fax: (410) 333-7943</td>
</tr>
<tr>
<td>Division of Insurance Commonwealth of Massachusetts 1000 Washington St., Suite 810 Boston, MA 02118-6200 (617) 521-7794 or (617) 521-7794 Fax: (617) 753-6830 <a href="http://www.mass.gov/doi">www.mass.gov/doi</a></td>
<td>Serving Health Information Needs of Elders 1-800-AGE-INFO (617) 727-7750 Fax: (617) 727-9368</td>
<td>Massachusetts Executive Office of Elder Affairs One Ashburton Place, 5th floor Boston, MA 02108 (617) 727-7750 or 800-243-4636 Fax: (617) 727-9368</td>
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| Office of Financial and Insurance Services  
State of Michigan  
P.O. Box 30220  
Lansing, MI 48909-7720  
(517) 373-0220  
877-999-6442  
Fax: (517) 335-4978  
[www.michigan.gov/ofir](http://www.michigan.gov/ofir)  | MMAP, Inc.  
1-800-803-7174  
(517) 886-0899  
Fax: (517) 886-1305  | Michigan Offices of Services to the Aging  
P.O. Box 30676  
Lansing, MI 48909  
(517) 373-8230  
Fax: (517) 373-4092  |
| Minnesota Dept. of Commerce  
85 7th Place East, Suite 500  
St. Paul, MN 55101-2198  
(651) 296-6025  
Fax: (651) 297-1959  
[www.state.mn.us](http://www.state.mn.us)  | Minnesota State Health Insurance Assistance Program/Senior LinkAge Line  
1-800-333-2433  
Fax: (651) 431-7415  | Minnesota Board on Aging  
Aging and Adult Services Division  
P.O. Box 64976  
St. Paul, MN 55164-0976  
(651) 431-2500  
Fax: (651) 431-7453  |
| Mississippi Insurance Department  
1001 Woolfolk State Office Building  
501 N. West St.  
P.O. Box 79  
Jackson, MS 39205-0079  
(601) 359-3569  
Fax: (601) 359-1077  
[www.mid.state.ms.us](http://www.mid.state.ms.us)  | MS State Health Insurance Assistance Program  
In State Only  
1-800-948-3090  
(601) 359-4956  
Fax: (601) 359-9664  | Mississippi Council on Aging  
Division of Aging & Adult Services  
750 N. State Street  
Jackson, MS 39202  
(601) 359-4929  
800-948-3090  |
| Missouri Department of Insurance  
301 West High Street, Suite 530  
Jefferson City, MO 65101  
(573) 751-4126  
1-800-726-7390  
Fax: (573) 526-6075  
[www.insurance.mo.gov](http://www.insurance.mo.gov)  | Missouri CLAIM  
(573) 817-8320  
In State Only  
1-800-390-3330  
Fax: (573) 817-8341  | Missouri Department of Health and Senior Services  
912 Wildwood  
P.O. Box 570  
Jefferson City, MO 65102  
(573) 751-6400  
Fax: (573) 751-6010  |
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| Montana Department of Insurance  
840 Helena Avenue  
Helena, MT 59601  
(406) 444-2040  
Fax: (406) 444-3497  
www.csi.mt.gov | Montana State Health Insurance Assistance Program  
1-800-551-3191  
Fax: (406) 444-7743  
TDD: (406) 444-2590 | Montana Office on Aging  
Senior Long Term Care Division  
Department of Public Health and Human Services  
P.O. Box 4210  
Helena, MT 59604  
1-800-332-2272  
Fax: (406) 444-7743 |
| Nebraska Department of Insurance  
P.O. Box 82089  
Terminal Building, Suite 400  
941 'O' Street  
Lincoln, NE 68508  
(402) 471-2201  
877-564-7323  
Fax: (402) 471-4610  
www.doi.ne.gov | Nebraska Senior Health Insurance Information Program  
(402) 471-2201  
In State Only  
1-800-234-7119  
Fax: (402) 471-6559  
TDD: 1-800-833-7352 | Nebraska Division of Aging and Disability Services  
P.O. Box 95026  
301 Centennial Mall-South  
Lincoln, NE 68508  
(402) 471-4624  
Fax: (402) 471-4619 |
| Nevada Division of Insurance  
1818 E. College Pkwy., Suite 103  
Carson City, NV 89706  
(775) 687-0700  
888-872-3234  
Fax: (775) 687-0787  
www.doi.nv.gov | Nevada State Health Insurance Assistance Program  
1-800-307-4444  
(702) 486-3478  
Fax: (702) 486-0865 | Nevada Division For Aging Services  
Department of Human Resources  
3416 Goni Road, Building, D-132  
Carson City, NV 89706  
(775) 687-4210  
Fax: (775) 687-0574 |
| New Hampshire Insurance Department  
21 South Fruit Street, Suite 14  
Concord, NH 03301  
(603) 271-2261  
800-852-3416  
Fax: (603) 271-1406  
www.nh.gov/insurance | New Hampshire SHIP-ServiceLink Resource Center  
(866)-634-9412  
(603) 271-4394  
Fax: (603) 271-4643  
TDD: 1-800-735-2964 | New Hampshire Division of Elderly & Adult Services  
State Office Park South  
Brown Building  
129 Pleasant St.  
Concord, NH 03301-3857  
(603) 271-4375  
Fax: (603) 271-5574 |
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<td>New Jersey Department of Insurance</td>
<td>New Jersey State Health Insurance Assistance Program</td>
<td>New Jersey Division of Aging and Community Services</td>
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<tr>
<td>20 West State Street</td>
<td>1-800-792-8820</td>
<td>Department of Health &amp; Senior Services</td>
</tr>
<tr>
<td>P.O. Box 325</td>
<td>(609) 292-1447</td>
<td>P.O. Box 812</td>
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<tr>
<td>Trenton, NJ 08625</td>
<td>Fax: (609) 943-4669</td>
<td>Trenton, NJ 08625-0812</td>
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<tr>
<td>(609) 292-7272</td>
<td></td>
<td>(609) 943-3437</td>
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<tr>
<td>1-800-446-7467</td>
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<td>800-792-8820</td>
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<tr>
<td>Fax: (609) 984-5273</td>
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<td><a href="http://www.state.nj.us/dobi">www.state.nj.us/dobi</a></td>
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<tr>
<td>New Mexico Public Regulation Commission</td>
<td>New Mexico ARDC/SHIP</td>
<td>New Mexico Aging &amp; LTC Services Department</td>
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<tr>
<td>P.O. Box 1269</td>
<td>(505) 476-4781</td>
<td>2550 Cerrillos Road</td>
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<tr>
<td>Santa Fe, NM 87504-1269</td>
<td>In State Only</td>
<td>Santa Fe, NM 87505</td>
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<tr>
<td>(888) 427-5772</td>
<td>1-800-432-2080</td>
<td>(505) 476-4799</td>
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<tr>
<td><a href="http://www.nmprc.state.nm/id.htm">www.nmprc.state.nm/id.htm</a></td>
<td>Fax: (505) 476-4710</td>
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<td>New York State Insurance Department</td>
<td>New York Health Insurance Information Counseling and Assistance Program (HIICAP)</td>
<td>New York Office for the Aging</td>
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<tr>
<td>One State Street</td>
<td>1-800-701-0501</td>
<td>Two Empire State Plaza</td>
</tr>
<tr>
<td>New York, NY 10004</td>
<td>(518) 474-7012</td>
<td>Albany, NY 12223-1251</td>
</tr>
<tr>
<td>(212) 480-6400</td>
<td>Fax: (518) 486-2225</td>
<td>1-800-342-9871</td>
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<tr>
<td>Fax: (212) 709-3520</td>
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<tr>
<td><a href="http://www.ins.state.ny.us">www.ins.state.ny.us</a></td>
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<tr>
<td>North Carolina Dept. of Insurance</td>
<td>North Carolina Seniors’ Health Insurance Information Program</td>
<td>North Carolina Division of Aging</td>
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<tr>
<td>1201 Mail Service Center</td>
<td>1-800-443-9354</td>
<td>2101 Mail Service Center</td>
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<tr>
<td>Raleigh, NC 27699-1201</td>
<td>(919) 807-6900</td>
<td>Raleigh, NC 27699</td>
</tr>
<tr>
<td>(919) 807-6750</td>
<td>Fax: (919) 807-6901</td>
<td>(919) 855-3400</td>
</tr>
<tr>
<td>Fax: (919) 733-6495</td>
<td></td>
<td>Fax: (919) 733-0443</td>
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<td><a href="http://www.ncdoi.com">www.ncdoi.com</a></td>
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| North Dakota Dept. of Insurance  
600 E. Boulevard, 5th Floor  
Bismarck, ND 58505-0320  
(701) 328-2440  
Fax: (701) 328-4880  
www.nd.gov/ndins | North Dakota State Health Insurance Counseling  
(888) 575-6611  
(701) 328-2440  
TDD: 1-800-366-6888  
Fax: (701) 328-9610 | North Dakota Aging Services Division  
Department of Human Services  
1237 West Divide Ave., Suite 6  
Bismarck, ND 58501-0208  
(701) 328-4601  
Fax: (701) 328-8744 |
| Ohio Department of Insurance  
50 W. Town Street, 3rd Floor, Suite 300  
Columbus, OH 43215  
(614) 644-2658  
1-800-686-1526  
Fax: (614) 644-3744  
www.insurance.ohio.gov | Ohio Senior Health Insurance Information Program  
1-800-686-1578  
(614) 644-3458  
TDD (614) 644-3745  
Fax: (614) 752-0740 | Ohio Department of Aging  
50 West Broad Street, 3rd Fl.  
Columbus, OH 43215-3363  
(614) 644-3458  
866-266-4346  
Fax: (614) 752-0740 |
| Oklahoma Department of Insurance  
Five Corporate Plaza  
3625 N.W. 56th, Suite 100  
Oklahoma City, OK 73112-4511  
(405) 521-2828  
1-800-522-0071  
Fax: (405) 521-6635  
www.ok.gov/oid | Oklahoma Senior Health Insurance Counseling Program  
(405) 521-6628  
In State Only  
1-800-763-2828  
Fax: (405) 522-4492 | Oklahoma Dept. of Human Services  
Aging Services Division  
P.O. Box 25352  
2401 N.W. 23rd St., St. 40  
Oklahoma City, OK 73107  
(405) 521-2281  
Fax: (405) 521-2086 |
| Oregon Insurance Division  
P.O. Box 14480  
Salem, OR 97310-0405  
350 Winter Street NE  
Salem, OR 97301-3838  
(503) 947-7980  
Fax: (503) 378-4351  
www.insurance.oregon.gov | Oregon Senior Health Insurance Benefits Assistance  
(503) 947-7979  
In State Only  
1-800-722-4134  
Fax: (503) 947-7092  
TDD: 1-800-735-2900 | Oregon Senior & Disabled Services Division  
500 Summer St., N.E., E12  
Salem, OR 97310-1073  
(503) 945-5811  
TTY:503-282-8096  
Fax: 503-373-7823 |
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<td>Pennsylvania Insurance Dept. 1326 Strawberry Square Harrisburg, PA 17120 (717) 783-0442 Fax: (717) 772-1969 <a href="http://www.ins.state.pa.us">www.ins.state.pa.us</a></td>
<td>Pennsylvania APPRISE 1-800-783-7067 (717) 783-1550 Fax: (717) 772-3382</td>
<td>Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 (717) 783-1550 Fax: (717) 783-6842</td>
</tr>
<tr>
<td>Puerto Rico Dept. of Insurance B5 Calle Tabonuco Suite 216 PMB 356 Guaynabo, PR 00968-3029 (787) 304-8686 Fax: (787) 237-6082 <a href="http://www.ocs.gobierno.pr">www.ocs.gobierno.pr</a></td>
<td>Puerto Rico State Health Insurance Assistance Program 1-877-725-4300 (787) 721-6121 Fax: (787) 724-1152</td>
<td>Governors Office For Elderly Affairs P.O. Box 191179 San Juan, PR 00919-1179 (787) 721-6121 Fax: (787) 721-6510</td>
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<tr>
<td>Rhode Island Dept. of Business Regulation Insurance Division (401) 462-9520</td>
<td>Rhode Island State Health Insurance Program (401) 462-0501 (401) 462-0530 Fax: (401) 462-0503 TDD: (401) 462-0740</td>
<td>Department of Elderly Affairs 74 West Rd. Hazard Bldg., 2nd Floor Cranston, RI 02920 (401) 462-3000 Fax: (401) 462-0740</td>
</tr>
<tr>
<td>South Carolina Dept. of Insurance Capitol Center P.O. Box 100105 Columbia, SC 29202 1201 Maine Street, Suite 1000 Columbia, SC 29201 (803) 737-6160 Fax: 803-737-6205 <a href="http://www.doi.sc.gov">www.doi.sc.gov</a></td>
<td>South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1-800-868-9095 (803) 734-9900 Fax: (803) 734-9887</td>
<td>Dept. of Health and Human Services Bureau of Senior Services P.O. Box 8206 1801 Main Street Columbia, SC 29202-8206 (803) 898-2850 Fax: (803) 898-4515</td>
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<td>South Dakota Division of Insurance Dept. of Commerce and Regulation 445 East Capitol Avenue Pierre, SD 57501-3185 (605) 773-3563 Fax: 605-773-5369 <a href="http://www.dlr.sd.gov/insurance">www.dlr.sd.gov/insurance</a></td>
<td>South Dakota Senior Health Information &amp; Insurance Education 1-877-331-4834 (605) 224-3212 Fax: (605) 773-4085</td>
<td>Aging and Disability Resource Connections Department of Social Services 700 Governors Drive Pierre, SD 57501 (605) 773-3656 866-854-5465 Fax: (605) 773-4085</td>
</tr>
<tr>
<td>Tennessee Dept. of Commerce &amp; Ins. Davy Crockett Tower 500 James Robertson Parkway Nashville, TN 37243-0565 (615) 741-2241 <a href="http://www.state.tn.us">www.state.tn.us</a></td>
<td>Tennessee SHIP 1-877-801-0044 (615) 741-2056 TDD (615) 532-3893 Fax: (731) 741-3309</td>
<td>Tennessee Commission on Aging and Disability Andrew Jackson Building 500 Deaderick Street, No. 825 Nashville, TN 37243-0860 (615) 741-2056</td>
</tr>
<tr>
<td>Texas Department of Insurance 333 Guadalupe Street Austin, TX 78701 1-800 252-3439 Consumer Help Line (512) 463-6169 <a href="http://www.tdi.state.tx.us">www.tdi.state.tx.us</a></td>
<td>Texas Health Information Counseling and Advocacy Program (HICAP) 1-800-252-9240 (512) 438-4205 TDD: 1-800-735-2989 Fax: (512) 438-4374</td>
<td>Texas Department of Aging &amp; Disability Services P.O. Box 149030 Austin, TX 78714-9030 1-800-458-9858 (512) 438-3011</td>
</tr>
<tr>
<td>Utah Department of Insurance 3110 State Office Building Salt Lake City, UT 84114-1201 (801) 538-3800 800-439-3805 Fax: 801-538-3829 <a href="http://www.insurance.utah.gov">www.insurance.utah.gov</a></td>
<td>Utah Senior Health Insurance Information Program 1-800-541-7735 (801) 538-3910 Fax: (801) 538-4395</td>
<td>Utah Division of Aging &amp; Adult Services Department of Human Services 195 North 1950 West Salt Lake City, UT 84116 (801) 538-3910 Fax: (801) 538-4395</td>
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<tr>
<td>Vermont Division of Insurance</td>
<td>Vermont State Health Insurance Assistance Program</td>
<td>Vermont Department of Aging and Disabilities</td>
</tr>
<tr>
<td>Dept. of Banking, Ins. &amp; Securities</td>
<td>1-800-642-5119</td>
<td>103 South Main Street</td>
</tr>
<tr>
<td>89 Main Street</td>
<td>(802)-748-5182</td>
<td>Waterbury, VT 05671-1601</td>
</tr>
<tr>
<td>Montpelier, VT 05620-3101</td>
<td>Fax: (802) 748-6622</td>
<td>(802) 871-3065</td>
</tr>
<tr>
<td>(802) 828-3301</td>
<td></td>
<td>Fax: 802-871-3052</td>
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<tr>
<td>800-964-1784</td>
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<td>TTY: 802-241-3557</td>
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<tr>
<td><a href="http://www.dfr.vermont.gov/insurance">www.dfr.vermont.gov/insurance</a></td>
<td></td>
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<tr>
<td>Office of the Lieutenant Governor</td>
<td>Virgin Islands State Health Insurance Assistance Program</td>
<td>Senior Citizen Affairs</td>
</tr>
<tr>
<td>5049 Kongens Gade</td>
<td>(340) 714-4354</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>St. Thomas, Virgin Islands 00802</td>
<td>Fax: (340) 772-2636</td>
<td>3011 Golden Rock Christiansted</td>
</tr>
<tr>
<td>(340) 774-7166</td>
<td></td>
<td>St. Croix, VI 00820</td>
</tr>
<tr>
<td>Fax: (340) 774-9458 or Ltg.gov.vi</td>
<td></td>
<td>(340) 773-2323</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: (340) 772-9849</td>
</tr>
<tr>
<td>State Corporation Commission</td>
<td>Virginia Insurance Counseling and Assistance (VICAP)</td>
<td>Virginia Department For The Aging</td>
</tr>
<tr>
<td>Bureau of Insurance</td>
<td>1-800-552-3402</td>
<td>1610 Forest Avenue</td>
</tr>
<tr>
<td>Commonwealth of Virginia</td>
<td>(804) 662-9333</td>
<td>Preston Building, Suite 100</td>
</tr>
<tr>
<td>P.O. Box 1157</td>
<td>Fax: (804) 662-9354</td>
<td>Richmond, VA 23229</td>
</tr>
<tr>
<td>Richmond, VA 23218</td>
<td>TDD: 1-800-552-3402</td>
<td>(804) 662-9333</td>
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<tr>
<td>(804) 371-9741</td>
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<td>Fax: (804) 662-9354</td>
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<td>800-552-7945</td>
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<td>Fax: 804-371-9944</td>
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<tr>
<td>302 Sid Snyder Avenue SW</td>
<td>1-800-562-6900</td>
<td>Dept. of Social &amp; Health Services</td>
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<tr>
<td>Insurance Suite 200</td>
<td>(360) 725-710</td>
<td>Blake Office Park West</td>
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<tr>
<td>Olympia, WA. 98504-0255</td>
<td>1-800-562-6900</td>
<td>4450 10th Avenue SE</td>
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<td>(360) 725-710</td>
<td>(360) 725-7171</td>
<td>Lacey, WA 98503</td>
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<tr>
<td>1-800-562-6900</td>
<td>Fax: (360) 586-4103</td>
<td>(360) 725-2300</td>
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<td><a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a></td>
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<td>INSURANCE DEPARTMENTS</td>
<td>STATE HEALTH INSURANCE ASSISTANCE PROGRAMS</td>
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<td>West Virginia Dept. of Insurance</td>
<td>West Virginia State Health Insurance Assistance Program</td>
<td>West Virginia Bureau of Senior Services</td>
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<tr>
<td>P.O. Box 50540</td>
<td>1-877-987-4463</td>
<td>1900 Kanawha Blvd, East</td>
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<tr>
<td>Charleston, WV 25305-0540</td>
<td>(304) 558-3317</td>
<td>Charleston, WV 25305-0160</td>
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<td>(304) 558-3354</td>
<td>(304) 558-0004</td>
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<td>1-888-879-9842</td>
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<td>West Virginia Bureau of Senior Services</td>
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<td>Office of the Commissioner of Ins.</td>
<td>Wisconsin SHIP</td>
<td>Wisconsin Bureau of Aging &amp; LTC</td>
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<tr>
<td>State of Wisconsin</td>
<td>(608) 266-1865</td>
<td>Resources</td>
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<tr>
<td>P.O. Box 7873</td>
<td>800-242-1060</td>
<td>Dept. of Health and Family Services</td>
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<tr>
<td>125 South Webster Street</td>
<td>Fax: (608) 267-3203</td>
<td>1402 Pankratz St., Ste. 111</td>
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<tr>
<td>Madison, WI 53703-3474</td>
<td>TTY: 888-701-1251</td>
<td>Madison, WI 53704-4001</td>
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<td>(608) 266-3585</td>
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<td>800-815-0015</td>
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<td>Fax: (608) 266-9935</td>
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<td>Wyoming Department of Insurance</td>
<td>Wyoming State Health Insurance Information Program</td>
<td>Wyoming Aging Division</td>
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<tr>
<td>106 East 6th Avenue</td>
<td>1-800-856-4398</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Cheyenne, WY 82002-0440</td>
<td>Fax: (307) 777-2446</td>
<td>6101 Yellowstone Road, Room 259B</td>
</tr>
<tr>
<td>(307) 777-7401</td>
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<td>Cheyenne, WY 82002</td>
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<tr>
<td>Fax: (307) 777-2446</td>
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<td>(307) 777-7986 or 1-800-442-2766</td>
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<tr>
<td><a href="http://insurance.state.wy.us/">http://insurance.state.wy.us/</a></td>
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<td>Fax: (307) 777-5340</td>
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Report of the
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

The Property and Casualty Insurance (C) Committee met April 8, 2019. During this meeting, the Committee:

1. Adopted its March 28, 2019, minutes, which included the following action:
   a. Adopted its 2018 Fall National Meeting minutes.
   c. Appointed the Pet Insurance (C) Working Group.
   d. Heard an update on the status of the private passenger auto report.
   e. Heard a preview of the 2019 Spring National Meeting.

2. Adopted the following task force and working group reports:
   a. Casualty Actuarial and Statistical (C) Task Force
   b. Surplus Lines (C) Task Force
   c. Title Insurance (C) Task Force
   d. Workers’ Compensation (C) Task Force
   e. Advisory Organization Examination Oversight (C) Working Group
   f. Cannabis Insurance (C) Working Group
   g. Catastrophe Insurance (C) Working Group
   h. Climate Change and Global Warming (C) Working Group
   i. Lender-Placed Insurance Model Act (C) Working Group
   j. Terrorism Insurance Implementation (C) Working Group
   k. Transparency and Readability of Consumer Information (C) Working Group

3. Adopted revised 2019 charges including:
   a. Change the name of the Climate Change and Global Warming (C) Working Group to the Climate Risk and Resilience (C) Working Group with the following charges:
      i. Engage with the industry and stakeholders in the U.S. and abroad on climate related risk and resiliency issues.
      ii. Investigate and recommend measures to reduce risks of climate change related to catastrophic events.
      iii. Identify insurance and other financial mechanisms to protect infrastructure and reduce exposure to the public.
      iv. Identify sustainability, resilience and mitigation issues and solutions related to the insurance industry.
      v. Evaluate private-public partnerships to improve insurance market capacity related to catastrophe perils.
      vi. Investigate and receive information regarding the use of modeling by carriers and their reinsurers concerning climate risk.
      vii. Review the impact of climate change on insurers through presentations by interested parties.
      viii. Review innovative insurer solutions to climate risk, including new insurance products through presentations by interested parties.
   b. The following charges for the Pet Insurance (C) Working Group:
      i. Review *A Regulator’s Guide to Pet Insurance* and consider whether a model law or guideline is needed to establish appropriate regulatory standards for the pet insurance industry.
   c. Movement of the Advisory Organization Examination Oversight (C) Working Group and its charges to the Market Regulation and Consumer Affairs (D) Committee.

4. Adopted an extension for revisions to the proposed Real Property Lender-Placed Insurance Model Act.

5. Heard a presentation from David Maurstad of the Federal Emergency Management Agency (FEMA) on FEMA’s efforts to improve flood insurance uptake rates and mitigation efforts.

6. Heard a presentation from Laura Kane (NAIC) on the NAIC’s communications toolkit related to communicating flood risks and information to consumers.

7. Received a written report on 2018 private flood insurance data and decided to discuss additional data collection related to private flood insurance at a later date.
8. Heard an update from Greg Scott of the Global Alliance for Vehicle Data Access (GAVDA) on GAVDA members’ efforts to ensure that vehicle owners control data access.

9. Heard an update on Congressional activities related to autonomous vehicles.
GUIDELINE ON NONADMITTED ACCIDENT AND HEALTH COVERAGES

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Section 8. Licensing of Producers and Surplus Lines Brokers
Section 9. Requirements for Placement
Section 10. Premium Taxes and Reporting Requirements
Section 11. Home State Regulation

Section 1. Purpose

This guideline provides assistance to states updating laws and establishing procedures for allowing accident and health coverage to be procured in the nonadmitted market either independently or through surplus lines brokers. States considering any action to allow accident and health coverage placement with nonadmitted insurers should consider this guideline during a review of existing laws, regulations, and procedures, with particular attention to whether existing insurance laws, tax laws, or regulations expressly prohibit the export of accident and health coverage, contain restrictive definitions with a similar effect, or include substantive provisions that specifically refer in some manner to property and casualty insurance. Amending or interpreting some of these laws to permit placement of accident and health coverage while leaving other property and casualty-specific laws in place in their current form could result in conflicts or unintended consequences.

The types of accident and health coverage that some states are permitting in their nonadmitted market include, but are not limited to, the following: short term medical, international major medical, excess disability, high-risk disability and other similar coverages. It should be noted that comprehensive health plans, Medicare supplement insurance and standard disability insurance coverage are not suitable for the nonadmitted market.

Section 2. Background

The term “nonadmitted insurance” refers to coverage that is not found in the admitted insurance market and can lawfully be sold on a nonadmitted basis. Nonadmitted insurance coverage is typically utilized to insure against a loss that exceeds the maximum limits or benefits found in coverages available within the admitted market.

While nonadmitted insurance coverages are traditionally found within the property and casualty market, there is an increasing need to supplement the admitted market for certain types of accident and health coverages. The federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), passed as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act, applies only to property and casualty insurance.

Nonadmitted accident and health coverage can be utilized to fulfill the risk mitigation needs of certain potential insureds. However, as discussed in more detail in Sections 4 and 6, the greater flexibility found in the nonadmitted market involves tradeoffs with less stringent consumer protections. The following background highlights certain coverages and identifies why the coverage may not be available from admitted insurers:

- There are high-income individuals who cannot procure sufficient disability income coverage in the market as admitted carriers may only offer maximum limits that would replace a lower percentage of these individuals’ income than they might require to sustain their needs in case of a disability.

- Individuals in high-risk occupations, such as sports, entertainment, and aviation, are often not eligible for adequate
disability coverage in the admitted market.

- International major medical insurance is insurance coverage provided to individuals while outside of their home country. This is a specialty line that might have limited or no availability in the admitted market. Comprehensive health plans issued in the U.S. often restrict or exclude coverage for health care obtained while the covered U.S. resident is visiting another country, for a short or long duration. Also, a foreign national visiting the U.S. may not be eligible for medical coverage from U.S. insurers. In either case, an individual’s medical insurance from his or her home jurisdiction may not provide coverage in other countries.

- International travel insurance is designed to provide coverage to U.S. residents traveling abroad where domestic insurers do not provide coverage. It should be noted that this insurance may be subject to coverage requirements of the laws of the jurisdiction where it is effective (i.e., destination country) that may differ from the U.S. These policies contemplate the unique risks involved in travel and can be tailored to fit a particular destination or activity: (e.g., a traveler backpacking in several European countries or a student participating in a study abroad program). In addition, this coverage may be purchased to satisfy insurance requirements for entry into a destination country or to qualify for a student visa.

States have already established laws and processes to which carriers and brokers of surplus lines insurance must adhere. There are jurisdictions that have created a list of types of coverages that may be exported to the nonadmitted market, or that specifically prohibit certain coverage types from being exported to a surplus lines insurer. Additional requirements also apply, such as the obligation to exercise due diligence before a surplus lines broker can place coverage, which may be subject to specific procedures in some states.

### Section 3. Definition

Some states have enacted laws that recognize the types of insurance that are eligible for placement with nonadmitted insurers. The NAIC *Nonadmitted Insurance Model Act* (#870), states in part:

> “Surplus lines insurance means any property and casualty insurance in this state on properties, risks or exposures, located or to be performed in this state, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance…."

A state’s definition of “Surplus Lines Insurance” or “Nonadmitted Insurance” will often specify the types of insurance permitted by law. A state could elect to expand these definitions to include accident and health coverages. For states that identify specific coverages within their definitions of surplus lines or nonadmitted insurance, this list could be revised to describe the types of accident and health coverage the state has chosen to permit or prohibit.

### Section 4. Consumer Protection

The admitted market is closely regulated and features strong, prescriptive consumer protection measures. States should take into consideration the differences between these regulatory philosophies when deciding which types of accident and health coverages may be offered in the nonadmitted market. Steps to ensure consumer protection can be implemented at a statutory level (slowly expanding a restrictive list of allowed coverage in nonadmitted markets) or at a consumer level by requiring disclosures that the coverage is issued by a nonadmitted insurer and what that means for the consumer. These disclosures are particularly important for types of coverage that might be marketed as alternatives to comprehensive health plans, where consumers may expect a high level of consumer protection. This is the tradeoff states should address if they are considering allowing coverage such as short-term medical plans, limited-benefit medical plans, or stop-loss insurance to be offered in the nonadmitted market.

### Section 5. Eligibility Criteria for Nonadmitted Insurers

States should review their laws and regulations that set forth eligibility requirements for nonadmitted insurers domiciled in United States jurisdictions to ascertain whether the state’s thresholds are adequate for accident and health coverage. Although nonadmitted alien insurers may be eligible on an individual state basis, the NRRA mandates that inclusion on the NAIC’s *Quarterly Listing of Alien Insurers* provides eligibility across all jurisdictions for nonadmitted property and casualty insurance. Many states have incorporated this provision into state law. States that maintain an eligibility listing of nonadmitted insurers should consider whether these procedures should be modified to address accident and health insurers.
Section 6. Lines Open for Export; Export Lists

In some states, current law provides broad authority for the Commissioner to designate a particular type of coverage to be eligible for export without compliance with certain conditions, such as satisfying a diligent search requirement. In some states, these laws could permit accident and health coverages to be included on the export list. But other states have explicit prohibitions against exporting accident and health coverage or other provisions that might operate to limit the scope of their export list laws.

Section 7. Exemption from Filing Rates and Forms; Policy Language

Existing state laws establish a regulatory system for transacting nonadmitted insurance. Fundamental to the nature of this business is the exemption from rate and form filings for all types of nonadmitted insurance. Many states have specific provisions that are required or prohibited in some or all nonadmitted policies, but the mechanism for enforcing these requirements is not through a mandatory rate and form review procedure. Some types of accident and health insurance, by contrast, are subject to specific rate and form filing requirements, in some cases mandated by federal laws or regulations. States need to determine how to accommodate these requirements if they are considering allowing these types of coverage to be offered in the nonadmitted market.

Section 8. Licensing of Producers and Surplus Lines Brokers

States need to assess licensing requirements for producers and surplus lines brokers for placement of accident and health coverage. Existing laws might specifically require property and casualty authority as a necessary prerequisite for surplus lines authority.

Section 9. Requirements for Placement

States should review any statutory and regulatory requirements for a diligent search in the admitted market by a producer or surplus lines broker for the type of coverage the customer has requested. Some states may have further restrictions on eligibility for export, such as limitations on the amount of insurance that is procurable over the amount available from admitted insurers. Furthermore, some states do not allow export for the purpose of securing certain advantages, such as lower premium rates or more favorable terms of the insurance policy.

Section 10. Premium Taxes and Reporting Requirements

States should review their existing laws regarding nonadmitted insurance premium tax and consider applying the same tax rate for the calculation and reporting of premium taxes for all nonadmitted insurance. Otherwise, states should amend those laws with specific provisions for the calculation of premium tax for accident and health insurance.

State laws and procedures for consumer notices, reporting policy transactions, premium tax payments, filing affidavits, reports, and other required documents could be expanded to apply to accident and health coverages.

Section 11. Home State Regulation

The NRRA enacts a federal definition of “home state” and provides that the placement of nonadmitted insurance is subject solely to the statutory and regulatory requirements of the insured’s home state. This provides for a consistent method of determining jurisdiction for the regulation of nonadmitted insurance. Many states have incorporated this framework into state law. States should consider applying it to nonadmitted accident and health coverages.
PROJECT HISTORY
NONADMITTED ACCIDENT AND HEALTH COVERAGE GUIDELINE

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

This guideline will provide assistance to states updating laws and establishing procedures for allowing accident and health (A&H) coverage to be procured in the nonadmitted market either independently or through surplus lines brokers. Due to current market demands, the types of A&H coverage that some states are permitting in their nonadmitted market include, but are not limited to, the following: short-term medical, international major medical, excess disability, high-risk disability and other similar coverages. States considering any action to allow A&H coverage placement with nonadmitted insurers should consider this guideline during a review of existing laws, regulations and procedures.

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

The Surplus Lines (C) Task Force formed the Nonadmitted A&H Drafting Group, which consisted of Colorado, Louisiana, Maine, Maryland and Wyoming.

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

The Surplus Lines (C) Task Force charge indicates that the group is to, “Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.”

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

The guideline was drafted by the members of the Drafting Group through a series of conference calls and a webinar from October 2017 through September 2018. Each member of the Drafting Group was responsible for research and drafting responsibilities. Following an initial draft of the guideline, the Drafting Group members each proofed the document, and a subsequent conference call was held to discuss modifications.

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

The Guideline was discussed within an open forum during the Surplus Lines (C) Task Force meetings during the 2017 Summer National Meeting and 2017 Fall National Meeting, during an open conference call in February 2018, during the 2018 Spring National Meeting and 2018 Summer National Meeting, and during a conference call in December 2018. During this time period, there were two open exposures of the guideline.

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

Although comments were addressed from several state insurance regulators and interested parties, there were no issues that would rise to the level of “significant.” All comments received during the exposure periods were addressed, and where appropriate, textual revisions were made to the guideline.

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

Not applicable.
The Market Regulation and Consumer Affairs (D) Committee met April 8, 2019. During this meeting, the Committee:

1. Adopted its Feb. 8 minutes, which included the following action:
   a. Adopted its 2018 Fall National Meeting minutes.
   b. Adopted a motion to move the filing deadline for the 2019 Health Market Conduct Annual Statement (MCAS) data from May 31 to June 30.
   c. Adopted June 30, 2020 as the filing deadline for the disability income MCAS.
   d. Discussed its 2019 charges and working groups.

2. Adopted the Mental Health Parity Guidance and Data-Collection Tool for Mental Health Parity Analysis to be incorporated into the Market Regulation Handbook to provide guidance to examiners for the examination of mental health parity issues.

3. Adopted revised 2019 charges. A new charge to review the Best Practices and Guidelines for Consumer Information Disclosures was added in response to a request from the NAIC consumer representatives to consider guidelines for consumer information disclosures. The Advisory Organization Examination Oversight (C) Working Group and its charges were moved to the Market Regulation and Consumer Affairs (D) Committee pending approval of the Property and Casualty Insurance (C) Committee.

4. Adopted the reports of its task forces and working groups: the Antifraud (D) Task Force; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Standards (D) Working Group; the Market Actions (D) Working Group; and the Market Analysis Procedures (D) Working Group.

5. Discussed next steps to update the Best Practices and Guidelines for Consumer Information Disclosures document, which was originally adopted in October 2012. The document is exposed for a public comment period ending July 1.
The Financial Condition (E) Committee met April 8, 2019. During this meeting, the Committee:

1. Adopted its Feb. 19, 2019, and 2018 Fall National Meeting minutes. During its Feb. 19 meeting, the Committee took the following action:
   a. Adopted proposed recommendations from the Reinsurance Leadership Group regarding modifying the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786).

2. Adopted the reports of the following task forces and working groups: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Long-Term Care Insurance (B/E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group; National Treatment and Coordination (E) Working Group; Restructuring Mechanisms (E) Working Group; Risk-Focused Surveillance (E) Working Group; and Variable Annuities Issues (E) Working Group.
The Financial Regulation Standards and Accreditation (F) Committee met April 5, 2019. The meeting was held in regulator-to-regulator session pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee discussed state-specific accreditation issues and voted to award continued accreditation to the insurance departments of Arizona, California and Florida.

The Financial Regulation Standards and Accreditation (F) Committee met April 6, 2019. During this meeting, the Committee:

1. Adopted its 2018 Fall National Meeting minutes.

2. Adopted, immediately by reference, revisions made during 2018 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual) that were deemed insignificant.

3. Exposed the proposed revisions to the Part A: Laws and Regulations Preamble for a 30-day public comment period ending May 8, 2019. The proposed revisions include fraternal benefit societies in regard to principle-based reserving (PBR) specific to the Liabilities and Reserves standard.

4. Exposed the proposed revisions to Part D: Organization, Licensing and Change of Control of Domestic Insurers for a 30-day public comment period ending May 8, 2019. The proposed revisions consist of updates to reflect current practices, expansion of the standards to include redomestications and inclusion of Part D in the review team’s recommendation, with the result that the outcome can affect a state’s accredited status.
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE
Saturday, April 6, 2019
3:30 – 5:00 p.m.

Meeting Summary Report

The International Insurance Relations (G) Committee met April 6, 2019. During this meeting, the Committee:

1. Adopted its Jan. 24, 2019; Jan. 3, 2019; Dec. 13, 2018; and 2018 Fall National Meeting minutes. During the Jan. 24, 2019; Jan. 3, 2019; and Dec. 13, 2018, meetings, the Committee took the following action:
   a. Approved submission of NAIC comments on the International Association of Insurance Supervisors (IAIS) draft holistic framework to assess and mitigate systemic risk in the insurance sector.
   b. Approved submission of NAIC comments on the IAIS draft Application Paper on Recovery Planning.
   c. Approved submission of NAIC comments on the IAIS draft Application Paper on Proactive Supervision of Corporate Governance.

2. Reported that it met March 22 and Feb. 12 in regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

3. Adopted the report of the ComFrame Development and Analysis (G) Working Group. The Working Group met April 6 in regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss and provide input on issues related to implementation of the IAIS Common Framework for Supervision of Internationally Active Insurance Groups (ComFrame) and the international capital standard (ICS) monitoring process.

4. Discussed with interested parties key 2019 projects of the IAIS, focusing on the ICS and the holistic framework on systemic risk. Committee members and interested parties discussed various aspects of these projects, including concerns on design elements, potential impacts and views on ongoing development.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Adoption of the new Insurance Data Security Model Law (#668)—This model was adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. Three states have enacted this model.

Life Insurance and Annuities (A) Committee

- Amendments to the Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contracts Model Regulation (#200)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. One state has enacted these revisions to the model.

- Amendments to the Life Insurance Disclosure Model Regulation (#580)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2018 Summer National Meeting. Three states have enacted this model.

- Amendments to the Standard Nonforfeiture Law for Individual Deferred Annuities (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Summer National Meeting. Two states have enacted these revisions to the model.

Health Insurance and Managed Care (B) Committee

- Amendments to the Health Insurance Reserves Model Regulation (#10) (Cancer Expense Table)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Three states have enacted these revisions to the model.

- Amendments to the Health Carrier Prescription Drug Benefit Management Model Act (#22)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2018 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Long-Term Care Insurance Model Act (#640)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Long-Term Care Insurance Model Regulation (#641)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2014 Summer National Meeting. NAIC staff are not aware of any state activity regarding this model. Three states have enacted these revisions to the model.

- Adoption of the Limited Long-Term Care Insurance Model Act (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Limited Long-Term Care Insurance Model Regulation (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)—These revisions were for consistency with the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and were adopted by the Executive (EX) Committee and Plenary at the 2016 Summer National Meeting. Thirteen states have enacted these revisions to the model.
Property and Casualty Insurance (C) Committee

- Adoption of the *Travel Insurance Model Act* (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Three states have enacted this model.

Market Regulation and Consumer Affairs (D) Committee

- Amendments to the *Privacy of Consumer Financial and Health Information Regulation* (#672)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Seven states have enacted these revisions to the model.

Financial Condition (E) Committee

- Amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. Thirteen states have enacted elements of this model.

- Amendments to the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. Four states have enacted this model.