



## Rising Cost of Healthcare in America



Dr. Uma Dua

**T**he World Bank reported that among the top ten nations with the largest gross domestic product (GDP), the United States spent about twice as much on health care as the average of the other nine nations. Health-share of GDP is expected to rise from 17.8% in 2015 to 19.9% in 2025. Countries that the US topped in spending including the United Kingdom (UK), Canada, Germany, Australia, Switzerland, Japan, France, China, Italy, Brazil, & Spain.

Let's dive into the reasons for escalating healthcare costs and potential solutions

One area that has contributed to the rise in health care costs includes administrative overhead and labor, such as high-paid healthcare professionals relative to other countries. For example, a 2018 Journal of American Medical Association article reported that general practice physicians in the U.S. had an average yearly salary of \$218,173, while in other countries the yearly salary range was \$86,607-\$154,126. In some countries that have universal healthcare, physicians are employees of the federal government and salaries are capped by discipline.

Add to this the large amount of uninsured in the US, approximately 9% in 2015, which is expected to decrease by less than 1% by 2025, which is another contributing factor. This is partly due to the fact that healthcare services rendered to the uninsured are absorbed by public and private providers, society, and the community, providing services often at no charge. These increased costs are shifted to the insured population or taxpayers. The uninsured persons on average use less health care than do insured persons and members of fully insured families. However, The Institute of Medicine (US) Committee on the consequences of un-insurance, revealed that uncompensated care costs may lead to higher local taxes to subsidize or reimburse uncompensated care, pulling resources and funds from publically funded programs, resulting in reduced availability of certain kinds of services within communities.

All these layers add to the total cost of healthcare. In 2014, NerdWallet.com reported that approximately 60% of personal bankruptcies were due to medical bills. In 2015, a poll conducted by NPR, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health, found that 7% of respondents

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### MARK YOUR CALENDAR

**May 3, 2018**

Webinar: Big Data in Insurance - Opportunities and Challenges for Regulators

**August 12-15, 2018**

CDS & Regulatory Skills Workshop | San Antonio, TX

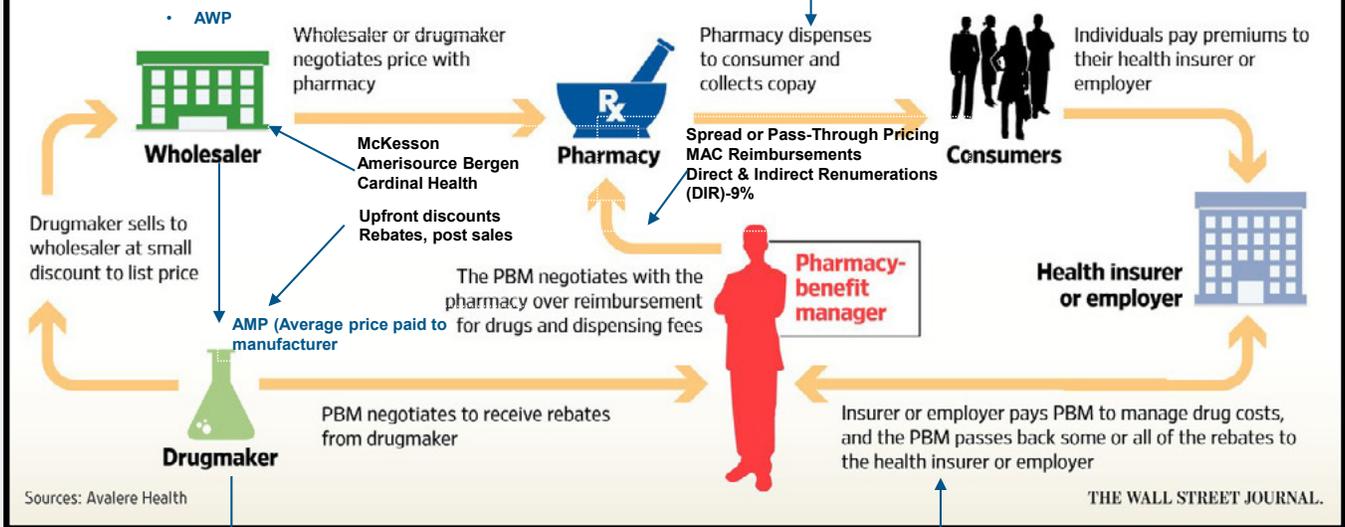
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# PBM: RETAIL-INSURER-MANUFACTURER-WHOLESALE

## How Drug Distribution Works

A complex supply chain determines how prescription drugs are paid for in the U.S.:



ASP-Calculated by CMS

- **Rebates:** 89%-90% rebates passed on to insurer/employer
- **Administrative Fees-** What % of discounts and coupons are actually passed through to the clients?
- **Side-** Reported with manufacturer? Relabeled? Morphed?

had declared bankruptcy due to healthcare expenses over the previous two-year period.

Another significant cost driver points to the pharmaceutical industry. To start with, there is a lack of regulatory controls over drug prices. A May 2017 AARP article states that pharmaceutical companies set the price. Pharmaceutical companies build into their formula for drug prices, the ability to recapture their investment costs and in turn can make a sizable profit. Contributing factors include the US intellectual property laws and exclusivity statutes. A November 2017 report by the US Government Accountability Office (GAO), Report to Congressional Requesters, titled Drug Industry: Profits, Research and Development Spending, and Merger and Acquisition Deals, disclosed that 67% of all drug companies saw an increase in their annual average profit margins from 2006 to 2015. Among the largest 25 companies, the annual average profit margin fluctuated between 15 and 20%. Compare that with the annual average

profit margin across non-drug companies among the largest 500 companies, which fluctuated between 4 and 9%.

The regulations allow the manufacturer to monopolize the market for the drug for a prolonged period of time, sometimes as long as 20 years for a new patent. This is because the pharmaceutical companies argue that after a drug is invented, it takes on average eight years for the drug to be approved by the US Food and Drug Administration (FDA). In addition, drug companies try to extend patents and use legal loopholes to block the release of cheaper generic versions of the brand name drug. In turn, the generic manufacturer counter-sues, further delaying the timeframe for the approval of a generic formulation. A solution may be to limit the 20-year patents and close the loophole to allow more competition by generic manufacturers

Also related to the pharmaceutical industry is another cost driver – unregulated and uncontrolled drug prices. Here again, there is a lack of oversight and controls on drug prices, some of which has

led to price gouging. On September 21, 2016, Mylan CEO Heather Bresch faced tough questioning at the House Committee on Oversight and Government Reform, over the 400% price increase of EpiPen auto-injectors, going from \$100 for a two-dose package in 2007 to \$600 in 2017. Similarly, as reported in a July 2014 Time Magazine article titled, “Why Medical Bills Are Killing Us”, the Charge Description Master (CDM) in hospitals may have drug prices as high as 10,000% higher than other developed countries’ drug price for the same drug. The CDM drug prices differ from hospital to hospital with no clear rationale for the basis of the mark-up. Value Based Pricing, also known as Value Optimized Pricing, may change the landscape by providing a method of setting a calculated price based upon differentiating factors that determine the unique worth of the drug compared to a competitor drug currently on the market.



A March 8, 2016 Issue Brief titled, *The Observations on Trends in Prescription Drug Spending*, published by the Department of Health & Human Services & National Health Expenditure Accounts (NHEA), reported that a contributing factor is prescription drug spending growing faster than any other part of the healthcare dollar. This same report stated that prescription drug spending is expected to grow cumulatively by an average of 7.3 % annually from 2018-2019. Increased advertising from the pharmaceutical companies, also known as direct to consumer (DTC) advertising, has contributed to the high growth, with AARP reporting in May 2017 (AARP.ORG), that nine out of ten big pharmaceutical companies spend more on marketing than on research. In addition, the lack of comparative effectiveness

research (CER), allowing for the comparison of Drug A to Drug B based upon cost and effectiveness, has contributed to the cost increase. There is also a growing senior population (i.e., the baby boomers), leading to an increase in prescriptions, as well as an increased use of more costly specialty drugs.

Add to this the nebulous cloud of how pharmacy benefit managers (PBMs) are used in the industry and how they operate. Originally created to provide billing services for pharmacies and reduce healthcare costs, the lack of transparency and complex and restrictive contractual agreements with the parties involved stifle the ability to negotiate prices for the sole benefit of the consumer. Instead, PBMs may provide backdoor rebates, discounts and higher reimbursements to affiliated or high volume pharmacies to the detriment of independent pharmacies. Agreements between PBMs and independent pharmacies may include “gag” clauses prohibiting certain communications with consumers about lower “off plan” cost options or communications with regulators or media. Adding to the complexity and cost of these agreements, there may be an affiliated (or unaffiliated) Pharmacy Services Administration Organization (PSAO) in the middle of transactions between PBMs and pharmacies. The PSAO contracts and negotiates the drug prices with the pharmacy on behalf of the PBM and, in turn, “sells” the drugs to the PBM. Thus, in examining a PBM, it may be challenging to obtain and review pharmacy contracts because the PSAO has the contract with the pharmacies rather than the PBM.

A number of states are currently addressing and/or have recently passed laws to regulate PBMs. For instance, Arkansas recently passed a law (House Bill 1010) requiring PBMs to be licensed and regulated by the insurance department. The bill also states that gag clauses cannot be enforced and that drug prices can be negotiated. Other states have passed laws requiring the insurance department to review pharmacy reimbursement rates, prohibiting PBMs from reimbursing unaffiliated pharmacies at less than affiliated pharmacies, prohibiting gag clauses relating to informing consumers of lower cost options, requiring periodic data calls, creating a PBM network adequacy standard, and allowing rulemaking to address issues as they arise. The National Council of Insurance Legislators (NCOIL) is in the process of developing a model law to present to the National Association of Insurance Commissioners (NAIC) on the regulation of PBMs.

The US has the highest paid lobbyists than any other country. It is no surprise that in 2015, the top 10 lobbyists included healthcare organizations such as the Blue Cross Blue Shield Association, the American Hospital Association, the Pharmaceutical Research & Manufacturers of America, and the American Medical Association.

The 2.3% medical device excise tax (IRC §4191) that manufacturers and importers began to pay on the sales of certain medical devices

□ *Rising Cost of Healthcare in America* – continued from page 3

started in 2013. On December 18, 2015, there was a moratorium placed on this tax, and it has since been extended to January 22, 2020. The “Bitter Pill” Time Magazine article, published in 2013, illustrates how Congress has continually prohibited the Centers for Medicare and Medicaid Services (CMS) from negotiating prices with drug makers. The same article adds that Medicare simply gets reimbursed by adding 6% to the Average Sales Price (ASP). Contrast this to the Veterans Health Administration (VHA), the part of the Department of Veterans Affairs that handles veteran’s medical care, which has the ability to negotiate drug prices. In 2017, AARP reported that in 2015 alone, the VHA paid 80% less for brand name drugs than Medicare Part D.

**Despite all these factors contributing to a rise in healthcare cost and drug prices, as there was no increase in goods and services, there is no logical rationale for the drug price increase.**

Despite all these factors contributing to a rise in healthcare cost and drug prices, as there was no increase in goods and services, there is no logical rationale for the drug price increase. An article published in Bloomberg.com on August 2, 2017 reported that the Organization for Economic Cooperation and Development, The World Bank, World Health Organization, and The International Diabetes Federation and Diabetes Atlas have stated that better health outcomes, such as an increase in life expectancy and a reduction in infant mortality, do not appear to correlate with the increase in healthcare costs and drug prices.

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## Dr. Uma Dua

Uma Dua is a Manager/Practice Lead of the Pharmacy & Healthcare Solutions practice with Risk & Regulatory Consulting, LLC. She provides pharmacy and healthcare consulting services to state insurance departments and the federal government. Uma is a seasoned pharmaceutical leader with clinical, Affordable Care Act, managed care, and revenue-cycle pharmacy experience. She has in-depth experience across claims, corporate finance, treasury, and investor functions. Her expertise includes strategic planning & analysis, operations management, pharmacy healthcare IT, and Mental Health Parity and Addiction Equity Act (MHPAEA) requirements, including formularies, medication assisted treatments (MATs) and substance use disorders (SUDs).

Uma holds her Doctor of Pharmacy from the University of the Sciences in Philadelphia, her Bachelor of Science from the University of Pittsburgh, School of Pharmacy and completed her Drug Information Residency at Mercer University / Solvay Pharmaceuticals in Atlanta. Uma holds her Market Conduct Management (MCM) designation, is a Registered Pharmacist in Georgia and Pennsylvania and an Insurance Regulatory Examiners Society (IRES) Board Member.

Her experience includes utilization management reviews, formulary reviews, clinical assessments, and review of claims and policy and procedures, including mental health parity, MATs and SUDs reviews related to pharmacy. Uma serves as the project lead on all pharmacy reviews. Additionally, for state Medicaid programs, Uma has created a blueprint for various injectable drug lists (PIDLs). Her recent experience includes providing pharmacy consulting to the Center for Medicare & Medicaid Services (CMS) as well as state insurance regulators in the northeast.

Uma can be reached at 404.610.0595 or by email at [uma.dua@riskreg.com](mailto:uma.dua@riskreg.com).

# **CONGRATULATIONS**

## **TO THE 2018 RECIPIENTS OF**

**THE PAUL L. DEANGELO MEMORIAL TEACHING AWARD AND THE GARY A. HERNANDEZ MEMORIAL INSURANCE EDUCATION LEADERSHIP AWARD**



The Paul L. DeAngelo Memorial Teaching Award recognizes excellence in insurance education and honors an insurance regulator who has demonstrated continued commitment to insurance regulatory education. This year's recipient is Angela Nelson from the Missouri Department of Insurance.

The Gary A. Hernandez Memorial Insurance Education Leadership Award recognizes industry volunteers who have demonstrated tireless commitment in support of IRES and the IRES Foundation and leadership in the field of insurance compliance education. This year's recipient is Lewis Melahn, Attorney at Law.

**CONGRATULATIONS TO ANGELA AND LEWIS!**

# Final Thoughts On The ‘How Big Data Analytics Affects The Insurance Industry’ Webinar



Mark Plesha

In my recent “How Big Data Analytics affects the Insurance Industry” webinar, I said the one biggest drawback is the dissolution of the Law of Large Numbers as we know it. Someone during the Q & A asked me to further explain, and I did not give it justice in the few minutes I had remaining.

First off, the Law of Large Numbers won’t go away; it’s immutable. Just because we don’t follow it or work around it doesn’t mean it goes away. The law of gravity didn’t go away just because we fly.

But our reliance on it as the foundational bedrock of establishing rates will. Here’s why.

Rating is predicated on homogeneous risks. That is, all the risks have the same general characteristics. Harkening back to my days as a Personal Lines Underwriter back in the 70’s, frame vs brick houses is the example I used. So immediately, we had these two big buckets of homogeneous risks; very easy to determine past experience. The Law of Large Numbers ruled.

From there, it was segmented into smaller buckets; we’ll use ISO’s Protection Classes 1-10. We then had twenty not-as-big buckets of homogeneous risk; again, very easy to determine each bucket’s past experience.

As you can surmise, not much deviation (Veterans may recall such policies as having three-year terms and inflation protection not even a concept). An attribute is that the experience was distinct and concrete. Brick house in PC 1, Frame house in PC 9 ...there are only so many of them so the experience gathered was solid and could be built upon. The Law of Large Numbers still ruled.

As carriers introduced and took the various credits (smoke alarms, dead-bolts, security systems, new construction, age of roof) into account, we can see the twenty buckets getting broken into smaller and smaller buckets. Brick house in PC 1 with a smoke alarm, Frame house in PC 9 with a new roof; smaller buckets, yes, but still with enough exposures to make the Law of Large Numbers work. After all, there are only so many factors available (key word) that can lead to credits (and debits), right?

Enter Big Data Analytics.

Recall as we talked about technology and its impact on Internal and External data. We saw how carriers are now able to use what they had already internally gathered and how they could now gather from external sources they never could before. Why never before? For Internal, the technology hadn’t advance enough to give carriers the computing horsepower available today. As for External, again, the technology wasn’t there (now you can tie into the town’s Public Safety Department for immediate notification of who just got a dog license) to external sources that didn’t exist (Facebook shows you have a lot of pool parties at your house where alcohol is prevalent... are those minors? Is that a diving board?)

**Suddenly, an unlimited number of factors become available, manifesting themselves to make each risk virtually unique. Internally, there is a limit (for now), but externally, the cloud’s the limit.**

Suddenly, an unlimited number of factors become available, manifesting themselves to make each risk virtually unique. Internally, there is a limit (for now), but externally, the cloud’s the limit. Technology and the resultant big data analytics means those “smaller & smaller buckets” (Brick house in PC 1 with a smoke alarm, Frame house in PC 9 with a new roof), now can be segmented to the point where the risk is as unique as we are.

So why do I say it is a drawback? Insurance has many definitions, but always these three characteristics: risk-transfer-sharing. To me, the “sharing”, or rather the lack of sharing, aspect concerns me the most, long term.

Risks are placed in homogeneous groups. Each of these have the same general characteristics. Losses are shared within that group, with the historically proven fact that your bad luck (loss) will be offset by the many, many more risks who had good luck (no loss). The group experience is shared.

But what if there is no group? Who offsets your bad luck?

Big data analytics is here. I am not a data scientist and exposure to it only came about by my CPCU teaching, so I am sure I have not come close to understanding where it is going. But we have all been witness to technological changes in our industry, and big data analytics is the latest one that no doubt will be the new normal.

Carriers who stop at the “smaller and smaller buckets” stage will find themselves at the wrong end of another immutable law, that of Adverse Selection. ■

### **Mark Plesha, CWCP, AIE, MCM, CPCU, AIS, IR**

Mr. Plesha currently functions as a Market Conduct Examiner for the INS Companies where his primary responsibilities include Property & Casualty examining and providing insight into a Company's approach and reaction to an exam. Prior to joining the INS Companies in January 2013, Mr. Plesha worked for the Liberty Mutual Insurance Company, where for over 20 years he functioned as the coordinator of over 200 state Market Conduct Examinations & Audits, state Department of Labor & Division of Workers Compensation Audits, and NCCI & AIPSO Servicing Carrier Audits. In this coordinating role, Mr. Plesha handled these exercises from receipt of the Engagement Letter to the Final Orders.

## IRES WEBINAR SERIES

# Big Data in Insurance: Opportunities and Challenges for Regulators

May 3, 2018  
3:00 pm ET / 2:00 pm CT / 12:00 am PT

Insurers' use of Big Data has huge potential to benefit consumers and insurers by transforming the insurer-consumer relationship and by discovering new insights into and creating new tools for loss mitigation. Insurers' use of Big Data has huge implications for fairness, access and affordability of insurance and for regulators' ability to keep up with the changes and protect consumers from unfair practices. The webinar will identify and suggest approaches to respond to these challenges.



### **Birny Birnbaum** Executive Director, Center for Economic Justice (CEJ)

Birny Birnbaum is a nationally acclaimed expert on insurance availability, data, and ratemaking issues. Birnbaum has a long history of working on behalf on consumers on energy, economic development, and insurance issues. Before his work for Center for Economic Justice (CEJ), Birnbaum was the Associate Commissioner for Policy and Research and Chief Economist at the Texas Department of Insurance and Chief Economist at the Office of Public Insurance Counsel. In those capacities, he provided expert testimony in numerous proceedings regarding insurance rates and availability.

Birnbaum has been an expert witness in dozens of administrative and judicial proceedings on both economic and actuarial issues. In addition to his expertise in insurance rates and risk classification, Birnbaum holds special knowledge of insurance data collection and public access to the data necessary for consumers to hold insurers accountable for their market practices.

### **Registration Details**

Free to all IRES members.

Must be a current IRES member to participate and attend.

Register online at <https://go-ires.org/events/>

# CONGRATULATIONS TO THE NEWEST IRES DESIGNEES

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# State Chair Update



Holly Blanchard



**C**ongratulations! Hard work and dedication is something to be greatly rewarded for. One of the best rewards we give ourselves for the hard work and dedication through the years is retirement. Two of our state chairs have recently announced their retirement.

## Colorado

In March, Tom Abel, the Director of Life, Accident and Health Rates and Form section for the Colorado Department of Insurance, officially retired after 30 years and 3 months with DOI, almost 38 years in insurance and about 29 years with IRES.

## Utah

Suzette Green-Wright, the Market Conduct Director for the Utah Insurance Department, recently announced that she will be retiring at the end of April. Suzette has been a longstanding force with the Department, and has provided significant contributions to the NAIC Committee's, Market Conduct initiatives nationwide, as well as to the Utah consumers. Suzette plans to spend some time relaxing, and potentially take some college courses that she has been interested in.

While the states and other regulators will greatly miss the interaction with these two dynamic fellow regulators as well as their vast institutional knowledge, their contributions will always be remembered and greatly appreciated.

To Suzette and Tom- Thank you for everything you have done for the betterment of Insurance Regulation through the years. Good luck in retirement and enjoy the well-deserved rewards!

In our previous newsletter we mentioned the exciting upcoming enhancements that will be available to our members and our state chairs. Some of these enhancements include:

- A Blog for IRES members allowing them to discuss questions, comments or issues, as well as current events and state undertakings. This will allow our members a forum to get expert feedback on current issues effecting the insurance marketplace.

- Library: IRES members are a wealth of information. We have published articles, assisted with NAIC initiatives, presented on various topics, and are closely monitoring everything that is happening in the insurance market. Wouldn't it be great to have a repository for this information? IRES state chairs will create an online reference library where our members can easily access information regarding their insurance topics of interest.

Want more? If you have other ideas for enhancements, please reach out to your local state chair to share your thoughts. For a list of the current State Chairs in each state, please [click here](#).

The State Chairs will continue to keep our members updated on the enhancement initiatives. This information will be presented in *The Regulator*®, but will also be available on the IRES website at <https://www.go-ires.org/state-chapters#events>. Be sure to check the website regularly, as updates will frequently be added for your information.

If you would like to be involved with the state chairs, or have suggestions or ideas to assist the state chairs spread the word about IRES, please reach out to [hblanchard@riaconsulting.net](mailto:hblanchard@riaconsulting.net). ■

## Holly Blanchard

Holly is the President of Regulatory Insurance Advisors (RIA), a consulting firm offering expert services for insurance regulation and oversight. Holly has over 20 years of experience in the insurance industry, with most of those years as an insurance regulator. Holly brings extensive market conduct, Affordable Care Act (ACA) and overall regulatory expertise and experience.

# ZONING IN



Kathy Donovan

## Northeast Zone

### Connecticut

Under SB 242, certain individual and group accident and sickness insurance policies that are delivered or issued on or after Jan. 1, 2019, must provide coverage for long-term antibiotic therapy for patients with Lyme disease when so ordered by a licensed physician who determines it to be medically necessary after conducting an evaluation of the patient in the specified manner. Specified policies include individual and group health insurance policies, which provide coverage on an expense-incurred basis, all individual and group service or indemnity type contracts issued by nonprofit corporations, and HMOs.

### District of Columbia

A Notice dated March 9, 2018 indicated that notices of cancellation must advise insureds of appeal rights and procedures, reason(s) relied upon for the action, and possible eligibility for participation in DC's Assigned Risk Plans. The Notice further requires that auto insurers must also advise insureds that failure to maintain insurance may result in revocation or suspension of the vehicle registration, and that other coverage may be available through their agent or another insurer.

## Midwest Zone

### Kansas

HB 2469, effective July 1, 2018, establishes certain provisions for claims handling operations during catastrophic events. Included in this bill is a mandate that,

except as otherwise provided in the law, at the time of any catastrophic event threatening life or property, no political subdivision shall impose restrictions or enforce local licensing or registration ordinances with respect to an insurer's claims handling operations. Additionally, any insurer establishing claims handling operations under these provisions shall provide notice to a city or county prior to establishing such operations. "Claims handling operations" is defined to include, but not be limited to, the establishment of a base of operations on a temporary basis, not to exceed six months, by an insurer within the disaster area and the investigation and handling of claims by personnel authorized by any such insurer.

### Iowa

Effective July 1, 2018, SF 2135 revises §321.445 to reflect changes in contributory negligence provisions in circumstances involving the use of certain safety devices by persons in motor vehicle accidents. Specifically, if failure to use a safety belt or safety harness is found to contribute to the injury or injuries of the plaintiff, the amount by which the recovery may be reduced is increased from an amount not to exceed five percent of the damages awarded after any reductions for comparative fault to an amount not to exceed 25 percent of such damages.

### South Dakota

HB 1093, effective July 1, 2018, sets forth provisions permitting insurers to provide insurance policies, endorsements, riders, and any explanatory or advertising materials in a language other than English. Requirements applicable to this practice include the filing of a statement with the Division attesting that the policy in a language other than English is the translation of a policy form already filed and approved by the Division.

## Southeast Zone

### Arkansas

The "Arkansas Pharmacy Benefits Manager Licensure Act" (HB 1010/SB 2) became effective on March 19, 2018. This Act established the standards and criteria for the regulation and licensure of PBMs that provide health benefit plans with claims processing services or other services relating to prescription drugs or devices. Included in the standards is the requirement that persons and entities be licensed by the Department to operate as PBMs in Arkansas, as well as a requirement that the Department issue rules establishing the licensing, fees, application, financial standards and reporting requirements for PBMs, in accordance with the specified timeframes. Additional provisions address issues such as network adequacy requirements, the review of compensation programs between PBMs and health benefit plans, advertising prohibitions, fees, prohibitions on gag clauses, and disclosures to insureds.

### Tennessee

HB 1977, effective March 22, 2018, revised §56-7-102, which provides statutory law requiring policies to contain the entire contract, by adding the following:

- A policy of insurance is a contract and the rules of construction used to interpret a policy of insurance are the same as any other contract.
- A policy of insurance must be interpreted fairly and reasonably, giving the language of the policy of insurance its ordinary meaning.
- A policy of insurance must be construed reasonably and logically as a whole.

An insurance company's duty to defend depends solely on the allegations contained in the underlying complaint describing acts or events covered by the policy of insurance. Also noted is that this "duty to defend" reference does not impose a duty to defend on an insurance company that has no duty to defend pursuant to this title

□ Zoning – continued from page 10

(i.e. Title 56) or that has an express exclusion of the duty to defend in the policy of insurance.

## Western Zone

### Idaho

Bulletin No. 18-02, issued April 2, 2018, provides clarification regarding coverage of treatments for autism spectrum disorder. The Department noted that there is currently inconsistent coverage of treatments for autism spectrum disorder by Idaho health plans and that such treatments cannot be excluded from coverage if rehabilitative or habilitative services are covered. Additionally, the Bulletin addresses state and federal requirements and indicated that “the Department will consider an exclusion of treatments for autism spectrum disorder as discriminatory and prohibited when a plan includes coverage of rehabilitative or habilitative services, such as coverage of occupational therapy or speech therapy.”

### Utah

Effective May 8, 2018, SB 123 prohibits reserving discretionary authority clauses in life and health policies and defines “reserving discretionary authority” as a policy provision that:

Has the effect of conferring discretion on an insurer, or other claim administrator, to:

- determine eligibility for benefits; or
- interpret the terms or provisions of the policy, contract, certificate, or agreement; and
- Could lead to a deferential standard of review by a reviewing court.

Certain defined policy provision language exceptions are also addressed.

### Washington

Effective June 2, 2018, HB 2322 establishes provisions for property insurers to assist their insureds with risk mitigation and/or prevention goods and/or services that could help prevent, or reduce the severity of claims and losses. Specific provisions include, subject to the commissioner’s prior approval of the required rate filing, allowing a property insurer to include the following either goods or services, or both, intended to reduce either the probability of loss, or the extent of loss, or both, from a covered event as part of a policy of property insurance, except commercial property insurance:

- Goods, including a water monitor;
- Foundation strapping to mitigate losses due to earthquake;
- Ongoing services, including home safety monitoring or brush clearing to mitigate losses due to wildfire; and
- Other either goods or services, or both, as the commissioner may identify by rule.

Additional provisions include a requirement that any goods provided are owned by the insured, even if the insurance is subsequently canceled and that the value of goods and services to be provided is limited to \$1,500 in value in the aggregate in any twelve-month period. Special provisions apply to pilot programs involving risk mitigation or prevention.

### Kathy Donovan

Kathy Donovan is Senior Compliance Counsel, Insurance with Wolters Kluwer Financial Services. Kathy has more than two decades of experience in insurance compliance. Her expert commentary on legal and regulatory issues affecting the insurance industry is widely published and she is a regular presenter at various industry events.

— SOMETHING TO REMEMBER —  
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## Educational Corner



Jo LeDuc

**E**arlier this year, IRES changed companies responsible for managing the day to day activities of IRES. The change in management companies brings with it a change in the online platform IRES uses to manage our membership and the NICE Program.

The new membership platform, powered by YourMembership (YM), has many new features which give IRES the opportunity to help members build connections and a sense of community around the organization. Among the new benefits of YM is an enhanced system for reporting and tracking your continuing education (CE) credit under the NICE Program. The best part is that many of the new features offered by YM are things members have been asking for. For example, with YM:

Members will receive emails when CE credit submitted through YM has been accepted. That means you won't have to periodically check the IRES website to see if your CE has been accepted.

A single form is used to submit all types of CE. No more finding the right form to use based on the type of CE you are reporting.

Ability to update submissions that have not yet been accepted. That means if you spot a typo right after hitting submit, you can easily and quickly correct it.

Automated reminders of upcoming reporting deadlines.

Ability to attach documents to each submission. This means you don't have to maintain a separate file of your attendance certificates or proof of completion. You just attach the certificate/proof to your submission and it will become part of your CE record.

Streamlined process for granting CE credit for participating in an IRES webinar. This means starting with the May 3, 2018, IRES webinar, credit will be granted automatically for those that participate in the webinar. You won't be required to report it on your own.

While change isn't always easy, this change brings many new and exciting opportunities and benefits to our membership. Here are a few tips to help you navigate the new Professional Development section of the IRES website.

### How do I submit CE credits?

To submit CE credit, visit the IRES website and:

1. Log into your IRES account.
2. If you don't automatically land on the page that allows you to your profile, click on your name in the upper right corner. Then click Account + Settings.
3. Click on the Professional Development tab on the navigation rail on the left.
4. While on the Journal Entries tab, click on the +Add Entry button.
5. Complete the CE Submission form.
6. Attach a PDF of your certificate of attendance (or other proof of completion)
7. Click Submit.

## Exactly how should I complete the CE submission form?

Instructions on how to complete the new CE submission appear below. For your convenience, a link to these instructions also appears in the Professional Development section of your profile.

<b>Is this entry for a Certificate or Program?</b>	This should be Yes
<b>Certification/Program</b>	Use the drop-down menu and select NICE Program Requirement
<b>Credit Type</b>	Select the appropriate Credit Type from the drop-down box based on the type of continuing education you are reporting.  NOTE: AMCM Class, IRES Committee Service, IRES Webinar, and MCM Program credit types should not be entered. Upon successful completion of these items, IRES will automatically enter your CE credit.
<b>Entry Date</b>	Change the entry date to the date you completed the continuing education credit.
<b>Description Field</b>	Name of the item for which the credit applies. If possible, include the name of the sponsoring entity.  For example: <ul style="list-style-type: none"> <li>• NAIC Accreditation Update Webinar</li> <li>• LOMA 290 - Insurance Company Operations</li> <li>• CPCU 520 - Insurance Operations</li> <li>• CIPR Webinar - The Use of Drones in Insurance</li> </ul>
<b>Credits</b>	Enter the number of continuing education credits earned.
<b>Credits Expire</b>	Except for Reachback credits, credits expire on the last day of the reporting period (August 31st) under which they were earned. Reachback credits would be excess credit earned in the immediate prior period for which you seek credit for in the current period.  For example, if the current reporting year is September 1, 2017 to August 31, 2018: <ul style="list-style-type: none"> <li>• Credits earned on September 10, 2017 would expired August 31, 2018</li> <li>• Credits earned on July 2, 2018 would expire on August 31, 2018</li> <li>• Reachback credits earned on May 15, 2017 would expire August 31, 2018</li> </ul>
<b>Score (%)</b>	Leave this field blank.
<b>Activity Code</b>	Leave this field blank.
<b>Attachments</b>	Attach a PDF version of your certificate of attendance (or other proof of completion). You can also attach a copy of the course outline or agenda if needed to support that the course qualifies for CE under the NICE Program.

## How can I check to see how many CE credits I already have this compliance period?

To see how many CE credits have been accepted for the current compliance period, click on the Certifications/Programs tab in the Professional Development section. This tab displays the designations you have earned. In addition, once you have made at least one CE submission for the current reporting period, you will see an area named NICE Program Requirement. This area details how many CE credits have been accepted for each type of credit under the NICE program. Once you have reached a total of 15 accepted CE credits, the status will change from Incomplete to Complete.

## How can I check to which CE credits I already reported for a compliance period and their status?

Individual CE submissions appear on the Journal Entries tab of the Professional Development section. Using the filter options at the top of the list, you can easily find what has been reported, accepted and/or what is still pending.

## Can I print my CE transcript?

Yes. You can print your CE transcript using the Print Transcript button on the Journal Entries tab of the Professional

Development section of your profile. You can either print your entire transcript or just a portion of it by applying filters and using the Print Filtered Entries button. You can also email yourself a copy of your CE transcript or download your entries to a comma separated file.

Hopefully this is enough information to get you started on the new platform. Watch for more tips, tricks, and FAQs in future editions of *The Regulator*<sup>®</sup> and on the website. For more information on the NICE program, see the NICE Program Manual available online at [www.go-ires.org](http://www.go-ires.org) or contact IRES. ■

### Jo LeDuc

Ms. LeDuc is a member of and a past President of the Insurance Regulatory Examiners Society (IRES). She has a M.B.A. and a B.S. in Business Administration. In addition, she has earned the CIE (Certified Insurance Examiner), MCM (Market Conduct Management), CPCU (Chartered Property & Casualty Underwriter), AIRC (Associate, Insurance Regulatory Compliance), AIC (Associate in Claims), API (Associate in Personal Insurance) and Associate in Insurance Data Analytics (AIDA) designations.

## LET YOUR CREDENTIALS SPEAK FOR THEMSELVES

State insurance departments and the National Association of Insurance Commissioners (NAIC) formally recognize the professional designations developed and awarded by the Insurance Regulatory Examiners Society:

- Accredited Insurance Examiner (AIE<sup>®</sup>)
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- Certified Insurance Consumer Service Representative (CICSR<sup>®</sup>)
- Market Conduct Management (MCM<sup>®</sup>)
- Advanced Market Conduct Management (AMCM<sup>®</sup>)

So let your credentials show and learn how to earn IRES professional designations by visiting <http://go-ires.org/designation-programs/>



## President's Letter

**P**rior to the recent NAIC Spring National Meeting, I took advantage of an opportunity to have an in-person meeting with some key staff members of IRES' new Association Management Company, Van Petten Group. I met with Megan Van Petten, CEO & President, Lindsay Heatley, Membership Director, Kayla Wilson, the Account Executive for IRES, and Samantha Payne, the Account Executive Assistant for IRES.

All of IRES' meetings up to that point with the new VPG team had out of necessity been conducted via conference call or a partial video hook-up. And while the passion and dedication of the VPG team for managing IRES came across during those prior meetings, that passion and dedication was even more evident to me during the in-person meeting.

We discussed numerous topics including the upcoming CDS in San Antonio in August, future MCM courses, IRES finances, and a variety of issues that came up during the AMC transition process in January. Speaking of which, I recall mentioning in the Fall issue of *The Regulator*® that a few bumps or hiccups may occur during the AMC transition process. Well, we did hit a few bumps with an extra hiccup or two.

Unexpected curves and unanticipated challenges were left for IRES and VPG to deal with at the start of the AMC transition process which tied up resources for both groups throughout January and into February. That led to delays in getting the new IRES website up and running and getting the new IRES membership portal in proper working order. So my apologies to any IRES member who experienced any sort of angst by IRES not having its revamped website or membership database ready to go earlier than they became available, or for any resulting delays in getting a membership renewal for 2018. However, IRES and VPG have turned a corner, a good corner, and are now able to move forward. VPG's partnership with IRES means that currently and in the coming years there will be many opportunities for IRES to progress as a member-driven organization.

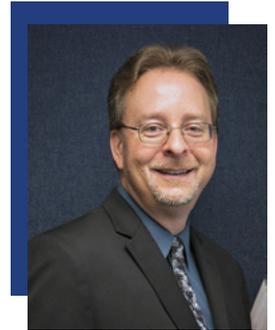
One such advancement, getting IRES membership integrated with and running on the YourMembership (YM) membership management portal, has already happened. Have you had the opportunity to try out the features that are available in YM? If not, simply access your IRES membership account login and check it out! You will see quite a few impressive membership activity functions that were not available to IRES members previously. Check out the news feed, update your profile, message with other members or groups, make connections, and maybe most importantly raise your rating on the engagement meter! Okay, this last one has a bit more of an entertaining or competitive angle to it, but only logging in for the first time myself recently (time constraints, you understand) and being shamed for having a low engagement meter level, as President I couldn't let that condition persist. Still a work in progress for me on this point, but my meter rating is increasing!

I'll close this letter with the following thought. For many years now, my commute includes a walk past Los Angeles City Hall. Quite a while ago, I noticed that on each of the four exterior sides of City Hall there is a quote inscribed about three or four stories above the

ground. Of the four inscribed quotes, the one that faces south is the one that has resonated with me: "He that violates his oath profanes the divinity of faith itself."

Thinking about the meaning of this and how it applies to me, whether in relation to what I call the paying job, that being protecting California insurance consumers from excessive, inadequate, or unfairly discriminatory insurance rates, or in terms of my family life or as IRES President, in each instance I took an oath to uphold my various responsibilities and duties. Seeing this inscription every day, not only in the morning on my way into work but again in the afternoon on my way home, is a good reminder that my words and actions are impactful to others who are ascribing a level of faith to my representations. I pride myself on always giving the best effort and trying to do the best job possible, whatever the circumstances, keeping to my word.

May each of you dutifully and ardently uphold every oath you have taken, and that others appreciate and respect your words and actions. ■



Ken Allen



### Ken Allen

Ken has been with the Rate Regulation Branch of the California Department of Insurance since 1989. He was promoted to Deputy Commissioner of the Rate Regulation Branch in September 2016. Joining IRES in 2000, Ken has served on the Accreditation & Ethics Committee and the Membership & Benefits Committee, was Chair of the CDS Committee in 2014-15, Chair of the Meetings & Elections Committee, and now President. Ken holds AIE® and CPCU designations, and he was elected to the IRES Board in 2013. Ken, his wife, and daughter live a commuter train's ride outside of Los Angeles and enjoy all of the amenities that Southern California has to offer.



## The Regulator®

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Stephanie Duchene

## Editor's Corner

**S**pring is in the air and, like you, IRES has been doing some Spring cleaning! Thanks to our new management company, Van Petten Group (VPG), we have the IRES website up and running and a new IRES membership portal integrated with the YourMembership (YM) membership management portal. If you haven't had the chance to give YM a try, now is the time!

In this issue Dr. Uma Dua explores the reasons behind escalating healthcare costs, in particular pharmaceutical costs, and potential solutions. Mark Plesha expands on his recent webinar "How Big Data Analytics affects the Insurance Industry" by further explaining why he believes one of the biggest drawbacks to Big Data in insurance is the dissolution of the Law of Large Numbers. Ken Allen, our IRES president, keeps us up-to-date on the transition to VPG and reminds us that as leaders in our professional and personal lives, our words and actions matter. Holly Blanchard provides us with an IRES State Chairs update including honoring a few soon to be retirees. Finally, Kathy Donovan keeps us Zoned In on changes in state law.

I hope everyone enjoyed the National School on Market Regulation earlier this month in warm and beautiful Tucson Arizona! Another hearty congratulations to the DeAngelo and Hernandez award winners - Angie Nelson and Lewis Melahn.

Please let me know if you have any feedback on this issue, or ideas for upcoming issues. It's *your* organization: make sure *your* voice is heard - right here in *The Regulator*®! ■

### Stephanie Duchene

Stephanie Duchene is a member of Dentons' Insurance Regulatory practice group. Her practice focuses on representing insurance companies, producers and other insurance licensees and insurance-related service providers in complex and sensitive regulatory matters, including single and multi-state examinations, sales practices compliance and product development and approval. Stephanie also regularly counsels insurtech companies, traditional carriers and non-insurance entities looking to understand the law's impact on innovation in the insurance industry. Stephanie represents clients in all lines of insurance, including accident, life and health, property and casualty, and surplus/excess lines.