

Comments Received to Sections 7 through 12 of the *Long-Term Care Insurance Model Regulation, #641*

Section 7 through 12

ACLI/AHIP: At this time, ACLI and AHIP believe that the language currently contained in Sections 7 through 12 remains flexible and compatible with the current long-term care insurance (LTCI) marketplace and that new language is unnecessary. However, as the subgroup continues its review of the remaining sections of the model regulation, we recognize that changes needed to those sections could result in a need to reconsider our position regarding the opening of Sections 7 through 12.

As stated in the call notice, the purpose of the review is to determine if the existing language in the model no longer meets the current LTCI marketplace. If someone feels that the language is no longer compatible or flexible, they should provide comment and explain why it is no longer flexible or compatible. To provide meaningful input and feedback on any stakeholder comments, we respectfully request that the subgroup adhere to this process and request that any stakeholder requesting changes provide an explanation as to why the current language no longer meets the current LTCI marketplace.

Section 7 (page 9 in Model #641)

Utah: Additional guidance may be appropriate regarding application of Section 7 of the model to the LTC benefits provided through a policy or contract without specified premiums. For example, when LTC benefits are provided through a Universal Life insurance policy, there is no required premium. Typically, by the time the policy enters the grace period, the premium required to continue the policy is prohibitive.

Section 7A(1) (page 9 in Model #641)

NAIC Consumer Representatives: Insurers should be required to send any changes in their contact information to the 3rd party as well as an insured. There have been instances when there was a change in address for an insurer and as a consequence past due premiums and notices of an impaired policyholder were returned to the 3rd party as they were mailed to an outdated address.

We suggest adding a confirmation notice to be sent to the current 3rd party every two years. Insurers are required to notify policyholders of the right to change a 3rd party for notification of a lapse in premium payment. There is no requirement that an insurer periodically confirm the current contact information for the 3rd party who is to be notified of a pending lapse. There have been instances where a 3rd party has moved or died, or the notice went to an outdated or even a wrong address.

Section 8A(2) (page 10 in Model #641)

NAIC Consumer Representatives: Policyholders often don't see the language about premium increases buried in the paragraph about guaranteed renewability. Notice of the right to increase premiums should be in a separate paragraph from guaranteed renewability.

Section 8E (page 10 in Model #641)

NAIC Consumer Representatives: This subsection should include a requirement for a clear notice of waiver of premium. That notice should describe any benefits covered by a premium waiver, clear notice of the benefits not covered by a premium waiver, and clear notice of how and when the premium waiver will be credited or refunded. Policy language generally describes that premium payment will be owed when benefits are no longer payable but may not clearly describe how and when waived premiums will be credited or returned. Generally, a premium waiver is described in one place in a policy while the return or credit of the waived premium is described separately.

Section 9 (page 11 in Model #641)

NAIC Consumer Representatives: Life and annuity contracts that provide for long term care benefits have internal costs associated with the policy and with the benefits paid by the policy. There is no mention of how those costs might change in this section. For instance, the cost of insurance charged in a policy might change, or the cost of long-term care insurance might change which could affect the earnings in a policy and the daily benefit amount paid for care. While this isn't a change in premium changes in internal costs affect the benefit a policyholder will receive.

Section 9B(5)(a) (page 11 in Model #641)

Utah: It isn't clear why rate increase history is limited to 10 years when most prospective buyers will keep their policies for much longer than that. A cumulative rate increase for each policy form might be preferable to a long list of individual increases.

Section 9B(5)(d) (page 11 in Model #641)

Utah: One should consider if this provision allows some rate increases not be reflected. If every company transferred business after the first increase, no company would be required to disclose more than one increase on a policy form.

Section 10 (page 12 in Model #641)

Utah: One should consider adopting retention requirements (for actuarial assumptions) similar to those in Section 10C of Model 643, the *Limited Long-Term Care Insurance Regulation*. Section 10C of Model 643 is on last page.

Section 11C(1) (page 14 in Model #641)

NAIC Consumer Representatives: Insurers have begun to ask questions about family health history as part of the application process that could lead to misinformation or mistaken information that could be used later to rescind coverage. Insurers and others have access to information and data from many sources that could contain erroneous information or information and data that are different from what the policyholder entered on the application. For instance, an applicant might know anecdotally about the cause of death of a family member but that might be inconsistent with the medical cause of death listed on a death certificate. Some older family members might conceal a health condition from other family members leading to an erroneous response on an application.

Section 12C – Drafting Note (page 15 in Model #641)

NAIC Consumer Representatives: Should the dollar amount of \$25 be increased? A home health care benefit that provided \$25 a day would be illusory based on costs today. In addition, the drafting note seems to conflict with the language in B.

- B: A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.
- C. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection C permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 365 benefit days and less than a \$25 daily maximum benefit constitute illusory home health care benefits.

Section 10 of the *Limited Long-Term Care Insurance Model Regulation*, #643

Section 10. Initial Filing Requirements

- A. This section applies to any limited long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the regulation].
- B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a limited long-term care insurance form available for sale.
- (1) A copy of the disclosure documents required in Section 9;
 - (2) Complete rate schedule;
 - (3) An actuarial memorandum that shall include:
 - (a) A statement regarding actuary's qualifications;
 - (b) An explanation of the review performed by the actuary;
 - (c) A complete description of all pricing assumptions, including sources and credibility of data;
 - (d) Development of the anticipated life time loss ratio supported by an exhibit showing lifetime projection of earned premiums and incurred claims based upon the pricing assumptions;
 - (e) A statement that the premium rate schedule is expected to result in a lifetime loss ratio not less than 55%;
 - (f) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - (g) A statement that the underwriting and claim adjudication processes have been reviewed and taken into consideration;
 - (h) A sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions (including sensitivity to the mix of business);
 - (i) A statement that the reserve requirements have been reviewed and taken in consideration;
 - (j) A description of the valuation assumptions with sufficient detail or sample calculation as to have a complete depiction of the reserve amounts to be held;
 - (k) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and
 - (l) An actuarial certification dated and signed by the actuary that all information presented in the actuarial memorandum is accurate and complete.

C. Retention Requirements

- (1) An insurer offering a limited long-term care policy shall retain sufficient documentation from the initial pricing that a qualified actuary could recreate the initial rates at a later date.
 - (a) The documentation shall be sufficient to provide actual to expected analyses of: claims; incidence rates, persistency, mix of business, and loss ratios at the same level of detail used in the initial pricing.
 - (b) If an insurer retains a consultant to price a limited long-term care product, the insurer shall require that the documentation be provided to the insurer, rather than being retained solely by the consultant.
 - (c) If an insurer sells (cedes) complete risk responsibility for a limited long-term care product, the insurer (cedant) shall provide the buyer (reinsurer) with the initial pricing documentation.
- (2) An insurer that requests a future premium rate schedule increase but has not retained the initial pricing documentation shall be limited to a lifetime loss ratio not less than [80%].
- (3) The insurer shall retain the initial pricing documentation at least until one year after the final policyholder is no longer eligible for benefits under the policy.