SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force, Sept. 22, 2009, Minutes
Adopted 2010 Senior Issues Task Force Charges (Attachment One)
Long-Term Care Partnership Data Summary (Attachment Two)

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Senior Issues (B) Task Force
Washington, DC
September 22, 2009

The Senior Issues (B) Task Force met in Washington, DC, Sept. 22, 2009. The following Task Force members participated: Kevin McCarty, Chair, represented by Mary Beth Senkewicz (FL), Sean Dilweg, Vice Chair, represented by Guenther Ruch (WI); Jim L. Ridling represented by Elizabeth Bookwalter and Steve Ostlund (AL); Jay Bradford represented by Dan Honey (AR); Steve Poizner represented by Denise Yuponce (CA); Karen Weldin Stewart represented by Linda Nemes (DE); J.P. Schmidt represented by Paul Yuen (HI); Michael T. McRaith represented by Bill McAndrew (IL); Carol Cutter (IN); Sandy Praeger represented by Linda Sheppard (KS); Glenn Wilson represented by Brian Pennington (MN); John Huff (MO); Mike Chaney represented by John Hornbach (MS); Ann Frohman represented by Martin Swanson and John Rink (NE); Scott J. Kipper represented by Kimberly Everett (NV); James J. Wrynn represented by Jack Chaskey (NY); Mary Jo Hudson represented by Sue Real (OH); Kim Holland represented by Marc Young (OK); Teresa Miller represented by Gayle Woods (OR); Joel Ario represented by Shelley Bain (PA); Ramón Cruz-Colón represented by Ana Maria Lopez Erquicia and Yvette Domenech Ailes (PR); Merle D. Scheiber represented by Randy Moses (SD); Mike Geeslin represented by Ana Smith-Daley (TX); Kent Michie represented by Tanji Northrup (UT); Alfred W. Gross represented by Jackie Cunningham (VA); Paulette Thabault represented by Christine Oliver and Rebecca Heintz (VT); and Jane L. Cline represented by Tim Murphy (WV).

1. Task Force Charges

a. 2010 Charges

The Task Force reviewed proposed charges for 2010 and agreed to delete a charge calling for the amendment of the NAIC Long-Term Care Insurance Model Act (#640) and Regulation (#641) for independent external review for certain claims denials, as this work has now been completed. The Task Force adopted its 2010 charges as revised, with Indiana, South Dakota and Florida as sponsors of the new charges (Attachment One).

b. New or Innovative Benefits

The Task Force discussed ongoing charges relating to Medicare supplement new or innovative benefits. These charges — in accordance with revisions made to the Medicare Supplement Insurance Minimum Standards Model Act (#650) and its corresponding compliance manual — direct the Task Force to monitor and maintain a record of all state approvals of Medicare supplement new or innovative benefits. This information will be made available for use by regulators and others, and will be periodically reviewed to consider whether the benefits should be made part of standard plan designs in the model regulation. The Task Force agreed to take the steps necessary to create this record. The states are urged to notify Jane Sung (NAIC) if they approve a new or innovative benefit. The states are also urged to notify NAIC staff upon receipt of such filings, in accordance with state public records policies and/or laws.

2. Federal Issues

Brian Webb (NAIC) presented an update on federal legislation impacting issues of interest to the Task Force.

The health insurance reform legislation passed by the Energy and Commerce Committee in July 2009 included an amendment by U.S. Rep. Kathy Castor (D-FL) that would request the NAIC to develop uniform marketing standards for private Medicare plans – Medicare Advantage and Prescription Drug Plans. If a state adopts those standards, then the state will have the sole authority to enforce them. The amendment also calls on the NAIC to produce a study on the standardization and regulation of private Medicare plans and make recommendations to Congress.

The U.S. Senate Health, Education, Labor and Pensions (HELP) Committee's health insurance reform bill, which was adopted in July 2009, included the Community Living Assistance Services and Supports (CLASS) Act, legislation that was a long-time priority for former-Chairman Edward Kennedy (D-MA). The provisions would create a voluntary program for individuals to pay low monthly premiums into a federal trust fund that would cover non-medical, community-based assistance services for them when they become elderly or disabled.

The mark introduced by U.S. Senate Finance Committee Chairman Max Baucus (D-MT), which is currently under consideration in the Committee, includes several provisions impacting senior programs. The mark would ask the NAIC to modify Medigap plans C and F to include cost-sharing. It expands the tax benefits of long-term care plans in employer

cafeteria plans and a "sense of the Senate" that the U.S. Congress should act on long-term care insurance improvement legislation by the end of the year.

In addition, U.S. Sen. Ron Wyden (D-OR) has submitted an amendment which mirrors legislation introduced by U.S. Sen. Herb Kohl (D-WI), S. 1177, as amended following discussions with the NAIC, the Wisconsin Insurance Department and the grandfathered Medicaid Long-Term Care Partnership states (California, Connecticut, Indiana and New York). The amendment (and the revised bill) would ask the NAIC to conduct a survey of the long-term care market every 5 years and develop standards for disclosures and uniform definitions; create a "Long-Term Care Compare" program that will help consumers compare insurance options; incorporate the consumer protections adopted by the NAIC in 2000 and 2006, as well as institute a process whereby future protections adopted by the NAIC may be added without congressional action; and adds new requirements to the Medicaid Long-Term Care Partnership program, including training, rate stability and reciprocity in the grandfathered states.

Mr. Webb noted that many more amendments that could impact senior programs will be offered and could be added to any of the bills.

3. Long Term Care Insurance Issues

a. Report of the Appendix E Subgroup

Mr. Moses, chair of the Appendix E Subgroup, reviewed proposed revisions to the Long-Term Care Insurance Model Regulation (#641). As a result of a data call in 2008, it was determined that companies were using different definitions for terms in reporting data on the Appendix E – Claims Denial Reporting Form. The Subgroup determined that an equal proportion of companies were using one of two different methodologies to report claims-denial information: per claimant and per transaction. The companies that count per claimant count each individual who makes one or a series of claim requests, whereas companies that count per transaction count each claim payment request. The industry reported that it would be difficult for companies to change methodologies and that there was no one dominant method being used; therefore, the Subgroup proposed revisions to the form that would specify reporting of which method was used.

The Subgroup also recommended two other changes to make Appendix E more useful to regulators, including the reporting of the total number of in-force policies, as well as the deletion of a drafting note after Section 15F of the model regulation that limits the definition of claim denied used in this form to reporting purposes as provided in the federal Health Insurance Portability and Accountability Act (HIPAA).

Mr. Ruch moved, and Ms. Bain seconded, to adopt the Subgroup revisions and expose the draft for public comment for a 30-day period. The motion passed. It is anticipated that these revisions will be considered by the Health Insurance and Managed Care Committee on a conference call prior to the Winter National Meeting.

b. Long-Term Care Partnership Program Update

Hunter McKay (U.S. Department of Health and Human Services—HHS) provided an update on the Partnership program. Aug. 1 marked the first deadline for registry data reporting pursuant to HIPAA, and the first deadline for claims data is Nov. 1. There are currently Partnership policies available for sale in 31 states (Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin and Wyoming). Three states (Arizona, Iowa and New Hampshire) have approved state plan amendments, and there is a state plan amendment pending (Maine). The states also are participating in a long-term care awareness campaign to alert seniors to the availability of Partnership policies.

Several implementation issues have arisen that will likely need to be addressed. There is no uniform approach for group partnerships or multi-state filings. Also, as companies offer policies with tiered inflation protection, state regulations have not always addressed the approaching cliffs in the legislation. Also, there is also no uniform notice provision in place to remind policyholders that they originally purchased policies with asset protection. Mr. Ruch noted that this is an issue that should be addressed, particularly as more Partnership policies are purchased at younger ages and policyholders may not remember several decades later the details of the asset protection. Mr. McKay noted that the grandfathered Partnership states require quarterly notice through the life of the policy, and that other ideas have been suggested as well.

There are now 26 Deficit Reduction Act (DRA) Partnership states participating in reciprocity agreements (Alabama, Arkansas, Colorado, Florida, Georgia, Idaho, Kansas, Kentucky, Maryland, Minnesota, Missouri, Nebraska, North Dakota,

Nevada, New Jersey, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas and Virginia). Of the four grandfathered Partnership states, two are participating (Connecticut and Indiana) and two are not (California and New York).

Files from the initial Aug. 1 data reporting submission are available on the Partnership Web site. The states can also build their own registry and contract with HHS. Data from the initial reporting was received from 27 insurers, with more than 130,000 policies sold. Sixty-five percent of these policies are new sales rather than exchanges. Sixty-five percent of Partnership policies in-force are from Florida, Minnesota, Virginia and Wisconsin. The average lifetime maximum for these policies is $252,000 and the average daily benefit amount is $168. Eight-six percent of buyers age 61 and younger have 5% compound inflation protection. The average premium for all insureds is $1,861. A summary of the reporting was provided to the Task Force (Attachment Two).

Several issues have arisen as a result of the reporting. For example, some insurers are calling policies Partnership policies even though they are not compliant with the DRA, particularly as it relates to inflation-protection features. HHS is trying to determine how best to address this issue and will likely verify that these are not just data-reporting errors and then will provide this information to the states to address. Mr. Ruch noted that if these policies do not comply with the DRA, then they likely do not comply with state law.

The total population of covered lives with Partnership policies continues to grow. There are 130,000 in DRA states and 242,833 in grandfathered Partnership states for a total of 372,833. Rapid implementation by the states and insurers continues, and issues that arise continue to be resolved.

4. Medicare Supplement Insurance Issues

a. SERFF Update

Julie Fritz (NAIC) provided an update on recent changes made to SERFF that relate to implementation of the revised Medicare supplement benefits and plans effective June 1, 2010. At the Spring National Meeting, the Speed to Market (EX) Task Force learned that SERFF was not prepared to accept filings for the new plans effective June 1, 2010. The Task Force worked quickly with the states to approve updates to SERFF codes so that the states would be prepared to accept electronic filings for these new plans as soon as possible. Ms. Fritz reported that some states were already accepting filings and 672 filings had already been received so far under the new codes.

Randi Reichel (America's Health Insurance Plans—AHIP) thanked Ms. Fritz and her staff for working so quickly to address this issue.

b. Advance / Transition Marketing

Ms. Senkewicz reported that there will be a time when 1990 Medicare supplement plans and 2010 Medicare supplement plans will be sold simultaneously in the states, because companies can begin to market the new plans once they are approved by the state and before the effective date of June 1, 2010. Ms. Senkewicz inquired as to what the states might be doing to avoid confusion in the marketplace as they receive filings for the new plans. Mr. McAndrew noted that the Task Force might want to consider how to avoid consumer confusion in the marketplace because there will be two different sets of plans being marketed simultaneously. Ms. Daley noted that Texas has not established additional restrictions on when companies can begin selling the new plans. Mr. Rink stated that the number of filings Nebraska has received has been fairly small.

c. 2010 Choosing a Medigap Policy Guide

Ms. Senkewicz reported that the NAIC is drafting proposed revisions to a draft of the 2010 *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*. A subgroup was created to draft the revisions to be proposed to U.S. Centers for Medicare & Medicaid Services (CMS). Subgroup members include Alabama, Florida, Illinois, Nebraska, Nevada, Pennsylvania, Texas and Wisconsin.

d. Report of the Accident and Health Working Group

Mr. Ostlund provided an update from the Accident and Health Working Group, which met by conference call to discuss the Medicare supplement loss ratio refund formula. The Working Group is drafting revisions to the refund formula and will draft a proposal to share with the Task Force. The Working Group also agreed to remove a charge instructing them to update the

Medicare supplement compliance manual to reflect the recent revisions to the model regulation, because the Working Group's work on that document is now completed.

e. CMS Update on Medicare Supplement Issues

Jay Dobbs (CMS) provided an update on Medicare supplement issues. CMS has begun its review of the 2010 *Choosing a Medicare Supplement Policy* consumer guide and will work with the NAIC to make revisions. CMS also is drafting beneficiary notices for Medicare Advantage nonrenewals. An increase in the number of nonrenewals is expected this year, and model notification letters have been sent to all plans, along with a separate notice regarding Medicare supplement guarantee issue provisions. These letters will be sent to beneficiaries no later than Nov. 2. Mr. Ruch noted that, in the past, the CMS notices included incorrect information about Medicare supplement plans available in waived states.

CMS is continuing to work with the NAIC to monitor state implementation of the Medicare supplement model law revisions. Almost all states are on track to meet the requirements of the federal Genetic Information Nondiscrimination Act (GINA) and the Medicare Improvement for Patients and Providers Act (MIPPA).

CMS has received a letter from the Task Force regarding non-Select Medicare supplement provider networks. CMS leadership has been briefed on this issue and CMS staff anticipates a response in the near future.

f. Other Implementation Issues

Mr. McAndrew expressed concern that, should the U.S. Congress follow through with the Senate proposal to require that Medicare supplement plans C and F be revised to include more beneficiary cost-sharing on a new timeline, there will likely be great confusion amongst consumers. This will compound the confusion that is already likely to occur in 2010 when the transition to 1990 standardized plans to 2010 standardized plans occurs.

Dotti Outland (UnitedHealthcare) stated that there needs to be an explanation made regarding the new Plan N copay. It is unclear which types of Medicare services will be covered by the copay. Once that decision is made, then the information also needs to be publicized to providers and insureds so that they are aware of when a copayment is due.

5. Medicare Private Plan Issues

a. NAIC-CMS Policy Group

Ms. Senkewicz reported that an informal policy working group between CMS and the NAIC has been created. This dialogue arose out of discussions that began during the development of the NAIC white paper on the regulation of Medicare private plans, and as a result of discussions that Commissioner Dilweg had with CMS leadership. The dialogue also stems from the lines of communication that were established between CMS and state insurance regulators on Medicare private plan issues during the development of the memorandum of understanding (MOU) between the states and CMS. The NAIC-CMS Policy Group consists of Florida, Illinois and Wisconsin, in addition to members of CMS' operational and policy staff. Other regulators and CMS staff will be included as issues arise. The group held their first meeting Sept. 22. The purpose of this group is to facilitate improved communications between CMS and state insurance regulators on CMS policy issues. This dialogue will not displace other existing lines of communication between CMS and state insurance regulators. The states involved will report regularly to the Task Force.

b. CMS Update on Medicare Private Plan Issues

Deanna DiVenanzio (CMS) provided an update on Medicare private plan issues. Revisions have been made to the CMS Medicare Managed Care Manual regarding marketing. CMS also has developed an online agent-broker training module, which has been released as a pilot. The content of the training module is available on the CMS Web site, and reports will be shared with the states. CMS also has completed a licensing agreement with the NIPR to make use of their systems. CMS also has contracted with MEDIC (Medicare Drug Integrity Contractor) to work with the states on issues surrounding agent misconduct. CMS also has worked with the Task Force and the states on a joint letter regarding marketing abuses and available federal and state resources and consumer protections. This letter is being sent to the states by CMS regional offices and will be sent to facility directors where many dual-eligible seniors reside.

Having no further business, the Senior Issues (B) Task Force adjourned.

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As of 9/22/09

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to consider policy issues, develop appropriate regulatory standards and revise the NAIC models, consumer guides and training material, as necessary, on Medicare supplement insurance, senior counseling programs and other insurance issues which affect older Americans.

Ongoing Maintenance of NAIC Programs, Products and Services

1. Review model laws adopted in 2004 and recommend whether they be retained, revised or deleted. Report by ~~2009~~2010 Winter National Meeting; *Essential*

2. Continue to monitor and work with federal agencies to advance appropriate regulatory standards for Medicare Supplement and other forms of health insurance applicable to older Americans. Report quarterly; *Essential*

3. Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law and revise if necessary. Report by ~~2009~~2010 Winter National Meeting; *Essential*

4. Monitor the Medicare Advantage and Medicare Part D marketplace, assist the states as necessary with regulatory issues, and maintain a dialogue and coordinate with CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Report quarterly; *Essential*

5. Monitor and assist states in the implementation of changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act to modernize the Medicare supplement market, as approved by the NAIC in March 2007 as required by the Medicare Improvement for Patients and Providers Act of 2008 and the Genetic Information Nondiscrimination Act of 2008. Report quarterly; *Essential*

6. Continue to monitor the changes in the Medicare Supplement insurance market and assist states with implementation of Medicare Supplement Model amendments due to federal statutory changes. Report quarterly; *Essential*

7. Provide the perspective of state insurance commissioners to the U.S. Congress, as appropriate, and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services on insurance issues, including concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme; *Essential*

8. Work with the Centers for Medicare & Medicaid Services to revise the annual joint publication, *Guide to Health Insurance for People with Medicare*; *Essential*

~~9. Amend the NAIC Long-Term Care Insurance Model Act and Regulation for independent external review for claim denials based upon failure to meet the ADL, cognitive impairment or medical necessity test. Report on progress quarterly and complete by December, 2009; *Essential*~~

~~10~~9. Monitor information on legislation impacting the funding of State Health Insurance Assistance Programs (SHIP). Report quarterly; *Important*

1~~1~~0. Assist the states and serve as clearinghouse for information on Medicare Advantage plan activity. Report quarterly. *Important*

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1~~2~~1. In accordance with changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act approved by the NAIC in March 2007, monitor and maintain a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by regulators and others. *Important*

1~~3~~2. In accordance with changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act approved by the NAIC in March 2007, periodically review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in the model regulation. *Important*

1~~4~~3. Review preferred provider arrangements with Medicare supplement policies and determine their legality and their effect on Medicare supplement standardization. Take appropriate action, as necessary. *Important*

Sponsors for 2010 Charges
(Except as noted, I support all charges)

Kevin McCarty	**Carol Cutter**	**Merle D. Scheiber**
Florida	**Indiana**	**South Dakota**

Staff Support: Jane Sung/Brian R. Webb

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Long Term Care Partnership Data Reporting System
Registry File 1 – Initial Submission on 8-1-09
Initial Data Summary – all records U.S. (update 8-31-09)

OVERVIEW:

- Data received from 27 insurers with over 130,000 PQ policies.
- The three largest insurers account for 76% of all PQ policies in force. Eight insurers have between 1,000 and 5,000 PQ policies and the remaining carriers have < 1,000.
- Almost two-thirds (65%) of the PQ policies are new sales vs. exchanges.
- Based on state of issue, FL, MN, VA and WI lead with the largest number of PQ policies in-force, accounting for about 65% of the total.
- The NTO and lapse rates respectively are 1.3% and 1.0%. Given that nearly half of the PQ policies are derived from exchanges it makes sense that these numbers would be low.
- Less than 1% of policies starting the reporting period as PQ lost that status (mostly as a result of dropping inflation protection).
- Just over two-thirds are individual policies and the rest are group.

DEMOGRAPHICS:

- Over half (56%) of new sales are to females.
- Insureds under age 61 account for 66% of the PQ policies.
- The specific age breakdowns are as follows:
  - Under age 41 11%
  - Age 41-45 6%
  - Age 46-50 10%
  - Age 51-55 17%
  - Age 56-60 22%
  - Age 61-65 21%
  - Age 66-70 9%
  - Age 71-75 2%
  - Age 76+ 2%

COVERAGE FEATURES:

- Almost all policies are comprehensive with a single lifetime maximum design, expressed in dollars, not days.
- Only 3% and 2% of policies are facility only or home care only respectively.
- The average lifetime maximum is about $252,000, with the following specific breakdown:
  - $36,599 or less 1%
  - $36,600 - $73,099 2%
  - $73,100 - $109,599 6%
  - $109,600 - $146,099 6%
  - $146,100-$182,599 11%
  - $182,600 and above 64%
  - Unlimited 7%

- The average daily benefit amount for facility care is $168 with roughly equivalent amounts for other levels of care.

INFLATION PROTECTION:

- Almost all buyers under age 61 (86%) have 5% compound Inflation Protection (IP).
- The rest have either 3% compound (2%), some other compound percentage (2%) or a CPI-based IP, graded IP or some other compound percentage (8%).
- For buyers ages 61-75, just over half have 5% compound IP and one-third have 5% simple.
- Over age 76, close to 61% of insureds have no IP.

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PREMIUMS:

- The average premium for all insureds is $1,861.
- For insureds under age 61, the average premium is $1,545.
- For those ages 61-75, the average is $2,444 and it is $2,898 for those ages 76 and over.
- The average premium distribution across all ages is as follows:
  - Under $500 13%
  - $500-$999 24%
  - $1,000-$1,499 13%
  - $1,500-$1,999 13%
  - $2,000-$2,499 10%
  - $2,500-$2,999 8%
  - $3,000-$3,499 6%
  - $3,500-$3,999 4%
  - Over $4,000 9%

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