NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 12/16/24

Virtual Meeting

LONG-TERM CARE INSURANCE (B) TASK FORCE
Wednesday, December 18, 2024
12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

Andrew N. Mais, Chair	Connecticut	D.J. Bettencourt	New Hampshire
Grace Arnold, Vice Chair	Minnesota	Justin Zimmerman	New Jersey
Mark Fowler	Alabama	Alice T. Kane	New Mexico
Lori K. Wing-Heier	Alaska	Mike Causey	North Carolina
Barbara D. Richardson	Arizona	Jon Godfread	North Dakota
Ricardo Lara	California	Judith L. French	Ohio
Michael Conway	Colorado	Glen Mulready	Oklahoma
Trinidad Navarro	Delaware	Andrew R. Stolfi	Oregon
Karima M. Woods	District of Columbia	Michael Humphreys	Pennsylvania
Gordon I. Ito	Hawaii	Elizabeth Kelleher Dwyer	Rhode Island
Dean L. Cameron	Idaho	Michael Wise	South Carolina
Holly W. Lambert	Indiana	Larry D. Deiter	South Dakota
Doug Ommen	Iowa	Carter Lawrence	Tennessee
Sharon P. Clark	Kentucky	Cassie Brown	Texas
Timothy J. Temple	Louisiana	Jon Pike	Utah
Robert L. Carey	Maine	Kevin Gaffney	Vermont
Marie Grant	Maryland	Scott A. White	Virginia
Michael T. Caljouw	Massachusetts	Mike Kreidler	Washington
Chlora Lindley-Myers	Missouri	Allan L. McVey	West Virginia
Eric Dunning	Nebraska	Nathan Houdek	Wisconsin
Scott Kipper	Nevada	Jeff Rude	Wyoming

NAIC Support Staff: Jane Koenigsman/David Torian

AGENA

1. Consider Adoption of the Fall National Meeting Minutes —*Paul Lombardo (CT)* — Attachment One

2. Discuss Comments Received on Amendments to the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) —*Paul Lombardo (CT)* — Attachment Two

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3. Consider Adoption of Two Sets of Amendments to the LTCI MSA Framework as follows:—*Paul Lombardo (CT)*

    a. Consider Adoption of the Current Minnesota Method as the Single Actuarial Methodology and Other Proposed Editorial Revisions (not including proposed revisions to the cost-sharing formula) to the LTCI MSA Framework — Attachment Three-*Unhighlighted Revisions*
    b. Consider Adoption of Proposed Revisions to the Cost-Sharing Formula (Cost-Sharing Proposal A) in the LTCI MSA Framework along with Two Additional Editorial Revisions to Existing Language — Attachment Three-*Highlighted Revisions*

4. Discuss Any Other Matters Brought Before the Task Force —*Paul Lombardo (CT)*

5. Adjournment

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Draft: 11/21/24

Long-Term Care Insurance (B) Task Force
Denver, Colorado
November 17, 2024

The Long-Term Care Insurance (B) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Sydney Sloan (CO); Trinidad Navarro represented by Jessica Luff (DE); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Scott Shover (IN); Sharon P. Clark represented by Angi Raley (KY); Timothy J. Temple represented by Vicki Dufrene (LA); Michael T. Caljouw represented by Kevin Beagan (MA); Marie Grant represented by Mary Kwei (MD); Robert L. Carey represented by Marti Hooper and Robert Wake (ME); Chlora Lindley-Myers represented by Jo LeDuc and William Leung (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Margaret Garrison and Maggie Reinert (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper represented by Todd Rich (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Numi Griffith (OR); Michael Humphreys represented by Dave Yanick and Lindsi Swartz (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise represented by Karl Bitzky (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented by Daniel McAdams (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Fairbanks (VA); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler represented by John Haworth (WA); Nathan Houdek represented by Rebecca Rebholz (WI); Allan L. McVey represented by Joylynn Fix (WV); and Jeff Rude represented by Tana Howard (WY).

1. Adopted its Oct. 2 and Summer National Meeting Minutes

The Task Force conducted an e-vote that concluded Oct. 2 to adopt a recommendation to the Health Insurance and Managed Care (B) Committee for 2025 proposed charges, which include disbanding the Long-Term Care Insurance (B) Task Force on Dec. 31, 2024, and recommending charges for the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force.

Smock made a motion, seconded by Kamil, to adopt the Task Force's Oct. 2 (Attachment One) and Aug. 13 minutes (*see NAIC Proceedings – Summer 2024, Long-Term Care Insurance (B) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Andersen said many regulators have been concerned about escalating long-term care insurance (LTCI) rates for policyholders who are over the age of 85. In the 25-years-and-over duration range, these policyholders have faced cumulative rate increases in excess of 400% and are facing future rate increases. This has been labeled the "85/25/400" policyholder issue. He said that during discussions, a suggestion to resolve the 85/25/400 issue is to adjust the cost-sharing factors in the Minnesota rate review methodology. The 400% cumulative rate increase issue would be addressed by flattening the slope of future rate increases after 400%. It was determined that it would be difficult to address the age 85 and duration 25 issues. However, after the study, it was determined that fixing the 400% cumulative rate increase issue indirectly addresses the age 85 and duration 25 issues.

Andersen said these discussions impact filings that insurers voluntarily submit to the multistate actuarial (MSA) team. The MSA process in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) is intended to increase uniformity between states, but it does not impose any requirements on state insurance departments regarding rate approvals.

Andersen said the Long-Term Care Actuarial (B) Working Group met Nov. 16 and Oct. 9. During its Nov. 16 meeting, the Working Group discussed comments received on proposed LTCI cost-sharing approaches. The Working Group adopted the proposed cost-sharing factors that would be applied to the Minnesota approach.

Fix made a motion, seconded by Chaudhuri, to adopt the report of the Long-Term Care Actuarial (B) Working Group(Attachment Two). It was noted the motion does not include adoption of revisions to the LTCI MSA Framework, as those revisions will be exposed and adopted by the Task Force separately. The motion passed unanimously.

3. Exposed Proposed Revisions to the LTCI Multistate Rate Review Framework

Lombardo said the Minnesota approach and cost-sharing are already included in the current LTCI MSA Framework. He said the Task Force was given two tasks by commissioners early in the year. The first is to develop a single methodology that was more explainable and understandable for commissioners, regulators, and consumers as to how the MSA team's recommendation was determined. There was significant support from the Long-Term Care Actuarial (B) Working Group for the Minnesota method to become the single rate review methodology, which the Working Group adopted at its Oct. 9 meeting.

Lombardo said the second task that commissioners asked the Task Force to address was to find a solution for the 85/25/400 policyholder issue. The Long-Term Care Actuarial (B) Working Group discussed ways to do this. Several individuals indicated there was a risk of discrimination in addressing this issue by increasing rates for younger policyholders in the block. The Working Group aimed to reduce the impact on the 85/25/400 policyholders without creating discrimination and without having each state pass different legislation limiting increases in the rate filings. He said if the Task Force keeps the existing cost-sharing approach in the LTCI MSA Framework, the Task Force will not have addressed the task given by the commissioners. The 85/25/400 issue will remain and will need to continue to be discussed.

Lombardo said Andersen proposed an approach where the curve is greater at the beginning years, winds down at 400%, and reduces rate increases after reaching a 400% cumulative rate increase level. He said Leung offered a different methodology. Lombardo said Andersen's proposal was adopted by the Working Group at its Nov. 16 meeting. He said he understands regulators continue to have questions. Lombardo said that he and Andersen will meet individually with any state insurance department that needs help understanding the approaches, but he will not tell states how to vote. He said each state insurance department should make its own educated decision on the cost-sharing approach.

Lombardo recommended exposing the draft revisions to the LTCI MSA Framework, including the proposed single LTCI MSA rate review approach and modifications to the cost-sharing formula as adopted by the Working Group, for a 25-day comment period ending Dec. 13, 2024. There was no objection to the exposure or comment deadline.

Lombardo said other issues that were discussed at the Working Group meeting on Nov. 16 will continue to be discussed by the Working Group in the future, including adding clarifying language and reader notes.

Chaudhuri said he does not understand the impact of the new cost-sharing formula compared to the existing cost-sharing formula and asked if an example of the impact could be provided. Fix suggested a regulator-only educational session before the Dec. 13 comment period deadline to walk regulators through an insurer's actual

rate increase filing using the revised cost-sharing formula. Lombardo and Andersen agreed to schedule an educational session.

Lombardo said the Long-Term Care Insurance (B) Task Force will schedule an open meeting during the week of Dec. 16 to receive and discuss comments on the exposure draft and consider adopting revisions to the LTCI MSA Framework. If adoption cannot be achieved at that meeting, the Health Actuarial (B) Task Force will conduct further discussion and re-exposure in 2025.

4. Heard a Presentation on the Results of the RBOs and Consumer Notices Research Project

Brenda Rourke (NAIC) provided an overview of the research project being conducted by the Center for Insurance Policy and Research (CIPR) on reduced benefit options (RBOs), consumer notices, and consumer choices (Attachment Three). Rourke said that, in conclusion, the study results indicated:

1. The clarity of the letters matters. Staff recommend revisiting the guidelines used to review rate increase letters to ensure communication is accessible to the general population and uses “plain language.”
2. Greater perceived behavioral control and financial knowledge impact choice. Therefore, it is important to provide education and resources to help consumers make this choice.
3. Individuals who received a prior rate increase and had a greater perception of the risk of needing long-term care were more likely to keep their policy and pay the higher premium, regardless of age, income, or education.

Rourke said a complete report on the findings is expected to be published by the CIPR by Dec. 31, 2024. In 2025, the CIPR will focus on further research related to: 1) the impact of modifying the language and adding a table of values to the consumer letter and 2) continuing to look at consumer understanding and perceptions of RBOs.

Lombardo said the CIPR may be asked to present the results of future work on this project during a future Senior Issues (B) Task Force meeting.

Having no further business, the Long-Term Care Insurance (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/LTCI TF/2024 FallNM LTCI TF/LTCITF 111724 Minutes.docx

Attachment Two – Comments Received on MSA Framework Exposure Draft

- Alabama Department of Insurance Page 2
- American Academy of Actuaries Page 5
- American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) Page 8
- Genworth Life Insurance Co. and Genworth Life Ins. Co. of New York Page 10
- Maryland Insurance Administration Page 15
- Missouri Department of Insurance, Financial Institutions, and Professional Registration Page 16
- Pennsylvania Insurance Department Page 22
- Risk and Regulatory Consulting Page 24
- Texas Department of Insurance Page 26
- Washington Office of Insurance Commissioner Page 31

December 13th, 2024

Jane M. Koenigsman,
FLMI Sr. Manager II, Life & Health Financial Analysis
NAIC Financial Regulatory Services
1100 Walnut St, Ste 1000 Kansas City, MO 64106-2197

Re: Exposure Draft of the Long-Term Care Insurance Multistate Rate Review Framework

Dear Ms. Koenigsman,

Alabama appreciates the opportunity to comment on the revisions to the Long-Term Care Insurance Multistate Rate Review Framework, including the proposed single LTCI MSA rate review approach and modifications to the cost-sharing formula.

We appreciate all the work done in developing the MSA Framework. We support the proposed single approach with the cost-sharing formula that was exposed, but with an additional level of cost-sharing. We propose increasing the haircut for the portion of the (blended) cumulative rate increase between 300% and 400% from the 20% in the exposure draft to 60%.

We currently have a cost-sharing formula that has been used in MSA filing to determine rate increases. In the formula that was exposed, it is our understanding that in an attempt to reduce the level of rate increases at higher attained ages/durations the haircut was increased from 50% to 80% for the share of the (blended) cumulative rate increases in excess of 400%. Additionally, to offset this increase, the haircut was reduced to 20% for the portion of the (blended) cumulative rate increase between 100% and 400%. Previously the haircuts were 35% and 50% of the (blended) cumulative rate increase between 100% and 150%, and between 150% and 400%, respectively.

We support the intent behind these changes but believe an additional level of haircut will provide a better balance in the cost-sharing. As such, we propose increasing the haircut from the 20% in the exposure draft to 60% for the portion of the (blended) cumulative rate increase between 300% and 400%.

Sincerely,

Sanjeev Chaudhuri
Chief Actuary, Alabama Department of Insurance

cc: Paul Lombardo, Fred Andersen

Exhibit I

The current, exposed and our proposed cost-sharing factors are given below:

Current

The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:

i. No haircut for the first 15%.
ii. 10% haircut for the portion of cumulative rate increase between 15% and 50%.
iii. 25% haircut for the portion of cumulative rate increase between 50% and 100%.
iv. 35% haircut for the portion of cumulative rate increase between 100% and 150%.
v. 50% haircut for the portion of the cumulative rate increase in excess of 150%.

Exposed

The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:

i. 5% haircut for the first 100%.
ii. 20% haircut for the portion of cumulative rate increase between 100% and 400%.
iii. 80% haircut for the portion of the cumulative rate increase in excess of 400%.

Our proposal

The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:

i. 5% haircut for the first 100%.
ii. 20% haircut for the portion of cumulative rate increase between 100% and 300%.
iii. 60% haircut for the portion of cumulative rate increase between 300% and 400%.
iv. 80% haircut for the portion of the cumulative rate increase in excess of 400%.

Exhibit II

The effects of the different cost-sharing options are given below:

Blended cum. rate inc.	Final cumulative rate increase		
	Current	Exposed	Proposed
15%	15%	14%	14%
50%	47%	48%	48%
100%	84%	95%	95%
150%	117%	135%	135%
200%	142%	175%	175%
250%	167%	215%	215%
300%	192%	**255%**	**255%**
350%	217%	295%	275%
400%	242%	**335%**	**295%**
576%	**330%**	370%	**330%**
712%	**398%**	**397%**	357%
1000%	542%	455%	415%
2000%	1042%	655%	615%
3000%	1542%	855%	815%
4000%	2042%	1055%	1015%

December 12, 2024

Andrew N. Mais, Chairperson
Grace Arnold, Vice Chairperson
Long-Term Care Insurance (B) Task Force
National Association of Insurance Commissioners (NAIC)

Via email: jkoenigsman@naic.org

Re: Exposure Draft of the Long-Term Care Insurance Multistate Rate Review Framework

Dear Chairperson Mais and Vice Chairperson Arnold,

On behalf of the American Academy of Actuaries (Academy)[1] Long-Term Care (LTC) Committee (Committee), I appreciate the opportunity to provide comments in response to the NAIC Long-Term Care Insurance (B) Task Force's November 20, 2024, request for comments on the exposure draft of the *Long-Term Care Insurance Multistate Rate Review (LTCI MSA) Framework*.

The Committee offers no comment on the selection of the Minnesota approach as the single cost-sharing formula. The Committee appreciates that the proposed "adjust[ment] of the cost-sharing components within the MSA method to address specific public policy challenges" is now discussed within Section V.F. of the *NAIC LTCI MSA Framework* which we suggested in our July 23, 2024 comment letter.

The MSA Review is designed to provide the opinion of one or more qualified actuaries regarding a rate filing submitted via the MSA process. Section II.A. of the Framework specifies the qualifications of an MSA Team Member, including recognized actuarial credentials and relevant experience with LTCI. Participation on the MSA Team is also expected to provide opportunities to meet the requirements of the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards or USQS). The MSA Advisory Report is expected to be relied upon, to varying degrees, by participating state departments of insurance. In this context, the Committee believes it is important to recognize when an MSA Team reviewing actuary is performing actuarial analysis and judgment, versus applying a pre-determined formula.

The Committee offers the following comments on the Exposure Draft which we believe would further clarify the distinction between the actuarial and non-actuarial aspects of the MSA Review:

- Section V.A. of the Framework discusses the MSA Team's Actuarial Review Considerations. It requires members to apply their expertise and professional judgment in reviewing insurer-provided experience and challenge when necessary (or, thoroughly assessing reasonableness of actuarial assumptions), validating projections of claims and premium (both current and "if-knew"), and requesting new projections where the reviewer deems necessary.
- The performance and communication of the results of the MSA Team's actuarial review by a qualified actuary are clearly actuarial functions, which the Committee believes would fall within

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

the scope of Actuarial Standards of Practice (ASOP) No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*, No. 18, *Long-Term Care*, which are applicable to regulatory filings for LTCI, as well as ASOP No. 41, *Actuarial Communications*.

- Once suitable actuarial projections are determined, the application of the non-actuarial cost-sharing formula adopted by the NAIC can be performed mechanically, without specialized actuarial expertise. The non-actuarial cost-sharing formula should not necessarily be a part of the reviewer's actuarial opinion.

The Committee would recommend the following edits to the sample report in Section VII.A (highlighted in yellow):

- Within the Executive Summary:

Executive Summary

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 34% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company's block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options (RBOs) may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the ~~actuarially justified~~ MSA approach. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

- Within the "Workstream-Related Review Aspects," section, the Committee recommends moving language from the seventh paragraph to the beginning of the "Actuarial Review" section, and adding additional language (addition in italics):

Workstream-Related Review Aspects

Actuarial Review

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. *In addition to its actuarial review,* [t]he MSA team applied the MSA approach to calculate the recommended, approvable rate increases. Aspects of the MSA approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states' laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues.
- Elimination of rate increases related to inappropriate recovery of past losses.

The MSA approach also has additional unique aspects: 1) consideration of adverse investment expectations related to the decline in market interest rates, 2) adjustments to

projected claim costs to ensure the impact of uncertainty is adequately borne by the insurer; and 3) a cost-sharing formula applied in typical circumstances.

[. . .]

~~The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also,~~ The initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

As the stated intention is to allow states to utilize the actuarial analysis when taking action on a rate filing, the Committee also suggests that the opinion of a qualified actuary who is a member of the MSA Team be included in the report. This actuary should specify which aspects of the actuarial review are subject to their opinion and which aspects are a result of agreed-upon formulas adopted in the MSA Framework, with consideration to the requirements of Section 3.4.4 of ASOP No 41.

*****

The Committee appreciates the opportunity to provide these comments on the LTCI MSA Framework. If you have any questions related to these comments, please contact Matthew Williams, the Academy's senior health policy analyst (williams@actuary.org).

Sincerely,

Andrew Dalton
Chairperson, LTC Committee
American Academy of Actuaries

CC:
Jane Koenigsman, NAIC
David Torian, NAIC
Eric King, NAIC

December 13, 2024

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Chairs Lombardo and Andersen,

The American Council of Life Insurers (ACLI)1 and the America's Health Insurance Plans2 (AHIP) appreciate the opportunity to comment on the redline revisions to the Long-Term Care Insurance (LTCI) Multistate Rate Review (MSRR) Framework released for public exposure on November 17, 2024. These revisions, including the proposed single rate review methodology and adjustments to the cost-sharing formula, represent a meaningful step toward fulfilling the MSRR's original charge of encouraging uniformity and consistency in rate review practices, while also addressing regulatory concerns regarding large cumulative rate increases on older age policyholders (i.e. the 85/25/400 issue).

We commend the Long-Term Care Actuarial Working Group and Task Force for advancing these revisions, which provide a practical foundation for addressing longstanding challenges in the rate review process. While companies remain concerned that certain aspects of the framework lack sufficient clarity, there is a shared understanding that delaying progress could result in greater uncertainty and complicate efforts to achieve a workable solution. These revisions, while not perfect, provide a reasonable foundation for promoting consistency and predictability in the rate review process, and moving forward is essential to maintaining momentum.

As the Task Force works toward finalizing the framework, we respectfully submit the following key considerations. These reflect the industry's priorities for ensuring the framework achieves its intended goals of promoting uniformity, predictability, and efficiency in the rate review process.

Key Considerations for Finalizing the Framework

- Accountability Mechanisms for State Alignment - A central objective of the MSRR is to foster greater consistency among states. To achieve this, it is critical to establish accountability mechanisms that encourage states to align with the MSRR's recommendations. Without such measures, the framework risks falling short of its intended purpose by perpetuating fragmented and inconsistent practices. Providing clear expectations and a mechanism to monitor how states utilize MSRR recommendations would strengthen the framework's impact and promote confidence among stakeholders.

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[1] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

- Recognizing Variability Across LTC Blocks - Differences among LTC blocks, both across and within companies, must be carefully considered in the MSRR recommendation. Historical pricing assumptions, benefit designs, and past rate increase approvals and disapprovals vary significantly and can affect the appropriateness of a single methodology. The framework should incorporate flexibility to account for these differences, ensuring that recommendations reflect the unique characteristics of each block.

ACLI and AHIP support advancing the proposed redline revisions as a practical step toward addressing regulatory challenges while upholding the MSRR's core objectives. Finalizing this framework is essential to achieving greater uniformity and efficiency in rate review process.

Thank you for your consideration. We look forward to continuing to work with the Task Force to enhance the LTCI rate review process and achieve the MSRR's goals.

Sincerely,

Jan Graeber
Senior Actuary, ACLI

Ray Nelson
Consultant for AHIP

Genworth Life Insurance Company & Genworth Life Insurance Company of New York
Response to MSA Framework Exposure Draft
December 13, 2024

Genworth Life Insurance Company and Genworth Life Insurance Company of New York (collectively, "Genworth" or the "Company") appreciate the opportunity for continued engagement in the MSA Single Review Method development process. Genworth has provided many of the following comments to the LTC Actuarial Working Group, but is restating them here for consideration by the LTC Task Force.

In attempting to use the MSA Framework guidance to determine the justification of requested rate increases, the presentation of results lacks the necessary transparency to support consistent results across states, and therefore is not, in its current form, an optimal tool for reviewing rate increase requests. **Any method used to support rate increase decision-making should be clear in its inputs and methodology** and should be expected to produce the same results across all jurisdictions using the same inputs. While there may be some subjectivity in final adjustments based on company or block-specific considerations, the modeled result should be clear and consistently produced. The current guidance in the MSA Framework does not provide sufficient detail to achieve this objective. While instructional presentations may be helpful for those regulators able to attend, they should not take the place of **clearly written, enduring guidance** that can be applied consistently by regulatory and industry participants over a long period of time.

Genworth would also like to make clear that while it understands that some state regulators may choose to use some form of a Blended If-Knew method (such as that invoked by the Minnesota Method) to inform rate increase decisions, **the inclusion of If-Knew in these decisions renders them non-actuarial**. A regulator's use of a policy adjustment, including the use of the Minnesota Method with its If-Knew component, does not make that adjustment actuarial in nature.

To begin, Genworth believes that **cumulative past increases should be backed out before blending**. Once this has been completed, it provides a very clear and transparent view to decision-makers of the exact contributions of the two components of the increase, and the amount of cost-sharing absorbed by the insurer. For the If-Knew portion, the result should be floored at zero so as not to imply that a rate *decrease* would be appropriate given that the initiation of the pricing exercise was the result of a deterioration in experience; a negative contribution from If-Knew would be logically unsound.

Genworth was asked to share an example to demonstrate how cumulative past increases should be backed out to avoid the implication of a negative contribution of an If-Knew increase. The example outlined below was shown in our second comment letter dated August 1, 2024, but the presentation has been updated to better highlight this issue.

Steps	Description	Rate Increase Result	Lifetime Loss Ratio
	Prior Cumulative Rate Increases	*325%*	
	Best Estimate Projections		*95%*
	Percentage of Block Remaining: 56.8%		
	Since Inception If-Knew	*127%*	
	Make-Up Cumulative Rate Increase	*2042%*	
MSA-1	MSA Blended Cumulative Rate Increase	1215%	
MSA-2	MSA Blended Cumul RI - with Add'l Cost-Sharing	548%	
MSA-3	MSA Blended RI - backout Prior Rate Increases	41%	89%
GNW-1	Make-Up Justified Rate Increase	404%	60%
GNW-2	Blended Rate Increase (Floored If-Knew)	229%	70%
GNW-3	Blended RI with Add'l Cost-Sharing (Prop A)	198%	72%

The following outlines an alternative approach to the steps outlined in the MSA Framework examples that we believe better applies the intended principles in a format that is transparent, easy to replicate, and makes reasonable adjustments such as eliminating instances where rate decreases are implied.

- Starting Point: The cumulative rate increases needed to get the block back to a lifetime loss ratio of 60%, established at initial product pricing, are 2042%. Note that the incremental increase above the already implemented rate increases would be 404%, as clearly shown in the GNW example. Note that the steps outlined in the MSA Framework obfuscate this critical datapoint. The Since-Inception If-Knew rate increase is 127%, well below previously approved and implemented rate increases of 325%.
- MSA Approach
    - Step MSA-1: Blending the If-Knew rate increase (127%) with the make-up increase (2042%)
    - Step MSA-2: Applying the cost-sharing factor to the blended amount
    - Step MSA-3: Backing out prior cumulative rate increases of 325%
    - Takeaway: without backing out the prior rate increases before blending, the approach lacks clarity into what exactly is being blended. In other words, the decision-maker has no insight into what the Make-Up would be compared to the If-Knew result on a standalone basis. **Further, since the past increases are larger than If-Knew but not backed out until after blending, it implies a rate *decrease* contributed by If-Knew**, as demonstrated in the more transparent approach below. This order of operations obfuscates the magnitude of cost-sharing applied to the actuarially justified increase.
- Genworth Proposal to correct for illogical results when prior cumulative increases are larger than the If-Knew result

- Step GNW-1: The prospective rate increase needed to get the block back to a lifetime loss ratio of 60% is a prospective increase to premiums of 404% (can be calculated by removing the 325% prior cumulative rate increases from the 2042% make-up cumulative increase)
- Step GNW-2: Since the prior cumulative rate increases are greater than the If-Knew result, it is most reasonable to back out the prior rate increases and floor the If-Knew portion of the calculation at 0%; otherwise the methodology suggests a rate *decrease* is appropriate (which is illogical given the exercise was initiated by a deterioration in experience). If the If-Knew portion were not floored at 0%, the result would be a Blended Rate Increase of 209%, implying an If-Knew contribution of (47)% (ie, a rate *decrease*).
- Step GNW-3: The resulting rate increase is then reduced by the additional cost-sharing provision
- Takeaway: while the result, using the current additional cost-sharing, results in a higher increase, the approach adds transparency to the exact level of cost-sharing applied. Additional cost-sharing could conceivably be adjusted to arrive at a similar result as the MSA approach, but the exact magnitude would at least be clear.

Cost-sharing is applied in a variety of ways, not all of which have been clearly disclosed in discussions on the MN method.

1. Blending with If-Knew, a hypothetical rate increase that relies on historical fictional premiums which cannot be collected by the company to pay actual claims.
2. Not flooring the If-Knew contribution at 0% when it is lower than prior justified and approved cumulative increases. In the GNW example, not flooring the if-knew contribution at 0% would mean a (47)% rate increase (ie, a rate *decrease*) was being used in the weighting, which would have driven down the blended increase from 229% to 209%. Genworth understands the additional cost-sharing provision is designed to be assessed on a cumulative rate increase basis, but not accounting for the implications of an If-Knew increase that is below increases already granted creates an additional form of cost-sharing that drives down increases without the transparency of the mechanics behind the individual contributions of each portion of the blended amount in the final incremental increase.
3. Additional cost-sharing. As seen in the GNW example, the LLR is driven up to 70% before the additional cost-sharing factors are applied, well above the 60% to which the block was originally priced. This does not suggest that a 70% LLR is always a reasonable target for a block of LTC, but an 10% increase in the LLR is a significant level of cost sharing already being produced.
4. Implementation delay. As the MSA Framework examples are silent on use of realistic implementation date in the calculations, use of the cash flow valuation date as the implicit assumed rate increase date results in an increase to the LLR due to the natural lag from valuation date to actual implementation date.

While the majority of the discussion on the Minnesota Method at Actuarial Working Group ("AWG") sessions has been to voice concerns over the non-actuarial components, Genworth believes **the AWG should discuss the truly actuarial components of the methodology**, such as the one listed above, to ensure agreement in approach. Genworth has significant first-hand experience, through its interactions with regulators as part of the rate increase filing process, with the various approaches

to calculating and blending rate increase methods and has noted some divergence in their application. A universal decision on each of the below components would better support stability within the industry and enable reliable modeling and risk management. Consistent with its experience in applying these methodologies over numerous filings and across several jurisdictions, Genworth believes the following approaches are most appropriate when attempting to blend an actuarially justified rate increase with an "If-Knew" rate increase, as is attempted in the Minnesota Method. (Please note that the following statements do not constitute a position that the use of "If-Knew" in any form could be deemed appropriate in certain applications)

- **Aggregate Approach.** The most appropriate, and most easily understood, approach to assessing the need for rate increases in a Blended If-Knew methodology is to use what the MSA Framework describes as the "Aggregate Application." The example in the MSA Framework documentation is based on this approach, providing clarity and leading to more consistent application. Genworth's experience has shown that this approach is used almost exclusively as it provides the most transparency without the subjectivity inherent in the assumed profit of the "Sample Policy-Level Verification."
- **Implementation Date.** As detailed in the AWG White Paper on this topic (issued October 2018), "delays in implementing actuarially justified rate increases due to either a carrier failing to file a needed rate increase, or delays in the regulatory approval of a needed rate increase, can pose a potential solvency risk." Insurers should be permitted to use a likely implementation date in the projections and update the implementation date as necessary for prolonged rate review timelines to avoid additional financial strain and more closely mimic the impact of the rate increases.
- **Consistency with Existing Laws.** As the MSA Framework is not currently tethered to existing regulations, the use of Blended If-Knew should comply with, but not supersede, existing law. For example, the final rate increases granted would be expected to comply with the 58/85 test described in Rate Stabilization regulations. Furthermore, the use of MAE should also be included for applicable products/policies, so as not to conflict with issued guidance and the ability for actuaries to certify to the rate increase requests. Removal of MAE from the final rate increase offered/granted is an additional form of cost-sharing above what the standard Blended If-Knew would recommend. To specifically avoid conflict, the Framework should be updated to clarify that the final result must comply with existing laws and regulations.

There are other topics which are less consistent nationwide, and while Genworth has strong positions on these matters, it understands there are additional conversations that may lend themselves better to individual interactions with state regulators as they arise on specific filings.

- **Waiver of Premium.** The inclusion or exclusion of Waiver of Premium (WOP) benefits should be consistent with original pricing methodology. If a company included WOP as a claim benefit and grossed up premiums when setting original rates which were approved for use by a regulator, such an approach should be permissible in subsequent rate increase calculations.
- **Phasing of Rate Increases.** For larger increases, Genworth believes it is sometimes reasonable, though not always preferable, to phase increases in over a number of years (usually two to three years) if the regulator chooses to approve on that basis. This approach works best when there is agreement between the company and regulator that future filings are not planned, meaning a sufficient approval is being granted to prevent an immediate refiling. Otherwise, phasing causes unnecessary delays in future filings, driving up the

ultimate level of increase needed to achieve a similar financial impact if implemented immediately.

- **Additional Cost-Sharing.** There are many downsides to a one-size-fits-all approach to the additional cost-sharing provision, as assumptions, benefit structures, and policyholder demographics can vary significantly from block-to-block. Furthermore, as this provision may be waived for unspecified "solvency concerns," the determination of whether additional cost-sharing is needed, and to what extent, may vary significantly from company-to-company. Given the dynamic nature of any additional cost-sharing that regulators may wish to impose, it seems most prudent to explicitly leave the determination to discussions between insurers and regulators so that regulators may preserve the ability to specifically address public policy concerns, as permitted by applicable law, for the consideration of policyholders within each state.

Genworth appreciates the opportunity to provide industry feedback on these efforts. While we would be reluctant to submit any new rate increase filings to the MSA at this time, we will continue to support opportunities for collaboration to address our concerns and memorialize solutions in the MSA Framework.

COMMENTS FROM MARYLAND

From: Bradley Boban -MDInsurance-
Sent: Thursday, December 12, 2024 8:12 AM
To: Koenigsman, Jane
Subject: Comments on LTCI MSA Framework document

Maryland notes that the revised cost-sharing formula reduces carrier cost-sharing below a 400% needed increase, increasing the share that the subscribers must pay. This leads to a net increase in blended rate increase for those increases that are 700% or less. This is contrary to the goal which was to reduce the rate increases for the 85/25/400 cohort. It's not until the cumulative increase gets up to 750% that the proposed methodology produces a lower blended increase.

Why was it necessary to change any of the existing haircuts? Wouldn't it have been better to just add a new haircut level at 400% on top of the existing haircut levels? That would have only reduced rates for consumers and led to lower premium increases for the 85/25/400 cohort. That's would be recommendation that MD could support.

Brad Boban, ASA, MAAA
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COMMENTS FROM MISSOURI

To: Jane Koenigsman (NAIC)

Cc: Paul Lombardo, Fred Andersen, Jo LeDuc, Chlora Lindley-Myers

Re: Exposure Draft Notice: LTCI (B) Task Force: MSA Framework. Comments Due Dec. 13 ,2024

Date: 12/06/2024

Jane,

Thank you for coordinating the exposure. Missouri supports the effort in the MSA Framework but has the following concerns regarding the exposure draft:

1. Item 6 of the MSA Approach shows revised cost-sharing factors with a reviewer's note, stating that the blending of the if-knew and makeup premiums (Step 5) and the cost-sharing formula (Step 6) were reviewed and updated in 2024 to address specific public policy challenges, particularly around significant increases for older-age policyholders, with longer durations. The LTC Actuarial Working Group did not adequately discuss the revision's purpose and effect. As such, adopting the MN revised cost-sharing factors appears to be premature.
   a. The Issue
      On slide 5 of the ppt document "Minnesota approach and MSA concepts" (LTCI Cost Sharing Formula_MN Method.pdf) dated 110124 and authored by Fred Andersen, it is said that a new set of factors is proposed to address the 85/25/400 issue, which contemplates higher cumulative rate increases. The revision directly adds additional cost-sharing above 400%, thus indirectly addressing the issue because 400% cumulative rate increases tend to occur more often for older ages and later durations, such as those above age 85 and duration 25.
   b. The Confusion
      While we can all agree on the high rate-increase burden put on seniors at late policy duration, there was inadequate discussion to define the issue using the term 85/25/400.
      (1) Why 85? Would regulators consider a rate filing needing special attention for policyholders 85 or above versus 80 or above? At what percentage of in-force policyholders reaching age 85 would one give special attention to the filing?
      (2) Similarly, why 25? Would one consider it a non-issue if the high rate increase affects policyholders aged 85 or above but before policy duration 25 at the time of the valuation/projection?
      (3) It is not clear which cumulative rate the 400 is referring to. At least three cumulative rate increases are of interest: the one resultant from the requested rate increase, the blended cumulative increase, and the resultant cumulative increase after applying the current cost-sharing factors. Since the MN proposal suggests an 80% haircut for the portion of the cumulative rate increase higher than 400%, the 400 is likely referring to the blended cumulative increase. However, referring to Appendix B, it is evident that the MN revision resultant cumulative increases continue to be higher than those resulting

from the current factors until the blended cumulative increase is 700%. The breakeven point is a blended cumulative increase of 712%; the result after cost sharing is 397%.

i. Suppose the purpose is to contain the cumulative increase when the blended cumulative increase is above 400%. In that case, the MN revision will increase the resultant rate increase for the range of blended rate increase from 400% to 712%, contradicting this purpose.

ii. Alternatively, the purpose may be to target restraining the resultant rate increase above 400%, demonstrated by the cross-over point of around 400% on slide 13 of the abovementioned PowerPoint. In this case, the analysis should focus on the blended cumulative rates exceeding 712% and see if the revision adequately addresses the issue. 2d below further discusses the effectiveness of the MN proposal in this area and possibly an improved proposal from Missouri.

(4) Why 400? Would a 300% cumulative rate increase be a concern? The MN revision has the effect of lower cost sharing for resultant cumulative rate increases currently between 300% and 400%. The cumulative rate increases after revised cost sharing are therefore higher. 2c below further discusses the effectiveness of the MN proposal in this area. Missouri's proposal dampens the impact of MN revision on this not-so-clear area.

2. Missouri's Proposal
   (see Appendix A for the proposal & Appendix B for a comparison of the effects)

   a. First 100% of rate increases
      We understand that the earlier rate increases are critical for an LTC plan's sustainability and would help reduce the need and magnitude of later duration increases. Therefore, it may be better for both the company and the policyholders if the cost-sharing for the 100% rate increase is 0% instead of the 5% in the MN revision. If the rate increase is reviewed and considered appropriate under the minimum standard loss ratio and 58/85 rule, the rate increase should be allowed when the cumulative rate increase is not more than 100%. It appears that the industry has been avoiding the MSA process but has filed with each state directly for rate increases within the first 100%, and most states would approve or non-disapprove the request without explicit or implicit margin for such direct filings. Missouri proposed that the adjustment to the single MSA approach would encourage companies to apply to the MSA Team in early duration and be consistent with current practices.

   b. Blended Cumulative increase between 100% and 500%
      The Missouri proposed 25% cost-sharing factors are higher than the 20% in the MN revision to catch up for the lower cost-sharing in the first 100%. The resultant rate increase under the Missouri proposal will continue to be higher than those from the MN revision for the first 200% blended cumulative increases. In general, starting from 200% blended cumulative increase, the resultant cumulative increases are trending slightly lower than those from the MN revision but higher than those from applying the current cost-sharing factors.

   c. Blended Cumulative increase between 500% and 700%

The current resultant increases are between 300% to 400% in this range. It is essential to explicitly state in the 85/25/400 definition that increasing the consequent increases in this range is desirable. At a blended increase of 500%, the MN revision increased the result from 292% to 355%, a net difference of 63%. There should be a discussion and agreement on whether rate increases at this level are of concern and if more (or less) rate increases should be allowed than the current MSA formula level. The Missouri proposal results in rate increases somewhat higher than the current MSA formula level but not as high as those permitted under the MN revision. The Missouri proposal resultant rate increase will start to be lower than the current MSA formula level when the blended rate increase is around 650%. The lower chart in Appendix C depicts the trade-off between higher resultant increases in earlier duration versus lower resultant increases after the cross-over of around 650%.

d. Blended Cumulative increase over 700%

The most crucial difference between the Missouri proposal and the MN revision is the cost-sharing effect at a blended increase of around 4000%, a realistic level seen in a 2023 MSA filing where the attained age 85+ in force policyholders represented about 32%. The current formula brings the resultant down to 2042%, the MN proposal 1055%, and the Missouri proposal 605%. The Missouri proposal better contains the cumulative increase when the increase is more impactful on the elderly policyholders. See the top chart in Appendix C for a visual comparison.

Appendix A

<u>Missouri Proposal vs. Current and Minnesota Proposal exposed</u>

Current:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%
- 25% for the portion of cumulative rate increase between 50% and 100%
- 35% for the portion of cumulative rate increase between 100% and 150%
- 50% for the portion of the cumulative rate increase in excess of 150%.

Minnesota Proposal (Proposal A):

- 5% haircut for the first 100%
- 20% haircut for the portion of cumulative rate increase between 100% and 400%
- 80% haircut for the portion of the cumulative rate increase in excess of 400%

Missouri Proposal:

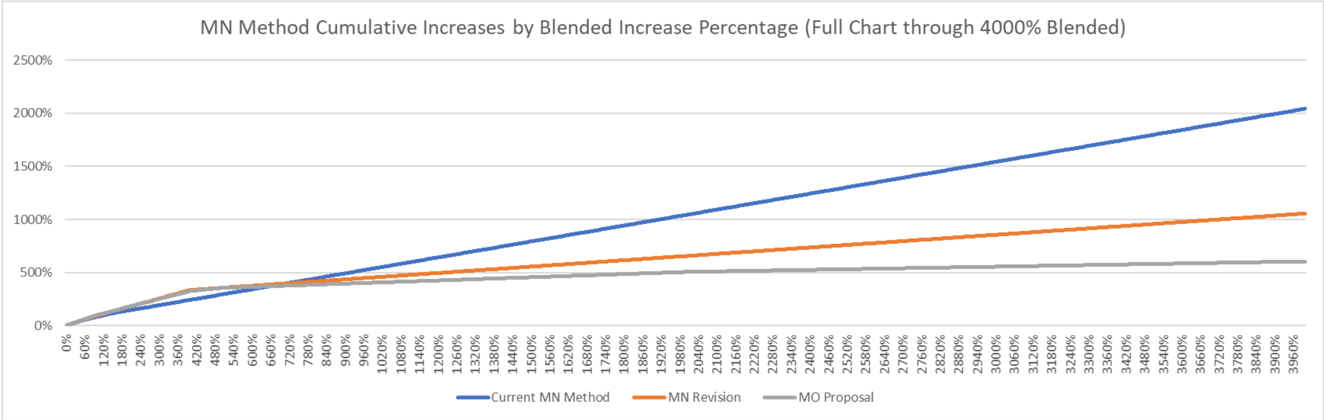
- No haircut for the first 100%.
- 25% for the portion of cumulative rate increase between 100% and 400%
- 70% for the portion of cumulative rate increase between 400% and 500%
- 90% for the portion of cumulative rate increase between 500% and 2000%
- 95% haircut for the portion of the cumulative rate increase in excess of 2000%

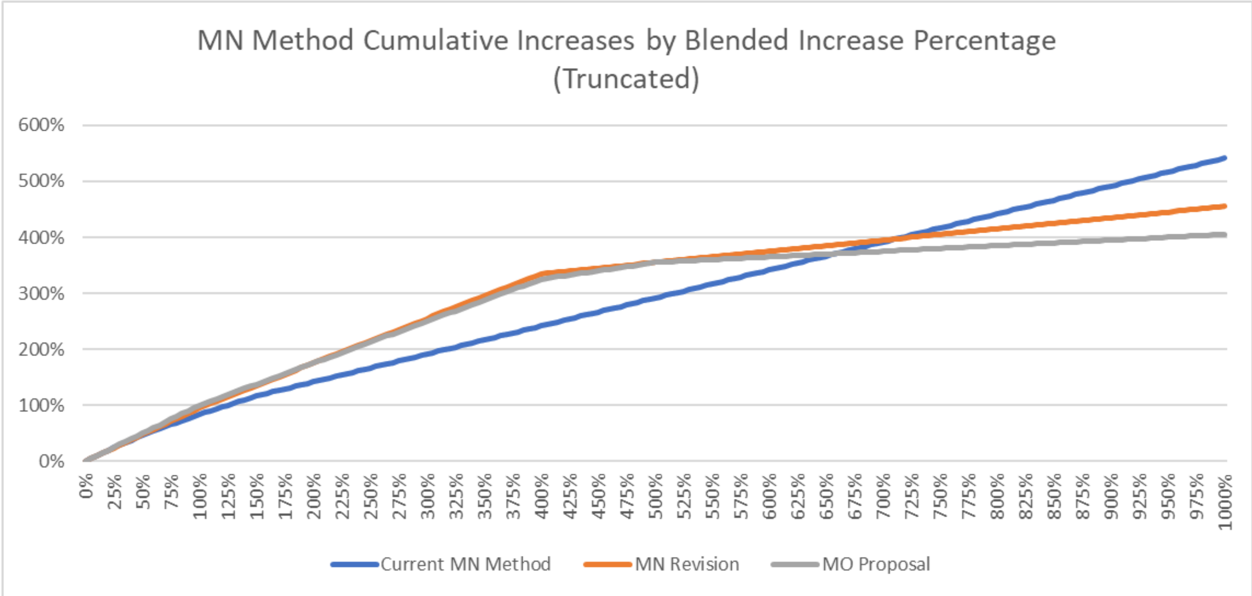
Appendix B

Comparing the effects of different cost-sharing factors

Blended cum. rate inc.	Current	MN Revision	MO Proposal
15%	15%	14%	15%
50%	47%	48%	50%
100%	84%	95%	100%
150%	117%	135%	138%
200%	142%	175%	175%
250%	167%	215%	213%
300%	192%	255%	250%
350%	217%	295%	288%
400%	242%	335%	325%
450%	267%	345%	340%
500%	292%	355%	355%
550%	317%	365%	360%
600%	342%	375%	365%
650%	367%	385%	370%
700%	392%	395%	375%
750%	417%	405%	380%
800%	442%	415%	385%
850%	467%	425%	390%
900%	492%	435%	395%
950%	517%	445%	400%
1000%	542%	455%	405%
2000%	1042%	655%	505%
3000%	1542%	855%	555%
4000%	2042%	1055%	605%

Appendix C





December 18th, 2024

Dave Yanick, FSA, MAAA
Pennsylvania Insurance Department
Actuarial Rate Review Supervisor LAH
717-724-7899

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Chairs Lombardo and Andersen,

The Pennsylvania Insurance Department (PID) appreciates the opportunity to provide comments on the recently released redline revisions to the Long-Term Care Insurance Multistate Rate Review Framework, which includes updates to the single rate review methodology, adjustments to the cost-sharing formula, the transition of LTCI MSA Framework governance to the HATF, and shifting certain work including reduced benefit options to the SITF and the HATF.

Singular and Transparent Rate Review Methodology

Firstly, and as previously communicated, the PID supports the development of a singular and transparent rate review methodology, compared to an approach that combines two differing actuarial rate review methodologies together. The current approach requires weighting both methodologies, which is hard to explain judgement and difficult to replicate. A singular methodology will remove the need to weight two separate methodologies to arrive at the final recommended rate increase. As a result, the weighting is eliminated with a singular approach and when authority allows, it enables states to replicate the methodology for state filed long term care rate filings, further aiding in creating an approach that applies, no matter how the filing is received.

Cost-Sharing Formula

Regarding the proposed updates to the cost-sharing formula within the MSA approach, the PID is cognizant of how these modifications may impact current and future LTCI policyholders and is in agreement that as cumulative rate increases rise, the insurer's cost sharing burden should increase as well since the insurer should have had more information on the probability of large rate increases than the policyholder had at the time of policy issuance.

Although the revised cost-sharing formula is aimed at reducing the rate increases that mature-adult policyholders and longer duration policies may encounter, the PID is concerned that regardless of what the formula is for cost-sharing, insurers know the rate increase that they need and have many levers of which they can utilize to get that rate increase post any prescribed cost-sharing adjustment. For example, insurers could potentially modify mortality, morbidity, lapse, interest rate assumptions to get the rate increase they initially desired after any cost-sharing adjustments. With this issue in mind, the PID believes the LTCAWG and the HATF should be spending more time on developing regulators' understanding on the reasonableness of the assumptions (mortality, lapse, morbidity, interest rates, etc.) going into LTC insurers' rate developments (i.e., projected claims costs), as these are the true components that are driving the large rate increases being requested by LTC insurers.

While the PID can support Proposal A, which contains the revised cost-sharing adjustments, the PID also believes it is worth discussing the need for capping any requested aggregate rate increase at 100%. Doubling an insured's premium is a situation that should be taken extremely seriously, as this could have a significant impact on an insured's financial condition, especially those older-aged policyholders on a fixed income. While this may increase the number of filings the MSA would need to review, the burden should be placed on insurers to update their experience, reexamine future assumptions, and submit a new rate increase filing if needed. A disclosure should also be required to inform the policyholder that while their rate increase has been capped, the anticipated required rate increase was X.X% and could be implemented in future years. This could help policyholders prepare for future increases while providing them with the information that they need to make informed decisions on RBOs and terminations.

The PID would like to suggest that a separate vote (outside of the other modifications being made to the LTCI MSA Framework) be taken on the adoption of the revised cost-sharing parameters, and that it is clearly spelled out on what a "No" vote implies – whether it means keeping what is currently included in the MSA approach, or if it implies a vote for Proposal B, as it appears to the PID that there are 3 options currently on the table:

1. The current cost-sharing formula as prescribed in the MSA approach,
2. A revised cost-sharing formula as prescribed under Proposal A, or
3. An alternative proposal provided and identified as Proposal B

Prior to such a vote, the PID feels that it would be beneficial for the committee to review the voting options, with examples of the consumer impact in each scenario, and allow for other recommendations. Then explain the significance of an abstention to the overall vote.

Other Amendments

The PID supports moving the governance of the LTCI MSA Framework to the HATF. While the PID also supports moving other related work such as reduced benefit options to the SITF, the PID would like to stress the importance of any RBOs being offered to policyholders facing large LTC rate increases that the rate increase forgone is actuarially equivalent to the benefit reduction being implemented, and in cases where the tradeoff is not equivalent a detailed explanation describing why actuarial equivalence cannot be provided.

The PID appreciates both the effort that has gone into the development of the LTCI MSA Framework and the opportunity to submit these comments. We look forward to the continued discussion on these matters and future issues and the adoption of the 2025 Amendments to the LTCI MSA Framework.

Sincerely,

Dave Yanick, FSA, MAAA
Pennsylvania Insurance Department

Memo

To:	Jane Koenigsman, NAIC, Senior Manager II, Life and Health Financial Analysis
From:	Lynn Manchester, FSA, MAAA, Director, RRC Andrew Larocque, ASA, MAAA, Supervisor, RRC
Date:	December 13, 2024
Subject:	RRC Comments regarding Long Term Care Insurance Multistate Rate Review Framework

Background

The Long Term Care Insurance Multistate Rate Review Subgroup ("the Subgroup") exposed a Long Term Care Insurance (LTCI) Multistate Rate Review Framework ("the Framework") which covers a potential approach to increase consistency of LTCI rate review actions across states and improve efficiency of LTCI rate reviews for insurers. RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the Subgroup members.

RRC Comments

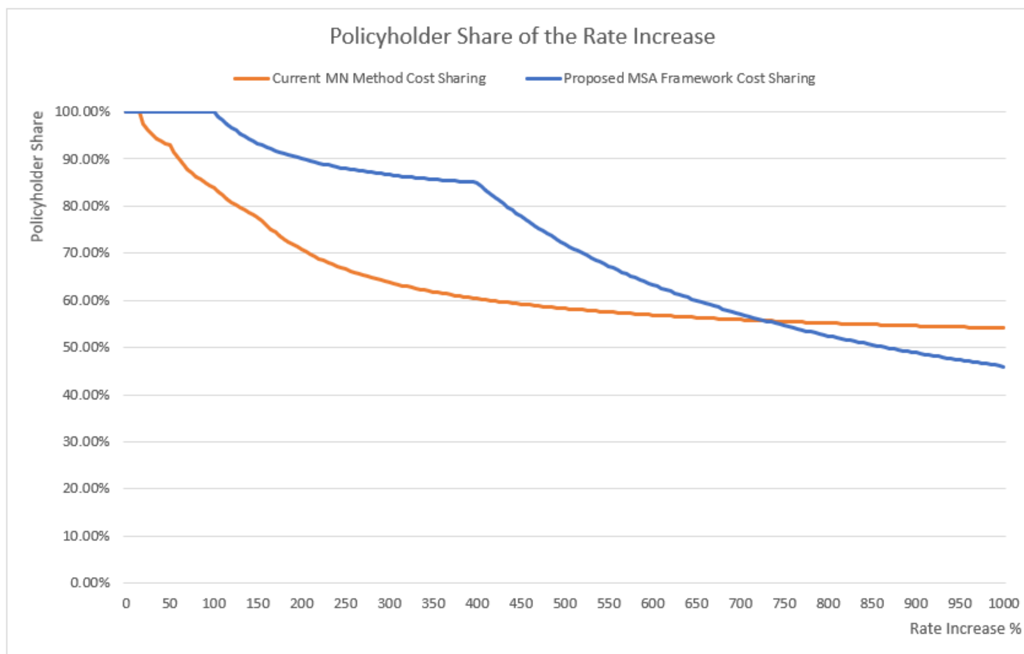
1. Overall, we applaud these continued efforts. We understand that there are current industry challenges associated with differences in rate approval practices among states and agree with efforts to increase uniformity of those practices while continuing to maintain the individual state decision making authority.

2. On page 15, under Future Non-Actuarial Considerations, there is new language that states "…the LTCI MSA Framework was amended in 2024 to adjust the cost-sharing components within the MSA method to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations."

    a. We recommend including a description of those specific public policy challenges, and by whom they were raised.

    b. It is not clear from the new cost-sharing formula how the impact differs for older-age policyholders versus other policyholders. We recommend the MSA Framework explain this difference.

3. Regarding the MSA Rate Review Approach, this approach is similar to the Minnesota Approach with a revised cost-sharing formula. The revised cost-sharing formula has a larger "haircut" for rate increases above 400%, and less grading of the haircut percentages for rate increases between 100% and 400%. The result is that the policyholder will bear more of the burden of rate increases than under the current MN method. The graph below shows the impact of the revised formula on policyholders.



We recommend that the Subgroup consider whether a phased in approach to the proposed change may be appropriate, to avoid the relatively large changes in cost sharing by policyholders for relatively smaller rate increases.

4. We suggest, if not already underway, that the Subgroup consider reaching out specifically to insured groups and their representatives for input on the changes, for example through consumer advocate offices.
5. The Subgroup may wish to consider varying the method based on the nature of the underlying block of business. For example, using the revised cost-sharing formula for blocks that have no previous rate increase approvals, and using a more graded formula for other blocks.

Thank you for the opportunity to provide comments on this important initiative. We can be reached at 813-506-7238/Lynn.Manchester@riskreg.com or 617-429-0069/Andrew.Larocque@riskreg.com if you have any questions.

Texas Response to Adoption of the Minnesota Method as the Single Method of Rate Review and of Adoption of the Revised Cost Sharing Techniques.

Cost Sharing Methods

- **Current Method**
  Given the MN Method as applied, we believe the current cost sharing may be optimal. However, if assumptions are "tightened", the Current Method may become too restrictive.

- **Recently Adopted**
  This method justifies larger rate increases with restrictions once the cumulative rate increase exceeds 400%.

Texas prefers the Current Method since we believe The Recently Adopted method is too restrictive. If a new method is adopted, we would support the cost sharing proposal from the revised methodology.

Texas is opposed to adoption of the Minnesota Method

Texas' primary concern with the current MN Method is that it may justify excessive rate increases. There are three reasons for this:

- Use of the statutory discount interest rate for projections
- Use of a 60% pricing loss ratio
- When applicable, not considering the 58/85 test rate stabilization requirement (Model Regulation 641) that was adopted by most states. While uncommon, Texas has seen a few filings where the proposed increase fails the 58/85 dual loss ratio test, but is justified under alternative approaches, including the TX PPV method.

Discount Rate

Any lifetime approach method is highly sensitive to the discount rate, including the MN Method. The standard valuation rate (which is used to determine minimal contract reserves) will immediately justify a significant rate increase.

Why is an adjustment to the discount rate necessary? If the average yield and the pricing yield is 5.5%, for example, and the standard valuation rate is 4.0%, the model will project non-existent historical losses. As a possible solution, Texas recommends use of Moody's Monthly Average Corporate Yields found on the NAIC website.

For historical projections, the minimum of the geometric average or the pricing yield is appropriate (to measure impact of historically low yields). For future projections, the pricing yield seems appropriate but could be modified if excessive.

Target Loss Ratio
The justified rate increase is also highly sensitive to the target loss ratio. The target loss ratio should reflect rate stability for consistency with the NAIC LTC Model Regulation (MDL – 641). This requirement is also consistent with the LTC Multistate Rate Review Framework.

This adjustment is similar to that used for the TX PPV Method except the Cumulative Rate Increase (C) includes the approved rate increase for the current rate adjustment filing. This is necessary because of the future projection of experience.

$$Target\ Loss\ Ratio = \frac{.58 + .85 * C}{1 + C}$$

Why is an adjustment to the loss ratio necessary? Use of the initial pricing loss ratio (60%) permits recoupment of non-existent expense losses. The initial pricing loss ratio includes initial commissions and other acquisition costs. These expenses reflect premiums at issue and should be omitted for future rate increases.

Texas Modification to the Minnesota Method

Texas has explored a hybrid review method that calls for a modification of the MN Method primarily with the considerations above in our internal analysis of rate filings (“TX Modified-MN Method”). Under this hybrid review method, we have found that the TX PPV Method routinely justifies a rate increase between the TX Modified-MN Method without cost sharing, and the TX Modified-MN Method with cost sharing.

The TX PPV Method has no cost sharing (although it requires the company to assume interest rate risk) and for some older blocks, the TX PPV Method may support rate increases that exceed the TX Modified-MN Method without cost sharing. We therefore appreciate and support any suggestions for cost sharing to restrict rate increases to older blocks in late durations where there is limited access to future premiums that would address any deficiencies.

While Texas does not rely on the TX Modified-MN Method for our approved rate increases, we now routinely evaluate and compare the results of the two methods. We attempt to reconcile any large discrepancies during our normal review process.

Balance between Company Solvency and Fairness to Policyholders

Texas strives to strike a balance between rates that support company solvency and that is fair to consumers.

While mindful of the importance of a premium rate that supports claims obligations, we are required by Texas law (Texas Insurance Code Section 560.002 (c)(3)(B)) to ensure that rates represent a "reasonable relationship to the expected loss." This statute is consistent with Actuarial Standards of Practice (ASOP) 8 - Section 3.11.3.

These are the types of questions we consider with respect to Section 560.002 and ASOP 8:

- Large rate increases to older, declining blocks commonly have an insignificant impact on the lifetime loss ratio. We increasingly see company strategies to implement extremely large increases, hopeful that policyholders will either significantly reduce benefits or lapse coverage and qualify for nonforfeiture. We question whether such a strategy is fair to the average consumer in these blocks – typically aged in the eighties or even nineties – who often have limited to no alternative market options.

- With rate increase that may exceed 500%, consumers (and regulators) are justified to ask: "Where is the transfer of risk?"

- Since LTC premiums are issue-age based, the rate charged to a person who purchased a policy at age 55, and who is now 85, should bear a reasonable relationship to rates charged to someone who is 55.

Additional Observations

Transparency

Texas conducts independent thorough analysis of LTC rate increase filings to ensure these rates are justified before approval. Our analysis must be transparent in accordance with ASOP 41, Section 3.2. This is also required of the multistate actuarial review (MSA) according to the Framework Checklist (Item 13 found on page 20).

In short, we must be able to actuarially support any rate increase that we approve. Likewise, Texas is transparent with our analysis subject to proprietary and confidentiality concerns with respect to our independent analysis and conclusions.

Waiver of Premium

This is more of a theoretical concern. In our internal analysis, we are uncertain if historical experience includes policies on waiver of premium as losses, and it may be a reasonable assumption that waived premium losses do not significantly impact the results.

Since currently, we do not use our analysis to justify rate increase, Texas generally does not insist that the company excludes policies on wavier of premium from the historical experience.

Why does this matter? The use of waived premium losses cannot be rectified by rate increases. For example, a 100% rate increase on a $100 monthly premium would only double the losses.

Contract Reserve Oversight
LTC products are like annuity products in that contract reserves are representative of assets backing the product. Contract reserves are crucially important to ensure sustainability for LTC contracts.

Still, if a lifetime approach produces consistent results, states can address contract reserve adequacy as they deem appropriate.

Maximum Permissible Rate Increase
Even before the application of cost sharing, the MN Method imposes a limitation on future rate increases based on the ratio of remaining policyholders to total policyholders. We modified this ratio to reflect available present value of future premium compared to total premium not as a matter of preference, but because we do not require tracking of historical policyholders by year.

Texas PPV Method Compared to the TX Modified-MN Method
The actuarial team in Texas appreciate the additional perspective that the MN Method provides. This approach compliments weaknesses of relying on a singular approach such as the TX PPV Method. The TX PPV Method can also be modified to address weaknesses such as the low interest rate environment and cost sharing. But if a singular approach is preferred, modifications can be made to reasonably address the weaknesses.

Some points to consider:

- The TX Method and the MN Method are different approaches to address the same concern – adequacy of rates.
- As such, both methods should produce similar results.
- Large differences in the calculated rate increase suggest issues with one or both methods.

While our recent reviews (currently over 30 filings) do not rely on the TX Modified-MN Method, as noted previously, we are consistently finding that the Texas PPV Method recommended rate increase falls between the TX Modified-MN Method rate increase without cost sharing, and the TX Modified-MN Method with cost sharing.

When the TX PPV approach exceeds TX Modified-MN Method without cost sharing
We have seen this happen with some filings. These blocks were characterized by a low number of remaining policyholders, and consequently limited access to future premiums. In cases such as these, we prefer the TX Modified-MN Method.

When the TX PPV approach is lower than the TX Modified-MN Method with cost sharing
This result indicates a loosening of assumptions in future projections resulting in lower claim reserves used in the gross premium analysis as well as asset adequacy testing such as used in AG-51. Still in these cases, the TX Modified – MN Method recommendation would be acceptable in most cases.

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

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OFFICE OF
INSURANCE COMMISSIONER

Dec. 10, 2024 Attachment Two

Jane M. Koenigsman, FLMI
Sr. Manager II, Life & Health Financial Analysis
NAIC Financial Regulatory Services
1100 Walnut St, Ste 1000
Kansas City, MO 64106-2197

RE: Comments for the LTCI (B) Task Force: MSA Framework

Dear Jane,

Our office appreciates the amount of effort it took in developing the MSA Framework. Unfortunately, the current framework conflicts with Washington state's LTC rating regulations. Under the pooling requirements [see WAC 284-54-620 (prior to 2009) and WAC 284-83-220 (starting 2009)] for closed blocks of business, our policy has been to enforce a flat percentage increase across the pool. A flat increase is not considered discriminatory. The reason for a flat increase is that a closed block in general is not credible for changing adjustment factors, such as age factors.

LTC polices are rated based on the issue age of the policyholder. Policyholders with the same issue age, benefits, and risk category, must be charged the same rates to avoid unfair discrimination [RCW 48.01.030, 48.18.480 and 48.30.010]. The Multistate Rate Review has included discussions of limiting increases for policyholders age 85+ or have owned a policy for 25+ years which can result in similar policyholders receiving different rate increases based on their attained age or policy duration. These adjustments are in conflict with current state law and regulation; therefore, our office cannot support this proposal at this time.

Thank you,

John Haworth
Deputy Insurance Commissioner – Company Supervision
Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504

Attachment Three
Long-Term Care Insurance (B) Task Force
12/18/24

Please Note for the Dec. 18, 2024, Task Force Meeting:

- **Unhighlighted tracked changes below include replacing the current Minnesota method as the single actuarial methodology and other proposed editorial revisions (not including proposed revisions to the cost-sharing formula) to the LTCI MSA Framework.**
- **Yellow highlighted tracked changes below include proposed revisions to the cost-sharing formula (Cost-Sharing Proposal A) in the LTCI MSA Framework along with two additional editorial revisions to existing language.**

PREFACE

Background

The Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) was drafted by the Ad Hoc Drafting Group of the NAIC Long-Term Care Insurance (EX) Task Force. The Ad Hoc Drafting Group consists of representatives from state insurance departments in Connecticut, Minnesota, Nebraska, Texas, Virginia, and Washington.

The LTCI MSA Framework was adopted by the NAIC Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance (EX) Task Force on Dec. 12, 2021, and the NAIC Executive Committee and Plenary on April 8, 2022.

2025 Amendments

Amendments to the LTCI MSA Framework were adopted by the Long-Term Care Insurance (B) Task Force on [date] and the NAIC Executive Committee and Plenary on [date]. Key amendments include a change from two actuarial rate review methodologies to a single rate review methodology, and updates to the cost-sharing formula. Other amendments include moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options, to the Senior Issues (B) Task Force.

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I. INTRODUCTION

A. Purpose

In 2019, ~~T~~the NAIC charged the Long-Term Care Insurance (EX) Task Force with developing a consistent national approach for reviewing current long-term care insurance (LTCI) rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the Task Force developed this framework for a multi-state actuarial (MSA) LTCI rate review process (MSA Review).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program's rate review team (Pilot Team). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team's approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or rate proposal[1] and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so they will voluntarily utilize the Multistate Actuarial LTCI Rate Review Team's (MSA Team's) recommendations when conducting their own state level reviews of in force LTCI rate increase filings.[2] Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This MSA framework is intended to communicate the governance, policies, procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the MSA Team's MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how the MSA Advisory Report may affect the insurer's in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the ~~Task Force~~Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee, or an appointed subgroup, and be revised as directed by the Health Actuarial (B) Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

The MSA Review of an insurer's rate proposal will be available to state insurance departments who are both an Impacted State and a Participating State. These are defined as follows.

[1] "Premium rate increase proposal(s)" or "rate proposal(s)" in this document refers only to an insurer's request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review.

[2] The term "rate increase filing" or "rate filing(s)" in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer's in force LTCI premium rate increase proposal is or has been issued.
- "Participating State" is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section IE(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/webinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to increase in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an MSA Advisory Report, which state insurance departments may consider when deciding on an insurer's rate increase filing or to supplement the state's own review process.

The MSA Review is conducted by a team of state's regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff and Interstate Insurance Product Regulation Commission (Compact) staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and ~~[P~~participating or ~~/I~~impacted ~~TBD[3]]~~ ~~S~~states. The NAIC's electronic infrastructure, SERFF, will be used to streamline the rate proposal and review process. Although the administrative services of Compact staff and SERFF's Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA Advisory Reports are prepared by the MSA Team. MSA rate proposals are not Compact filings, and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

The MSA Review begins when an insurer expresses interest in an MSA Review being performed for an in force LTCI rate proposal to the MSA Team through SERFF or supporting NAIC or Compact staff. The eligibility of the rate proposal will be reviewed and determined by the MSA Team with assistance, as needed, from supporting staff.

The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply ~~the Minnesota and Texas approaches~~a single approach ("MSA approach") to calculate recommended, approvable rate increases. While aspects ~~of the Minnesota and Texas~~of the MSA approach~~es~~ may result in lower rate increases than those resulting from loss ratio-based approaches and are outside the pure loss ratio requirements contained in many states' laws and rules, the approach~~es~~ falls in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA Team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will document how the proposal complies with the regulatory approach utilized by the MSA Team for Participating States. See Section V for more details on the actuarial review.

Throughout the MSA Review, the MSA Team will provide updates to the insurer. The MSA Team will deliver the final MSA advisory Report to the insurer and address any questions the insurer has about the results of the Review.

Additionally, the review will consider reduced benefit options (RBOs) that are offered in lieu of the requested rate increases and factor in non-actuarial considerations.

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States and insurers that provides both summary and detail information about the rate proposal, the review methodologies, the

~~[3] Certain processes for Impacted vs. Participating States are yet to be determined (TBD).~~

analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. The MSA Advisory Report will also indicate whether the recommendation differs from the insurer's proposal. Participating States can utilize the MSA Advisory Report or supplement their own state's rate review with it as described in the following Section ID. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

The rate proposal, review process, actuarial methodologies, and other review considerations are detailed within this framework document and accompanying appendices.

D. Benefits of Participating in the MSA Review

Both state insurance regulators and insurers will benefit by participating in the MSA Review in multiple ways. For state insurance regulators:

- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCI rate increase filings in their state. It is recognized that multiple states may not have significant actuarial expertise with LTCI, so participation in the MSA Review will allow those states to build on the specific, dedicated LTCI actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states and actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCI rate increase reviews, states who utilize the MSA Team will have the benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.
- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries, which affords them an opportunity to establish LTCI-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a qualified actuary include years of experience under the supervision of another already qualified actuary in that subject matter.
- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state's knowledge base in this area and promoting a more consistent national approach to in force LTCI rate review.

Note that states' use of and reliance on the MSA Advisory Report is expected to increase in the future as the MSA Review continues to be developed and refined, and the benefits of the MSA Review described above become more evident.

Long-Term Care (LTC) insurers will likewise see multiple benefits in participating in the MSA Review:

- First, by utilizing the MSA Review and through the receipt of MSA information and the MSA Advisory Report from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increase filings. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, it has functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states.
- Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the carrier's workload in developing often widely differing filings for states' review.

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific

state's laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state's regulatory authority, responsibility, and/or decision making. Each state remains ultimately responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law.

A Participating State's use of the MSA Advisory Report's recommendations with respect to one filing does not require that state to consider or use any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way: 1) eliminates the insurer's obligation to file for a rate increase in each Participating State; or, 2) modifies the substantive or procedural requirements for making such a filing. While encouraged to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

The MSA Advisory Reports, including the recommendations contained therein, are only for use by Participating States in considering and evaluating rate filings. The MSA Advisory Reports or their conclusions shall not be utilized by any insurer in a rate filing submitted to a non-Participating State, nor shall the MSA Advisory Reports be used outside of each state insurance regulator's own review process or challenge the results of any individual state's determination of whether to grant, partially grant, or deny a rate increase.

Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence on insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if certain information and documents related to specific companies that are confidential under the state law of an MSA Team member or a Participating State need to be shared with other state insurance regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement (Master Agreement) between states that governs the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

Confidentiality of the Rate Proposal

Members of the MSA Team and Participating States affirm and represent that they will provide any in force LTCI rate proposal, as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations.

Confidentiality of the MSA Reports

Likewise, members of the MSA Team and Participating States affirm and represent that they will provide any MSA Advisory Report(s), as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations for rate filings.

F. Governing Body and Role of the NAIC Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee~~Long-Term Care Insurance (EX) Task Force~~

The Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee will ~~Long-Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable future to~~ oversee the ~~implementation of the~~ MSA Review process, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Health Actuarial (B) Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed. The Health Actuarial (B) Task Force ~~Task Force~~ may create or appoint one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Health Actuarial (B) Task Force will be selected by the NAIC president and president-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.

II. MSA TEAM

The MSA Team comprises state insurance department actuarial staff. MSA Team members are chosen by their skill set and LTCI actuarial experience. The Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee, or an appointed subgroup~~Long-Term Care Insurance (EX) Task Force, or its appointed subgroup~~, will determine the appropriate experience and skill set for qualifying members for the MSA Team. It is expected that state participants will provide expertise and technical knowledge specifically regarding the array of LTCI products and solvency considerations. The desired MSA Team membership composition should include a minimum of five and up to seven members.

Membership must follow the requirements below and be approved by the chair of the Health Actuarial (B) Task Force or the chair of an appointed subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

To be eligible to participate as a member of the MSA Team, a state insurance regulator is required to:

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or LTCI.
- Be recommended by the insurance commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participate~~s~~ as a member of the Long-Term Care Actuarial (B) Working Group ~~Insurance Multistate Rate Review (EX) Subgroup~~ (or an equivalent Subgroup)~~ appointed by the Long-Term Care Insurance (EX) Task Force) and the LTC Pricing (B) Subgroup~~.
- Be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the ~~s~~Health Actuarial (B) Task Force or its appointed Subgroup, or the former Long-term Care insurance (B) Task Force

As both state insurance regulators and the MSA Review may benefit by developing and expanding specific LTCI actuarial expertise through participation in this process, having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team is critical to the viability of the MSA process. Participation also provides opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI.

Consideration will be given to joint membership where two actuaries within a state combine to meet the criteria stated above.

Consultants engaged by the state insurance department would not be considered for MSA Team membership.

B. Duties of an MSA Team Member

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- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month when rate reviews are in progress (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master Agreement. MSA Team members should communicate any request for public disclosure of MSA information or any obligation to disclose.
- Active involvement within NAIC LTCI actuarial groups.
- Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the chair and vice chair of the ~~Long-Term Care Insurance~~Health Actuarial (~~EX~~B) Task Force, or its appointed subgroup. Other interested state insurance regulators (e.g., domiciliary state insurance regulators) may be invited to participate on a call at the discretion of the MSA Team or the chair or vice chair of the Health Actuarial (B) Task Force or its appointed subgroup.

D. MSA Associate Program

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries that wish to gain expertise in LTCI. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

- As a mentee. The mentee would participate in aspects of the MSA Review. An MSA Team member will serve as a mentor to another state regulatory actuary and provide one-on-one guidance.
- To gain more knowledge and understanding of the ~~Minnesota and Texas actuarial~~MSA approach~~es~~.
- To share their own expertise through feedback to the MSA Team on MSA Advisory Reports to better enhance the overall MSA process.
- To participate on an ad hoc limited basis, i.e., where a regulatory actuary would like to participate but is unable to make the required time commitment.
- To meet the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI by serving under the supervision of a qualified actuary on the MSA Team.
- To serve as a peer reviewer of the MSA Advisory Reports.

E. Conflicts, Confidentiality, and Authority of the MSA Team

Authority of the MSA Team

Members of the MSA Team serve on a purely voluntary basis, and any member's participation shall not be viewed or construed to be any official act, determination, or finding on behalf of their respective jurisdictions.

Disclosures and Confidentiality Obligations, as Applicable

All members of the MSA Team acknowledge and understand that the MSA Review, including, but not limited to, meetings, calls, and correspondence are confidential and may not be shared, transmitted, or otherwise reproduced in any manner. Additionally, all members of the MSA Team affirm and represent that they will: a) provide any in force LTCI rate proposal with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations; and, b) provide any MSA Advisory Report with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations for rate filings.

Conflict of Interest Avoidance Procedures and Certifications

No member of the MSA Team may own, maintain, or otherwise direct any financial interest in any company or its affiliates subject to the regulation of any individual state, nor may any member serve or otherwise be affiliated with the management or board of directors in any company or its affiliates subject to the regulation of any individual state. All conflicts of interest, whether real or perceived are prohibited and no member of the MSA Team shall engage in any behaviors that would result in or create the appearance of impropriety.

F. Required NAIC and Compact Resources

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected that NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the ~~Long-Term Care Insurance (EX~~Health Actuarial (B) Task Force will be needed as well. As more experience with rate proposal volumes and average analysis time is gained, the full complement of human resources required will be better understood.

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate increase proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. The material substance of such communication can be documented within SERFF. NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA rate increase proposals at the direction of the MSA Team and as described in this framework.

III. REQUESTING AN MSA REVIEW

A. Scope and Eligibility of a Rate Proposals for MSA Review

The following are the preferred eligibility criteria for requesting an MSA Review of a rate proposal.

- Must be an in force LTCI product (individual or group).
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide.
- Includes any stand-alone LTCI product approved by states, not by the Compact.
- For Compact-approved products meeting certain criteria, the Compact office will provide the first-level advisory review subject to the input and quality review of the MSA.

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals

and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

The MSA Team reserves the right to deny a proposal that does not meet eligibility criteria. An insurer will be notified if the proposal for an MSA Review is denied.

An insurer may ask questions for more information about a potential rate proposal through communication to supporting NAIC and Compact staff and the MSA Team. This will be accomplished through a Communication Form that will be available on the Compact web page. Supporting NAIC and Compact staff will work with the insurer to complete the necessary steps to assess eligibility, discuss any technical or other issues, and answer questions.

The insurer will have access to primary and supplementary checklists in Appendix B that provide guidance to the insurer for information that should be included in a complete MSA rate proposal requested through the NAIC's SERFF application.

B. Process for Requesting an MSA Review

As noted in Section IC above, the MSA Review will utilize the Compact's multistate review platform within the NAIC's SERFF application and its format for in force LTCI rate increase proposals. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance regulators:

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless rate increase proposal.
- Instructions containing a checklist for information required to be included in the rate increase proposal, as reflected in Appendix B, will be available to insurers through the Compact's web page or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase proposal is or has been issued. Participating States will have access to view the insurer's rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [TBD].
- Rate increase proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the Impacted States upon receipt of the rate increase proposal with the SERFF Tracking Number.
- The MSA Team may utilize a "queue" process for managing workload and resources for incoming rate increase proposals through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team's review of objections and insurer responses are completed through SERFF.

C. Certification

The insurer shall provide certifications signed by an officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state's decision to approve, partially approve, or disapprove a rate increase filing except when: 1) the individual state is a ~~[~~Participating or ~~/~~ Impacted State~~ [TBD])~~ that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

Failure to abide by the terms of the insurer's certification will result in the insurer and its affiliates being excluded from any future MSA Reviews, and it will permit the MSA Team to terminate, at its sole discretion, any other ongoing review(s) related to the insurer and its affiliates.

Should the MSA Team exclude any insurer and its affiliates for failure to adhere to its certification, the MSA Team, at its sole discretion, may permit the insurer and its affiliates to resume submitting rate proposals for review upon written request of the insurer.

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication Form, which will be available through the Compact web page. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate increase proposal in SERFF. The MSA Team will be notified, via SERFF, when the rate increase proposal is available for review.

The supporting NAIC and Compact staff will notify ~~(P~~participating~~/~~ or ~~I~~impacted ~~S~~states~~ [TBD])~~ via SERFF or e-mail when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of the MSA Review

The MSA Team shall designate a lead reviewer to perform the initial review of each rate proposal. Once the rate increase proposal is made through SERFF, the MSA Review will resemble a state-specific review process.

The MSA Team will meet regularly ~~periodically~~ to assign MSA Team member responsibilities, discuss the review, ~~and~~ determine any needed correspondence with the insurer and establish timelines. NAIC staff will assist in facilitating MSA Team member meetings and communications. Objections and communications with filers will be conducted through SERFF, like any state-specific filing or Compact filing, to maintain a record of the key review items. Other supplemental communication between the insurer and the MSA Team or supporting NAIC and Compact staff, may occur, such as conference calls or emails, as appropriate.

The timeframe for completing the MSA Team's review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a "queue" process for managing workload and resources for incoming rate increase proposals through SERFF. The timeliness of any necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will affect the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review, and a final MSA Advisory Report with recommendations will be drafted and communicated to state insurance departments within the next month, which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and 2) the insurer will receive sufficient information regarding the MSA Team's recommendation to allow the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with the MSA Team in order to ask questions, and understand the MSA Team's reasoning.

C. Preparation and Distribution of the MSA Advisory Report

Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF "reviewer notes" for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States. Consultants engaged by state insurance department staff to perform rate reviews would be given access to the MSA Advisory Report, subject to the terms of the agreement between the consultant and the Participating State insurance department.

Consultants who are bound by the actuarial Code of Professional Conduct, adopted by the Academy of Actuaries, the Society of Actuaries (SOA) and the Conference of Consulting Actuaries (CCA), should consider whether receipt of the MSA Advisory Report is acceptable under Precept 7 regarding Conflicts of Interest. For other professions, similar consideration should be made if bound by similar professionalism standards.

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States.

The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

The MSA Advisory Report will include standardized content, as reflected in Appendix A, with modifications, as necessary, for any unique factors specific to the rate proposal. The content and format are based on feedback received from state insurance departments and the Long-Term Care Insurance (EX) Task Force during the pilot project.

The content and format of the MSA Advisory Report may be modified in the future under the direction of the Health Actuarial (B) Task Force, or an appointed subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback from Participating states and the insurer, through this process.

D. Timeline for Review and Distribution of the MSA Advisory Report

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to holidays or other unexpected events. Note that the MSA Review is intended to occur before filings are made to the state insurance departments, therefore not affecting state insurance departments' required timelines for review. However, use of the MSA Advisory Report by the state is expected to reduce the amount of time required for the state to complete its review.

Pre-Distribution - Share the draft MSA Advisory Report with the insurer. The insurer will be given the opportunity to interact with the MSA Team to ask questions and understand the MSA Team's reasoning.

- Day 1 – Distribution of a draft MSA Advisory Report to all Participating States.
- Day 5-7 – Regulator-to-regulator conference call of all Participating States during which the MSA Team will present the recommendations in the MSA Advisory Report and seek comments from states.
- Day 21 – Deadline for comments on the draft MSA Advisory Report.
- Day 35 – Distribution of the final MSA Advisory Report, with consideration of comments, to Participating States and the insurer.
- Date ~~TBD~~to be determined by the Insurer – Individual rate increase filings submitted to each state insurance department.
- Date ~~TBD~~to be determined by each state's DOI – Approval or disapproval of the rate increase filing submitted in each state.

E. Feedback to the MSA Team

At the direction of the ~~Long-Term Care Insurance (EX~~Health Actuarial (B) Task Force, or an appointed subgroup, state insurance departments will be requested to periodically provide data and feedback on their state rate increase approval amounts and their state's use of and reliance on the MSA Advisory Reports. The following items may be considered in a feedback survey:

1. The number of rate proposals made with the MSA Review Team.
2. The number of rate proposals reviewed by the MSA Review Team.
3. Information regarding states approval of MSA recommendations.
4. Feedback on additional information states requested.
5. Feedback regarding how the review process and methodology could be improved.

State responses will be confidential pursuant to the Master Agreement, and aggregated results of feedback surveys will not specifically identify state responses. The MSA Team and state insurance regulators welcome feedback from insurers on their experience using the MSA Review Process. This collective feedback will aid the Health Actuarial (B) Task Force in understanding the practical effects of the MSA Review in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process, improve future reports to better meet participants' needs, and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated feedback results will be shared with Participating States and insurers as determined appropriate.

V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections, and other information provided by the insurer as outlined in Appendix B. The MSA actuarial review process will be evaluated and evolve over time as more rate proposals are reviewed.

The ~~Minnesota and Texas~~MSA approach~~es~~ ensures remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The MSA~~innesota~~ approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. ~~The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.~~

The MSA Team will consider the following in performing their review, applying their expertise and professional judgement to the review, and reviewing the actuarial formulas and results:

- Review insurer experience, insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
  - Validate that the patterns of claims and premium projections over time reasonably align those reflected in the assumptions.
  - Adjust or request new projections of claims and premium to the extent that any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between the MSA Team and the insurer via SERFF.
  - After verifying loss ratio compliance, apply ~~both the Minnesota and Texas approaches~~the MSA approach for each rate proposal submitted.

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed~~ to determine the most appropriate method~~. ~~The MSA Team's recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, t~~The recommendation may be the result of ~~either the Texas or Minnesota approach, a blend of the two approaches: ~~MSA approach or may also use~~ing~~ professional judgement, where the MSA Team may recommend a rate increase outside of ~~these two~~this approach~~es~~. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In applying professional judgement, (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high. ~~As the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.~~

The MSA Team will consider how to reflect the differences in the histories of states' rate approvals. Current approach includes:

- The MSA Team's recommendation results in the same rate per unit in each state following the current rate increase round, leading to higher percentage rate increases in states that approved lower rate increases in the past.
- Analysis of state cost differences affecting justifiable rate increases will continue. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in lower-cost states should receive lower percentage rate increases. Part of the reason is that there was a tendency for people in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.
- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

Consideration of Solvency Concerns

If concerns exist regarding an insurer's financial solvency and the impact of rate increases on future solvency, each state DOI, by their authority over rate approval, has the flexibility to consider solvency adjustments in these rare instances. In rare, non-typical circumstances, adjustments could be considered within the MSA Review, including consultation with states as part of the MSA Advisory Report comment period.

Follow-Up Proposals on the Same Block

Any subsequent rate increase proposal to the MSA Team on a block of business previously reviewed by the MSA Team needs to involve the development of adverse experience and/or expectations. In the absence of adverse experience or expectation development, the MSA Team will consider a reasonable explanation from an insurer for an increase in credibility of morbidity data of being the reason for a rate increase. Prior rate increases would need to be implemented before the implementation of a subsequent rate increase. The MSA Team will not consider a new rate increase proposal on a block that did not receive the full percentage rate increase requested without the experience, expectation, or credibility criteria noted above. If an insurer did not receive the full percentage rate increase and has no adverse changes in experience or expectations, the insurer should work directly with the applicable state DOI.

B. Loss Ratio Approach

Key aspects of the loss ratio approach to the actuarial review of rate changes include:

1. At policy issuance, pricing based on a lifetime loss ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The

remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the *Long-Term Care Insurance Model Regulation* (#641), Section 19 for more details on compliance with loss ratio standards.

2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.

3. The loss ratio approach increases future premiums to a level, referred to as make-up premium, such that the original loss ratio target is once again attained.

4. The loss ratio approach, one of the minimum standards in many states' statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards, such as fair and reasonable rates.
   a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the ~~Minnesota, Texas~~MSA approach~~,~~ and other approaches.
   b. The loss ratio approach shifts all the risk to the policyholders. If the insurer is allowed to always return to the 60% loss ratio, there may be a lower incentive for more appropriate initial pricing.

5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58%/85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA Team. If this standard produced lower increases than the ~~Minnesota and Texas~~MSA approach~~es~~, it would produce the recommended rate increase.

C. MSA~~innesota~~ Approach

Key aspects of the MSA~~Minnesota~~ approach to the actuarial review of rate changes include:

1. Blended if-knew / makeup approach to address the shrinking block issue.
   a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
   c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care Pricing (B) Subgroup calls from 2015 to 2019[4] are incorporated, including the concept that rates will not substantially rise as the block shrinks, as policyholder persistency falls over time.

2. Cost-sharing formula that increases the insurer's burden as cumulative rate increases rise.
   a. This addition to the insurer's burden moves rates away from a direction that could potentially be seen as misleading. The insurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.

[4] NAIC Proceedings including meeting minutes are available from the NAIC Library, https://naic.soutronglobal.net/portal/Public/en-US/Search/SimpleSearch.

3. Assumption review.
    a. Verification that the insurer's original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the insurer.
    b. Verification of appropriateness of current assumptions.
        i. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.
        ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the insurer-provided assumptions. This conservatism can be released as credible experience develops.

4. Interest rate / investment return component
    a. The MSA~~innesota~~ approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
        i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
        ii. In the MSA~~innesota~~ approach, all factors impacting the business are considered.
            1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an insurer would get approval for rate increases even when profits on the block were higher than expected.
            2. If interest rates fall, this would tend to lead to higher rate increase approvals.
        iii. To prevent shifting of "good assets" and "bad assets" to supporting LTC rates and prevent an insurer from increasing rates based on risky investments turned into losses, an index of average corporate bond yields (e.g., Moody's) is relied on to reflect experience and current expectations.
        iv. Original pricing typically includes an assumption on investment returns, for which premiums and other positive cash flows are assumed to accumulate. This forms the interest component of the original assumption.
        v. The original pricing investment return in Section VC(4)iv is compared to the average corporate bond yields in Section VC(4)iii to determine the adversity associated with the interest rate factor.

5. Original Assumption Adjustment
    a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a "benchmark premium."
        i. This results in a lower rate increase.
        ii. This adjustment wears off over 20 years from policy issue.
            1. The rationale for the wearing off of this adjustment is the assumption that no insurer would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
        iii. This adjustment is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase).

~~D. Texas Approach~~

~~The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup's discussions regarding the recoupment of past losses in LTCI rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarially justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.~~

~~Key aspects of the Texas approach to the actuarial review of rate changes include:~~

~~1. Past losses are assumed by the insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits, the recoupment of past losses to some extent.~~

~~2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do noy pay for the past claims of policyholders who no longer pay premium.~~

~~3. Data Requirements for Calculation:~~
   ~~a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:~~
      ~~i. Present Value of Future Benefits (PVFB) under current assumptions.~~
      ~~ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).~~
      ~~iii. Present Value of Future Premiums (PVFP) under current assumptions.~~
      ~~iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).~~
         ~~1. Note that for all four projections above, the projection period is typically 40–50 years: although, some companies project for 60 or more years.~~

   ~~To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on wavier, on claim, or paid up) regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.~~

   ~~Also, the insurer should identify and explain any estimates or adjustments to the data, as applicable.~~

~~4. Assumptions~~
   ~~a. Rate increases are commonly driven by a change to the persistency, morbidity, mortality assumption, or a combination of the three.~~
   ~~b. Verification that assumption change(s) are supported by credible data.~~
   ~~c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the insurer, not the policyholder.~~

~~The formula used in the Texas approach is provided in Appendix C.~~

~~E.~~D. RBOs

In 2020, the former Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, developed a list of RBO principles to provide guidance for evaluating RBO offerings in Appendix D.

RBOs in the MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal that are extracontractual. The MSA Advisory Report will highlight how the insurer demonstrates the proposed RBOs' reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more

detailed assessment specific to their state's requirements. As the MSA Review develops~~ and as the Subgroup continues its work~~, this area of review may evolve.

Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA Review will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the Senior Issues (B) Task Force, ~~will encourage~~ or its appointed Subgroup and/or ~~an appropriate NAIC actuarial committee or group~~the Health Actuarial (B) Task Force, will encourage ~~to~~ collective~~ly~~ consideration of new RBOs as they arise. This process will provide for input and technical advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.

~~F.~~E. Non-Actuarial Considerations

The ~~Long-Term Care Insurance (EX~~Health Actuarial (B) Task Force or its appointed Subgroup and/or the Senior Issues (B) Task Force, will continue~~s~~ to review and consider non-actuarial considerations affecting states' approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

1. Caps or limits on approved rate changes.
2. Phase-in of approved rate changes over a period of years.
3. Waiting periods between rate change requests.
4. Considerations of prior rate change approvals and disapprovals.
5. Limits or disapproval on rate changes based solely or predominately on the number of policyholders in a particular state.
6. Limits or disapproval on rate changes based on attained age of the policyholder.
7. Fair and reasonableness considerations for policyholders.
8. The impact of the rate change on the financial solvency of the insurer.

Considerations in the MSA Advisory Report

As part of the MSA Review, the MSA Team will identify relevant aspects of the insurer's rate proposal, based on the information provided by the insurer, which may be affected by a state's non-actuarial considerations. Note that the MSA Team will not perform a state-by-state review of each state's non-actuarial considerations, statutes, or practices. Instead, the MSA Team will highlight in the MSA Advisory Report those aspects of the rate proposal that relate to or that may be affected by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those affected aspects of the rate proposal when completing their individual state's rate review. For example, the MSA Advisory Report may highlight:

- If cumulative rate increases are high, as this may affect the cost-sharing formula.
- If a rate proposal is for a block of business where the average policyholder age is predominately 85 or above, as this may affect states that consider age caps.
- If it is determined that the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may affect the potential need for adjustments to the cost-sharing formula.
- Aspects of the coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in its review.

Future Non-Actuarial Considerations

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The MSA Review will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTCI MSA Framework was amended in 2024 to adjust the cost-sharing components within the MSA method to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. ~~t~~The Health Actuarial (B) Task Force, ~~will encourage~~ or its appointed Subgroup, and/or ~~an appropriate NAIC actuarial committee or group~~the Senior Issues (B) Task Force, will encourage ~~to~~ collective~~ly~~ consideration of new future non-actuarial considerations as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate increase and the complexity of the rate proposal and the insurer's financial condition. See also the sample MSA Advisory Report in Exhibit A.

1. Executive Summary.
   a. Overall recommended rate increase, before consideration of different states' history of approvals.

2. Disclaimers.
   a. Purpose and intent of how states should use the MSA Advisory Report.
   b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer.
   c. Statement that the in force rate increase filing submitted to the respective states shall be subject to the approval of each state, and each state's applicable state laws and regulations shall apply to the entire rate schedule increase filing.

3. Background on the MSA Review.

4. Explanation of the insurer's Proposal.
   a. The explanation will be based on the aspects of the insurer's rate proposal, which may include details as to whether the rate increase submitted for review involved different types of coverages or groupings.

5. Summary of the MSA Team's rate review analysis, including these aspects:
   a. Actuarial review.
      i. The summary of the review and the MSA Team's recommendation will be based on the aspects of the insurer's rate proposal, and may include specific details of the review, for example analysis of projections, assumptions, margins, or other aspects.
   b. Summary of consideration of differences in the history of state's rate increase approvals.
   c. Non-actuarial considerations and findings.
   d. Financial solvency-related aspects and adjustments.
   e. Review for reasonableness and clarity of RBOs.
   f. Summary information about the mix of business.

6. Appendices.
   a. Summary of the drivers of the rate proposal.
   b. Details regarding the ~~Minnesota and Texas~~MSA approach~~es~~ as applied to the rate proposal.

c. Summary of rate proposal correspondence.
d. Examples of rate increases if an RBO is not selected.
e. Potential cost–sharing formula for typical circumstances.

B. Appendix B – Information Checklist

At the request of the former Long-Term Care Insurance (B/E) Task Force, the Long-Term Care Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all states. In this context, "checklist" means the list or template of inquiries that states typically send at the beginning of reviews of state-specific rate increase filings.

This document contains aspects of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*[5] (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0-10% of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual.

Information Required for an MSA Review of a Rate Proposal

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the "Consolidated, Most Commonly Asked Questions – States' LTC Rate Increase Reviews"[6] as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. Identify all states for which the product associated with the rate proposal is or has been issued.

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
   a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
   b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

3. Rate increase history that reflects the filed increase.
   a. Provide the month, year, and percentage amount of all previous rate revisions.
   b. Provide the SERFF MSA numbers associated with all previous rate revisions.

4. Actuarial memorandum justifying the new rate schedule, which includes:
   a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
      i. The projection should be by year.
      ii. Provide the count of covered lives and count of claims incurred by year.

[5] ~~https://www.naic.org/documents/committees_b_senior_issues_160609_ltc_guidance_manual.pdf~~ https://content.naic.org/sites/default/files/inline-files/committees_b_senior_issues_exposure_ltc_guide_manual.docx

[6] https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx

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   iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies that should be provided.
   iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
   a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
   b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.
   c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
   d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.

6. Statement that policy design, underwriting, and claims handling practices were considered.
   a. Show how benefit features (e.g., inflation and length of benefit period) and premium features (e.g., limited pay and lifetime pay) impact requested increases.
   b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
   c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

7. A demonstration that actual and projected costs exceed anticipated costs and the margin.

8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
   a. Provide applicable actual-to-expected ratios regarding key assumptions.
   b. Provide justification for any change in assumptions.

9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
   a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
   b. A comparison of the population or industry study to the in force related to the rate proposal should be performed, if applicable.
   c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
   d. Provide the year of the most recent morbidity experience study.

10. Information from the Guidance Manual Question and Answer (Q&A): Morbidity, Lapse, Mortality, Interest.
   a. Comparison with asset adequacy testing reserve assumptions.
      i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
      ii. Additional reserves that the insurer is holding above Health Insurance Reserves Model Regulation (#10) formula reserves should be provided, (such as premium deficiency reserves and *LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) reserves.

   b. Assumptions Template in Appendix 6 of the Guidance Manual for policies issued after 2017, where applicable.
   c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, <u>all</u> discounted at the maximum valuation interest rate*:
    a. Present value of future benefits (PVFB) under current assumptions
    b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
    c. Present value of future premiums (PVFP) under current assumptions.
    d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

*To emphasize, these projections should include only <u>active</u> nationwide policyholders currently paying premium, and they should not include any policyholders not paying premium, regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption or benefit reduction assumption.

    b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.

12. The Guidance Manual checklist items: 1) summaries (including past rate adjustments); 2) average premium; 3) distribution of business, including rate increases by state; 4) underwriting; 5) policy design and margins; 6) actuarial assumptions; 7) experience data; 8) loss ratios; 9) rationale for increase; and 10) reserve description.

13. Assert that analysis complies with Actuarial Standards of Practice (ASOPs), including 18 and 41.

14. Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

16. Policyholder notification letter should be clear and accurate.
    a. Provide a description of options for policyholders in lieu of or to reduce the increase.
    b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
    c. Explain the comparison of value between the rate increase and policyholder options.
    d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
    e. How are partnership policies addressed?

17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

<u>Supplemental Information</u>

As part of the Long-Term Care Insurance (EX) Task Force's pilot project in 2020–2021, the following supplemental information was identified by the MSA Team as beneficial; and, therefore, the Task Force may be requested to assist in the MSA Review.

1. Benefit utilization:

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   a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
   b. Explain how benefit utilization assumptions vary by maximum daily benefit.
   c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.

2. Attribution of rate increase
   a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other.
   b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
   c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.

3. RBOs
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonability analysis of the value of each significant type of offered RBO.

4. Investment returns:
   a. Provide original and updated / average investment return assumptions underlying the pricing.
   b. Explain how the updated assumption reflects experience.

5. Expected loss ratio:
   a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
   b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.

6. Shock lapse history:
   a. Provide shock lapse data related to prior rate increases on this block.

7. Waiver of premium handling:
   a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
   b. Explain how counting is appropriate (as opposed to double counting or undercounting).

8. Actual-to-expected differences:
   a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.

9. Assumption consistency with the most recent asset adequacy testing:
   a. Explain the consistency or any significant differences between assumptions underlying the rate increase proposal and those included in Actuarial Guideline 51 testing.

C. Appendix C—Actuarial Approach Detail

MSA~~innesota~~ Approach

Details on the key aspects of the MSA~~innesota~~ approach to the actuarial review of rate changes include:

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
   a. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.

2. If-knew premium and makeup premium aspects – aggregate application.

a. Makeup percentage:
    i. {[PV (claims) / original LLR] - PV (past premium)} / PV (future premium) – 1.
    ii. To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.
    iii.
b. If-knew percentage:
    i. [PV (claims) / PV (premiums)] / original LLR – 1.
    ii. Premiums in the formula are at the original rate level.
    iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
c. Definitions and explanations:
    i. PV means present value.
    ii. LLR means lifetime loss ratio.
    iii. Interest rates underlying PVs and LLRs are based on:
        1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
        2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over five years of the current rate to a target rate (currently 4%) is assumed.
    iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
    v. Insurer-provide premium and claim cash flows may be adjusted based on assumption review.
    vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification.
    a. Over a range of issue years, issue ages, benefit periods, and inflation protection:
        i. Calculate an estimate of the original premium.
            1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
            2. Apply first principles.
                a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
                b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
                c. Divide by the sum of the PV of an annuity of 1 per year.
                d. Multiply {b / c] times (1 + originally assumed profit percentage) to attain the original premium.
                e. This premium provides the basis for comparison against the makeup and if-knew premium.
            3. Replace the original premium with a benchmark premium.
                a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
                b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
                c. The benchmark aspect is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.
        ii. Calculate an estimate of the makeup premium.
            1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.

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2. Calculate an updated dollar PV of profits for the sample policy using:
    a. Actual history of premiums and claims.
    b. Expectations of future claims.
    c. “Backed into” makeup premium.
3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
    a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.

iii. Calculate an estimate of the if-knew premium.

1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
    b. Verifying the impact on expectation changes on rates
        i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
        ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
            1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
            2. Experience
            3. Impact on LLR of changes in expectations of morbidity.
            4. Industry information and trends (for reasonableness checks).
    c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
        i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer’s aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
        ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
            1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
            2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
        iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the insurer (after initial attempts to resolve significant differences or gaps).

4. Reconciliation of aggregate and sample policy applications.
    a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
    b. In other cases, some steps are taken to understand the difference, including additional requests for information.
    c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
    d. When reconciliation occurs after rounds of communication, decisions will be made based on the information provided.

5. Blending – same for aggregate and sample policy applications.
   a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
   b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
   c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
   d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.

6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. 5% haircut for the first 100%.
      ii. 20% haircut for the portion of cumulative rate increase between 100% and 400%.
      iii. 80% haircut for the portion of the cumulative rate increase in excess of 400%.
      ~~i. No haircut for the first 15%.~~
      ~~ii. 10% for the portion of cumulative rate increase between 15% and 50%.~~
      ~~iii. 25% for the portion of cumulative rate increase between 50% and 100%.~~
      ~~iv. 35% for the portion of cumulative rate increase between 100% and 150%.~~
      ~~v. 50% for the portion of cumulative rate increase in excess of 150%.~~

      Reviewers note: The blending of the if-knew and makeup premiums (Step 5) and the cost-sharing formula (Step 6) were reviewed and updated in 2024 to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations.

7. Reduction for past rate increase:
   a. Take 1 plus the cost-sharing-adjusted blend amount and divide by 1 plus the previous, cumulative rate increases, then subtract 1. This is the approvable rate increase.

8. Summary.
   a. Review current assumptions.
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.
   f. Deduct past rate increases.
   g. Example – if:
      i. The original premium is $1,000
      ii. Makeup premium is $8,500~~3,000~~.
      iii. If-knew premium is $~~1,500~~2,000.
      iv. 60% of policyholders remain.
      v. Past rate increases are three increases of 50% each:
      vi. Blended amount is:
         1. $8,500~~3,000~~ / $1,000 * 0.60 +
         2. $~~1,500~~2,000 / $1,000 * 0.40

3. – 1 =
4. 510~~180~~% + 80~~60~~% – 1 = 590~~240~~% – 1 = 490~~140~~%

vii. Post-~~Cost~~ cost sharing formula cumulative increase is:
1. 95~~100~~% * 1.00~~0.15~~ +
2. 80~~90~~% * 3.00~~0.35~~ +
~~3. 75% * 0.5 +~~
~~4.~~3. 20~~65~~% * 0.3~~90.4~~ =
~~5.~~4. 353~~110~~%

viii. Deduction for past rate increases results in:
1. (1 + 3.53~~1.1~~) / (1 + .5) / (1 + .5) / (1 + .5) – 1 =
2. 34.2~~40~~%

~~Texas PPV Formula~~

~~Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to **active, premium-paying policyholders.**~~

~~For rate stabilized policies:~~

$$\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.58 + .85C}{1 + C}\right)\Delta PV(\text{future earned premiums})}{.85\, PV_{\text{current}}(\text{future earned premiums})}$$

~~Where:~~

~~Δ indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.~~

~~C is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then C = 0.5.~~

~~The *current* subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the ΔPV(future incurred claims) term in the above formula could be multiplied by (1 + margin).~~

~~For pre-rate stabilized policies, we use 0.6 in place of 0.58 and 0.8 in place of 0.85:~~

$$\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.6 + .8C}{1 + C}\right)\Delta PV(\text{future earned premiums})}{.8\, PV_{\text{current}}(\text{future earned premiums})}$$

~~Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the state insurance regulator by a method other than the PPV approach. In this situation, for a current filing, the state insurance regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.~~

D. Appendix D—Principles of RBOs Associated with LTCI Rate Increases

In 2020, the former Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, was charged to *"Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases."* In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
    - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
    - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.

2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
    - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.

3. Clarity of communication with policyholders eligible for an RBO:
    - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
    - Companies should present RBOs in clear and simple language, format, and content, with clear instructions on how to proceed and whom to contact for assistance.

4. Consideration of encouragement or requirement for an insurer to offer certain RBOs:
    - State insurance regulators should evaluate legal constraints, the impact on remaining policyholders and insurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.

5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
    - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases (e.g., providing hand railings for fall prevention in high-risk homes) and identifying the pros and cons of such an approach.

Widely Established RBOs in Lieu of Rate Increases

1. Reduce inflation protection going forward, while preserving accumulated inflation protection.
2. Reduce daily benefit.
3. Decrease benefit period/maximum benefit pool.
4. Increase elimination period.
5. Contingent nonforfeiture (CNF).
    i. Claim amount can be the sum of past premiums paid.
    ii. Only receive that benefit if the policyholder qualifies for a claim.

Less Common RBOs for Potential Discussion

1. Cash buyout.
2. Copay percentage on benefits.

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review will likewise develop and evolve to consider the reasonableness of these RBOs. The Senior Issues (B) Task Force, or ~~will encourage~~ its appointed Subgroup and/or the Health Actuarial (B) Task Force, or an appropriate NAIC actuarial committee or group, will encourage ~~to~~ collective~~ly~~ consideration of new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

E. Appendix E—Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials

In 2020, the former Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force adopted the following guiding principles to ensure quality of consumer notices of rate increases and RBOs. This section seeks to provide guiding principles in answering this question: *"What are the recommendations for ensuring long-term care insurance policyholders have maximized opportunity to make reduced benefit decisions that are in their best interest?"*

To complete the charge, the Subgroup 1) evaluated the quality of consumer notices and RBO materials presented to policyholders; 2) considered the relevant lessons learned and consumer focus group studies from the liquidation of LTC insurer Penn Treaty Network America; 3) reviewed existing RBO consumer notice checklists or principles from multiple states (i.e., Nebraska, Pennsylvania, Texas, and Vermont); and 4) addressed stakeholder comments on RBO principles.

This document is intended to establish consistent high-level guiding principles for LTCI RBOs presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

Recognizing that each component outlined in these principles will not apply in all circumstances, this section:

- RECOMMENDS that insurance companies recognize these fundamental principles.
- CALLS ON all insurance companies to consider the following principles in communicating RBOs available to consumers in the event of a rate increase.
- UNDERLINES that the following principles are complementary and should be considered as a whole

Filing Rate Action Letters

Insurers should consider:

- Sending rate actions after the state has approved the rate action filing.
- Making the rate action effective on a policy anniversary date, recognizing that the *Long-Term Care Insurance Model Regulation* (#641) allows for the next anniversary date or next billing date.
- Mailing rate increase notification letters at least 45 days prior to the date(s) a rate action becomes effective, consistent with any applicable state laws and/or regulations.
- Sending rate increase notifications each year for rate increases that are phased-in over multiple years.
- Disclosing all associated future planned rate increases approved by state insurance regulators in the initial and phased-in rate increase notification letters.
- Filing rate action letter templates in the NAIC SERFF rate increase filing to include statements of variability and sample letters highlighting the differences between the communications, consistent with any applicable state laws and/or regulations.
- Presenting innovative options to state insurance regulators prior to filing new RBOs.

- This enables state insurance regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.

Readability and Accessibility

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
- Presenting the RBOs in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
- Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.
- Using illustrative tools, such as bullet points or illustrations, as appropriate, and graphs or charts enabling a side-by-side comparison.
- Including definitions of complex terms; and if a term, subject, or warning is repeated throughout the communication, consider making the language consistent throughout the document.
- Including a Q&A section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or policyholders for whom English is not a first language.

Identification

Insurers should consider drafting the RBO communication in a way that helps policyholders understand:

- What is happening.
- Why it is happening to them.
  - Ensure the letter does not negatively reference the state insurance department.
- When it is happening.
- What they can do about it.
- How they take action.

Communication Touch and Tone

Insurers should consider:

- Drafting the communication in a way that helps policyholders envision or reflect on the reason(s) why they purchased an LTCI policy.
- Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.
- Presenting RBOs fairly, refraining from the use of bolding, repeating, or emphasizing one option over another.
- Displaying the policyholder's ability to maintain current benefits by paying the increased premium.
- Using word choices that appreciate how those words could influence a policyholder's decision.
  - For instance, consider using "now" instead of "must"; or consider using "mitigation options," "offset premium impact" or "manage an increase" instead of "avoid an increase."

Consultation and Contact Information

The insurer should consider listing multiple contacts in the communication in an easy-to-identify location to include phone number, email address, and website when available. For example:

- Customer service.

- Lapse notifier.
- Insurance producer.
- State insurance department.
- State Health Insurance Assistance Program (SHIP).

The insurer should consider suggesting policyholders consult a family member or other trusted advisor, such as:

- Lapse notifier.
- Insurance producer.
- Financial advisor.
- Certified personal accountant or tax advisor (in the event cash buyouts are offered).

Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
  - For example, the header could say, "Your Long-Term Care Premiums Are Increasing."
- Including the RBOs with the rate action letter.
- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which RBO(s) have limited time frames.
- Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.
- Providing enough information in the communication to make a decision.
  - If supplemental materials (e.g., insurer's website) are provided, they would enhance the policyholder's understanding, but not be necessary to use when making a decision.

Insurers should consider indicating the window of time to act by:

- Clearly indicating what the policyholder's premium will increase to and by when.
- Displaying the due date(s) in an easy-to-identify location and repeating it multiple times throughout the document.
- Clearly differentiating due date(s) for each RBO, if available for a limited time.

Insurers should consider including disclosures regarding rate increase history by:

- Disclosing that future rate actions could occur.
- Advising if prior rate actions have or have not occurred to include:
  - Policy form(s) impacted.
  - Calendar year(s) the policy form(s) was available for purchase.
  - Percentage of increase approved to include the minimum and maximum if they vary by benefit type.
- Reminding policyholders that their policy is guaranteed renewable.

Insurers should consider advising policyholders of their current benefits:

- For example, the communication could disclose the policyholder's current benefits to include:
  - Daily maximum amount.
  - Inflation option.
  - Current pool of benefits for policies with a limited pool of benefits.

Insurers should consider personal needs decision-making by:

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- Only listing RBOs that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact LTC costs, such as:
  - The average cost of care for in-home care, assisted living, and nursing home care in their area.
  - The inflation rate of the cost of care for in-home and nursing home care in their area.
  - The average age and duration of an LTC claim for in-home and nursing home care.
  - Factors that influence the age, duration, and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
  - Buyout or cash-out disclosures.
    - The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

- Disclosing if the RBOs may not be of equal value and are dependent on the unique situation of each policyholder.

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
  - Daily/monthly benefit.
  - Benefit period.
  - Inflation option.
  - Maximum lifetime amount.
  - Premium increase percentage and/or new premium.
  - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
  - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
  - Current premium.

- Providing a series of questions to help policyholders contemplate the implications of each action, such as:

  - What will happen if they take no action?
  - What will happen if they make no payment before the policy anniversary date?
  - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
  - If they elect the cash buyout, there could be tax implications.
  - If they elect a paid-up NFO, how long will the reduced benefit last if they had a claim?
  - If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
  - Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

When rate actions span over multiple years, insurers should consider:

- Disclosing the full rate increase amount, how it is spread out across multiple years, and all associated future planned rate increases approved by state insurance regulators.
- Specifying if the premium increase referenced is the first, second, third, last, etc.
- Offering CNF based on the full increase amount and offered with each phase of the rate action.
- Notifying policyholders at least 45 days in advance of each phase of the rate increase, consistent with any applicable state laws and/or regulations.

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VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT[7]

FROM: Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Team
DATE: [Date]
RE: ABC Insurance Company – Block LTC1 – Draft of *Initial* MSA Advisory Report

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<u>Executive Summary</u>

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 34~~35~~% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company's block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options (RBOs) may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the actuarially justified ~~Texas and Minnesota~~MSA approach~~es~~. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

<u>Background</u>

The MSA Team was formed to assist ~~the Long-Term Care Insurance (EX) Task Force~~ in developing and implementing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase proposals as part of a pilot program. The MSA Review became operational on [insert date].

This MSA Advisory Report is related to the rate increase proposal filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team's actuarial analysis is provided below. The intention is that states can utilize this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

The MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer. As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal of the MSA Review process ~~Task Force~~ is for as much consistency as possible to occur between states in the rate increase approvals.

<u>Insurer's Proposal</u>

ABC Company requests a rate increase of 60% to be approved for inflation-protected products and 40% to be approved for products with no inflation.

In addition, ABC Company is requesting higher rate increases for states that did not grant full approval of prior rate increase requests.

[7] Information contained in this sample report is an example only and is not derived from any actual rate filing.

Workstream-Related Review Aspects

Actuarial Review

~~At the direction of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, t~~The MSA Team applied the ~~Minnesota and Texas~~MSA approach~~es~~ to calculate the recommended, approvable rate increases. Aspects of the MSA~~innesota~~ approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states' laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues.
- Elimination of rate increases related to inappropriate recovery of past losses.

The MSA~~innesota~~ approach also has additional unique aspects: 1) consideration of adverse investment expectations related to the decline in market interest rates, 2) adjustments to projected claim costs to ensure the impact of uncertainty is adequately borne by the insurer; and 3) a cost-sharing formula applied in typical circumstances.

Even though these additional aspects are outside the pure loss-ratio requirements, they fall in line with legal provisions that rates shall be fair, reasonable, and not misleading.

The MSA~~innesota~~ approach, including application of the typical-circumstance cost-sharing formula, results in an approvable rate increase of 34~~35~~% for inflation-protected products and 20% for products with no inflation protection.

~~The Texas approach results in an approvable rate increase of 29% in aggregate.~~

The MSA Team's recommendation, in consideration of the ~~Minnesota and Texas~~MSA approach~~es~~, is to approve a rate increase of ~~35~~34% for inflation-protected products and 20% for products with no inflation protection.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

Consideration of Differences in Histories of States' Rate Increase Approvals

According to the Historical Rate Level Summary, Appendix D in the insurer proposal, past rate increase approvals by state have varied and can be categorized as follows:

- 25 states have granted full or near-full approval of ABC Company's past requests (at or near 55%, cumulative).
- 18 states have granted cumulative approvals averaging 45%.
- Five states have granted cumulative approvals averaging 27%.
- Two states have granted cumulative approvals averaging 15%.

The insurer's stated goal is to bring rates in all states up to an equivalent rate level. Currently, the average annual premium rates for a policyholder range from below $1,700 in some states (with the lowest past approvals) to over $2,200 in other states (with the highest past approvals).

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The MSA Team's recommendation is based on a goal of rates per benefit unit being uniform between states going forward.

A table of examples of recommended rate increases based on past cumulative approval history is provided in Appendix 2.

Non-actuarial & Valuation/Solvency Considerations

Non-actuarial considerations, including flexibility regarding the phase-in of rate increases, waiting periods between rate increases being coordinated with phase-in periods, and other issues are being discussed at the ~~Task Force and the Subgroup.~~NAIC.

Even with future claims potentially being reduced due to COVID-19-related behavioral impact, ABC Company will continue to experience substantial losses on this block.

Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase proposal are consistent with assumptions underlying the reserve adequacy testing.

RBOs – Review for Reasonableness

Unless a rider was purchased, ABC Company policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:

1) Extending the elimination period.
2) Decreasing the benefit period.
3) Reducing future inflation accumulation.

The insurer produced rate tables which demonstrate that the RBOs provide reasonable value in relation to a case of a policyholder retaining full benefits and paying the full rate increase.

Financial Impact for Insurer

The requested rate increase associated with recent adverse development would result in around $50 million of reduced losses for this block according to information contained in the actuarial memorandum.

Mix of Business

From the insurer's actuarial memorandum:

Enrollees:

- Total enrollees as of date of proposal: 15,000
- Inflation protection: 9,000 (inflation protection) and 6,000 (no inflation)
- Benefit period: 8,500 (lifetime benefits) and 6,500 (limited benefits)

Product type: Expense reimbursement:

- Average issue age: 58
- Average attained age: 75
- Annualized premium: $30 million; $2,000 average per policyholder

Appendix 1

Drivers of Rate Increase Proposal – Summary

The primary drivers, summarized in the insurer actuarial memorandum, were lower lapses and longer average claim length. The insurer assumptions were based on actual-to-expected adjustments, based in part by insurer experience that has become more credible in recent years. The assumptions were determined to be reasonable and in line with industry and actuarial averages.

Details Regarding MSA~~innesota~~ Approach

For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:

- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
    - This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
- Blended if-knew / makeup rate cumulative rate increase since issue: 123%
    - = 0.62 * 177% + (1 - 0.62) * 36%, adjusted for rounding
- Insurer cost share based on ~~Minnesota~~ MSA formula (see Appendix 3): ~~12~~13%
- Recommended cumulative rate increase since issue: ~~109~~107%
    - = (1 - 0.13~~12~~) * 1.23, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: ~~35~~34%
    - = (1 + ~~1.09~~1.07) / (1 + 0.55) – 1, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): ~~35~~34%
    - Minimum of calculated approval rate of 35% and insurer proposal of 60%.
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the MSA~~innesota~~ approach includes the reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward due to a lack of credible support at extremely high ages, and a general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

~~Details Regarding Texas Approach~~

- ~~Insurer Calculation (aggregate): 52%~~

~~PPV calculations~~

- ~~Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%~~

~~LHAO Comments~~

- ~~For the purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.~~

~~Texas rate stabilized PPV Formula:~~

$$\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.58 + .85C}{1+C}\right)\Delta PV(\text{future earned premiums})}{.85\, PV_{\text{current}}(\text{future earned premiums})}$$

~~Reconciliation of Minnesota and Texas Approaches~~

~~The Texas PPV calculated amount of 29% aligns well with the Minnesota approach's recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs. non-inflation-protected cells is applied. The MSA Team's recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.~~

~~Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.~~

Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
    - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
    - Reasons for the rate increase, including which pricing assumptions were not realized and why.
    - Statement that policy design, underwriting, and claims handling practices were considered.
    - A demonstration that actual and projected costs exceed anticipated costs and the margin.
    - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
    - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
    - Information (from NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation, "Guidance Manual" Q&A): Morbidity, Lapse, Mortality, Interest.
        - Comparison with asset adequacy testing reserve assumptions.
        - Provide actuarial assumptions from original pricing and most recent rate increase filing, and, have the original actuarial memorandum available upon request.
    - Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
    - Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
    - Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

- Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

- Policyholder notification letter – should be clear and accurate.
    - Provide a description of options for policyholders in lieu of or to reduce the increase.
    - If inflation protection is removed or reduced, is accumulated inflation protection vested?
    - Explain the comparison of value between the rate increase and policyholder options.
    - Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
    - How are partnership policies addressed?

- Supplementary information, based on a list developed by the MSA Team following the review of initial pilot program proposals:
    - Information on benefit utilization.
    - Attribution of rate increase by factor.

  - RBO history and reasonability analysis.
  - Investment returns.
  - Expected loss ratio.
  - Shock lapse history.
  - Waiver of premium handling.
  - Actual-to-expected differences.
  - Assumption consistency with Actuarial Guideline 51 asset adequacy testing.

- Following initial review of the proposal, additional information was requested by the MSA Team related to:
  - Original pricing assumptions.
  - Lapse assumption by duration.
  - Premiums and incurred claims by calendar year based on original assumptions.
  - Distribution of in force by inflation protection.
  - Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
  - Description of waiver of premium handling in premium and claim projections.
  - Commentary on COVID-19 short-term and long-term LTC impact.

Appendix 2

Examples of Rate Increases If an RBO is Not Selected

ABC Company				
Jurisdiction Example*	**Past Cumulative Approved Increases**	**Increase to catch up**	**Recommended New**	**2021 Recommended Rate Incr**
Example: state with average past approvals	55%	0%	35%	**35%**
Example: state with lower than average past approvals	27%	22%	35%	**65%**
*The recommendation for each state is based on the actual past cumulative approved increases				
in that state.				

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

- ~~No haircut for the first 15%.~~
- ~~10% for the portion of cumulative rate increase between 15% and 50%.~~
- ~~25% for the portion of cumulative rate increase between 50% and 100%.~~
- ~~35% for the portion of cumulative rate increase between 100% and 150%.~~
- ~~50% for the portion of cumulative rate increase in excess of 150%.~~
- 5% haircut for the first 100%.
- 20% haircut for the portion of cumulative rate increase between 100% and 400%.
- 80% haircut for the portion of the cumulative rate increase in excess of 400%.

Example: if the pre-cost sharing MSA~~innesota~~ approach results in a cumulative 210% rate increase since issue:

- Break 210% into the following components: ~~15%, 35%, 50%, 50%, 60%~~100%, 110%
- Post haircut approval ~~is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%~~ 95% of 100% + 80% of 110%
- = ~~15% + 32% + 38% + 33% + 30%~~ 95% + 88%
- = ~~147%~~183%

Justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer’s solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or proposal.