Date: 12/2/22

Virtual Meeting
(in lieu of meeting at the 2022 Fall National Meeting)

HEALTH ACTUARIAL (B) TASK FORCE
Monday, December 5, 2022
2:00 – 4:00 p.m. ET / 1:00 – 3:00 p.m. CT / 12:00 – 2:00 p.m. MT / 11:00 a.m. – 1:00 p.m. PT

ROLL CALL

Andrew N. Mais, Chair Connecticut Grace Arnold Minnesota
Russell Toal, Vice Chair New Mexico Chlora Lindley-Myers Missouri
Mark Fowler Alabama Edward M. Deleon Guerrero N. Mariana Islands
Ricardo Lara California Eric Dunning Nebraska
Michael Conway Colorado Marlene Caride New Jersey
Karima M. Woods District of Columbia Judith L. French Ohio
Dean L. Cameron Idaho Glen Mulready Oklahoma
Amy L. Beard Indiana Michael Humphreys Pennsylvania
Doug Ommen Iowa Michael Wise South Carolina
Vicki Schmidt Kansas Cassie Brown Texas
Timothy N. Schott Maine Scott A. White Virginia
Kathleen A. Birrane Maryland Mike Kreidler Washington
Anita G. Fox Michigan Allan L. McVey West Virginia

NAIC Support Staff: Eric King

AGENDA

1. Consider Adoption of its Sept. 28, Sept. 6, and Summer National Meeting Minutes—Paul Lombardo (CT)

2. Consider Adoption of the Report of the Long-Term Care Actuarial (B) Working Group, Including its Oct. 17 Minutes—Paul Lombardo (CT)

3. Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO)—Megan Mason (CCIIO)

4. Hear a Presentation on Hybrid Long-Term Care Insurance (LTCI) Products—Jan Graeber (American Council of Life Insurers—ACLI)

5. Hear an Update on Society of Actuaries (SOA) Research Institute Activities—Achilles Natsis (SOA)
6. Hear an Update from the American Academy of Actuaries (Academy) Health Practice Council—*Academy*

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

8. Adjournment
The Health Actuarial (B) Task Force met Sept. 28, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM); Mark Fowler represented by Jennifer Li (AL); Michael Conway represented by Eric Unger (CO); Amy L. Beard represented by Heir Cooper (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Jeff Ji (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Michael Humphreys represented by Jim Laverty (PA); Cassie Brown represented by Aaron Hodges (TX); Scott A. White represented by David Shea (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. **Adopted a GLWPVT AG 44 Proposal**

   Mr. Lombardo said no comments were received on the Sept. 8 exposure of revisions to the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposal for changes to *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44).

   Ms. Weinberg made a motion, seconded by Mr. Dyke, to adopt the Academy and SOA Research Institute GLWPVT Work Group proposal for valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in AG 44, including the Sept. 8 revisions (Attachment XX) to AG 44. The motion passed unanimously. Mr. Lombardo said the replacement valuation tables and the revised version of AG 44 will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration.

2. **Adopted its 2023 Proposed Charges**

   Mr. Lombardo presented a draft of the Task Force’s 2023 proposed charges.

   Mr. Leung made a motion, seconded by Mr. Shea, to adopt the Task Force’s 2023 proposed charges (Attachment XX). The motion passed unanimously. Mr. Lombardo said the 2023 proposed charges will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.

Member Meetings\B CMTE\HATF\2022_Fall\Health Actuarial (B) TF\09-28-22\Minutes_HATF_09-28-22.docx
The Health Actuarial (B) Task Force met Sept. 6, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM); Ricardo Lara represented by Rodney Haviland (CA); Michael Conway represented by Eric Unger (CO); Doug Ommen represented by Andria Seip (IA); Amy L. Beard represented by Heir Cooper (IN); Kathleen A. Birrane represented by Jeff Ji (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Chris Murrah (MO); Marlene Caride represented by Seong-min Eom (NJ); Michael Humphreys represented by Jim Laverty (PA); Michael Wise represented by Andrew Dvorine (SC); Cassie Brown represented by Aaron Hodges (TX); Mike Kreidler represented by Lichiou Lee (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. **Discussed Revisions to a GLWPVT AG 44 Proposal**

Mr. Lombardo said no comments were received on the exposure of the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposal for valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves (AG 44).

Mr. Serbinowski said he is not comfortable with the language in Section VI(A) of the proposed revised AG 44 that states, “the selected claim mortality rates and recovery rates are deemed to be tables approved by the commissioner as the minimum standard for computing reserves as established by Section 4.G of the Standard Valuation Law.” Mr. Dyke agreed that reference to deeming by the commissioner should be removed. He said he will draft two suggested alternatives, and he asked that it be reviewed by industry. Steven Clayburn (American Council of life Insurers—ACLI) said he will forward Mr. Dyke’s suggestions to ACLI members for their review and input.

Mr. Lombardo said the Task Force will expose the revised language once it is available for a two-week public comment period, and a meeting of the Task Force will then be scheduled to discuss any comments received.

Having no further business, the Health Actuarial (B) Task Force adjourned.
The Health Actuarial (B) Task Force met Aug. 1, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM); Mark Fowler represented by Jennifer Li (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Eric Unger (CO); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Brad Boban (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Julia Lyng (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Jim Laverty (PA); Cassie Brown represented by Aaron Hodges (TX); Mike Kreidler represented by Lichiou Lee (WA); and Allan L. McVey represented by Joylynn Fix (WV). Also participating was: Tomasz Serbinowski (UT).

1. **Adopted its June 30 and May 16 Minutes**

   Mr. Lombardo said the Task Force met June 30 and May 16. During these meetings, the Task Force took the following action: 1) heard a Society of Actuaries (SOA) Research Institute 2022 Individual Life Waiver of Premium (ILWOP) Experience Study presentation; and 2) heard an update on the American Academy of Actuaries (Academy) and SOA Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group efforts towards developing valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44).

   Mr. Dyke made a motion, seconded by Ms. Weinberg, to adopt the Task Force’s June 30 (Attachment One) and May 16 (Attachment Two) minutes. The motion passed unanimously.

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

   Mr. Serbinowski said the Working Group met June 24. During this meeting, the Working Group discussed the Academy and SOA Research Institute’s final Long-Term Care Insurance Mortality and Lapse Study.

   Mr. Hodges made a motion, seconded by Mr. Schallhorn, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Three). The motion passed unanimously.

3. **Heard an Update on the SOA Research Institute/LIMRA Experience Studies Partnership**

   Marianne Purushotham (Life Insurance Marketing and Research Association—LIMRA) and Dale Hall (SOA) gave an update on the SOA Research Institute/LIMRA Experience Studies Partnership (Attachment Four).

4. **Heard an Update on the SOA Research Institute Activities**

   Mr. Hall gave an update on SOA Research Institute activities (Attachment Five).
5. **Heard an Update from the Academy Health Practice Council**

Barbara Klever (Blue Cross Blue Shield Association—BCBSA) gave an update on Academy Health Practice Council activities (Attachment Six).

6. **Heard an Academy Update on Professionalism**

Lisa Slotznick (Academy) said the Academy Committee on Qualifications (COQ) issued a final amended U.S. Qualification Standards (USQS) late in 2021 after exposing two drafts. She said during the exposure period, the COQ presented several webinars explaining the changes. She said the USQS specifies that qualifications for statements of actuarial opinion (SAO) are not limited to regulatory required opinions. She said the COQ has also updated frequently asked questions (FAQ) to help actuaries understand the USQS, and many of the FAQ started as questions received through the website. She said the COQ has received nine questions this year, two of which were referred to the Actuarial Board for Counseling and Discipline (ABCD) as requests for guidance. She said most of the other questions were about continuing education (CE) requirements and basic education.

Ms. Slotznick said actuaries who were qualified before the amended version of the USQS took effect remain qualified, and the changes mostly apply to new actuaries. She said the USQS now includes a new requirement for one hour of bias CE, which applies to all actuaries. She said CE can be obtained through self-study.

Darrell Knapp (Actuarial Standards Board—ASB) said the ASB has been focusing on six themes currently running through the ASB’s work: 1) addressing various tasks within scope, such as conducting reviews; 2) using a template to increase consistency in language across Actuarial Standards of Practice (ASOPs); 3) trying to avoid duplication with ASOP No. 1, Introductory Actuarial Standard of Practice, with “materiality” and “professional judgment” as examples; 4) adding guidance for reliance on other actuaries and experts; 5) focusing on the distinction between documentation and disclosures; and 6) focusing on gender, race, and employer type diversity on committees and task forces. He said because ASOP No. 1 calls on actuaries to always use professional judgment, the ASB is trying to avoid saying “the actuary should use professional judgment” in other ASOPs.

Mr. Knapp said the ASB approved an exposure draft of ASOP No. 41, Actuarial Communications in June, which will soon be released for exposure and go through the typical exposure process. He said the ASB will review the proposed exposure draft of ASOP No. 12, Risk Classification at its September meeting, and it should be exposed soon after that. He said the ASB is trying to find the right balance between the importance of risk classification systems to actuarial work and potential abuses in their application. He said a revision to ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities that was recently implemented took effect July 1. He said the ASB just released a technical correction to the scope of ASOP No. 28, along with that of ASOP No. 36, Statements of Actuarial Opinion Regarding Property/Casualty Loss, Loss Adjustment Expense, or Other Reserves. He said the current scope of each ASOP has a mutual exclusion where if one applies, the other does not. He said both ASOPs were originally written with the scope limited to NAIC SAOs. He said the scope of both ASOPs has been expanded to include broader SAOs, and as a result, the ASB must address those exclusions simultaneously and is therefore exposing just the scope of ASOP No. 28. He said the ASB is working on revisions to ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification.

Shawna Ackerman (California Earthquake Authority—CEA) said the ABCD performs the two primary functions of addressing requests for guidance (RFGs) and investigations into complaints. She said the ABCD may recommend discipline, but it is up to the organization the subject actuary is a member of to decide whether to discipline an actuary. She said recent RFGs in the health area included questions about the obligation to report under Precept 13, Violations of the Code of Professional Conduct of the Academy’s Code of Professional Conduct (CPC) and the procedures for doing that, as well as qualifications. She said the majority of RFGs are related to CPC Precept 1, Integrity and the actuary’s responsibility to the public.
Draft Pending Adoption

Mr. Lombardo asked when bias CE webinars will be conducted. Ms. Slotznick said several webinars that qualify for bias CE were produced and are available to Academy members on its website.

7. **Discussed an Academy and SOA Research Institute GLWPVT Work Group Valuation Tables Proposal**

Mr. Lombardo said the Academy and SOA Research Institute GLWPVT Work Group has proposed valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in AG 44. He said the proposed tables exhibit higher recovery rates and lower mortality factors than the current tables. He said the proposal is exposed for a public comment period ending Aug. 11.

Having no further business, the Health Actuarial (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/HATF/2022_Summer/08-01-22/ Minutes_HATF_08-01-22.docx
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met Oct. 17, 2022. The following Working Group members participated: Tomasz Serbinowski, Chair (UT); Charles Hale (AL); Lisa Luo (CA); Paul Lombardo (CT); Hannah Howard (FL); Wes Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman (OH); Andrew Schallhorn (OK); Jim Laverty (PA); and Aaron Hodges (TX). Also participating was: David Hippen (WA).

1. **Discussed an LTCI Mortality and Lapse Study Exposure**

Serbinowski presented comment letters received on the Working Group’s exposure of the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute’s Final Long-Term Care Insurance (LTCI) Mortality and Lapse Study from Risk & Regulatory Consulting LLC (RRC), the American Council of Life Insurers (ACLI), and America’s Health Insurance Plans (AHIP) (Attachment XX).

Serbinowski said since the proposed mortality tables will be used in the calculation of active life reserves, the table versions based on active lives, rather than total lives, should be used. He asked the Working Group for its thoughts on which version should be used. Andersen and Lombardo agreed that the active life versions should be used. Serbinowski said the version of the mortality tables will be specified in VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual*, and this issue will be discussed further during the drafting process for the changes to VM-25. Ray Nelson (America’s Health Insurance Plans—AHIP) suggested that flexibility in a company’s choice regarding the use of active or total lives tables should be allowed, as different companies use different bases in their reserving processes. Roger Loomis (Actuarial Resources Corporation—ARC) said he agrees that the use of active lives tables makes more sense theoretically. Hippen asked if the new reserving standards are intended to be applied to all in-force policies or only new issues after the effective adoption date. Serbinowski said he believes the new standards will only apply to new issues. He said this will be verified during the VM-25 changes drafting process. He said the Working Group will refrain from considering adoption of the proposed mortality and lapse tables until the necessary VM-25 language has been drafted and adopted.

Serbinowski said current reserve standards limit allowable lapses to 80% of lapse assumptions used in pricing for the first five years, then 100% of the pricing assumptions thereafter. He asked if the Working Group believes this convention should be applied to the proposed lapse tables, or if lapses used in reserving should be limited to the lesser of those indicated by the proposed tables or those used in pricing. Andersen said limiting lapses to the lesser of the proposed tables and pricing makes sense. Nelson said he agrees with this.

Serbinowski asked if the mortality tables to be used should be static or generational tables. Nelson said the ACLI/AHIP comment letter suggests using a static table, which already reflects 11 years of mortality improvement. He said any future mortality improvements can be evaluated during the asset adequacy testing (AAT) process, and they would not need to be reflected in the prescribed mortality tables. Andersen said if companies assume morbidity improvement in their valuations, they should also be required to assume mortality improvement. He said if it is decided that there will be no mortality improvements, there should be a requirement that morbidity improvements should not be assumed. Warren Jones (Academy-Retired) said the Academy/SOA Work Group did not make a recommendation regarding which version of the tables should be used. Serbinowski asked Working Group members about what their preference is for static versus generational mortality tables. Thirteen Working Group members said they prefer static, and one member said they prefer generational.
Serbinowski said both comment letters argued for flexibility regarding the use of adjustment factors for risk class and marital status, such as allowing factors to be used for some blocks but not others, or for allowing the use of the factors for lapses but not mortality. He said the Academy/SOA Work Group did not provide recommended factors for these adjustments. He asked the commenters what kind of guardrails will be in place and support documentation required if state insurance regulators allow for flexibility in factor application. Nelson said given the differences in definitions and experience for risk classifications and marital status discounts between companies, and from block to block within the same company, the ACLI/AHIP recommends flexibility in factor application be allowed. He said he agrees that companies should be able to support and document their assumptions, and this should be done at both the time of pricing and the time of setting reserving assumptions for each valuation. He said support and documentation will also need to be provided when AAT, as required by Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51). Serbinowski said risk class and marital status definitions vary between companies, and since these are not well-defined, perhaps it is better to use valuation tables that are not adjusted for risk class or marital status. Carmello, Lombardo, and Trexler said they agree with this. Serbinowski asked Working Group members what their preference is for allowing adjustment factors for risk class and marital status. Fourteen Working Group members said they prefer to not allow these adjustments.

Serbinowski said the next step is for the Working Group to draft changes to VM-25 to incorporate the use of the proposed valuation tables and discuss the draft when it is available.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2022_Fall/LTCAWG/10-17-22/Minutes_LTCAWG_10-17-22docx
Plan Year (PY) 2024 Rate Filing Submissions

December 5, 2022

NAIC, Health Actuarial Task Force Meeting

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The information provided in this presentation is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was shared. Links to certain source documents may have been provided for your reference. We encourage persons attending the presentation to refer to the applicable statutes, regulations, and other guidance for complete and current information.
Purposes of Rate Review

- Improve issuer accountability and transparency
- Carry out Secretary’s responsibility to monitor premium increases of health insurance coverage offered inside and outside the Exchange
- Ensure compliance with Federal rating requirements and reasonableness of proposed rate increases
Which issuers must submit the Unified Rate Review Template (URRT)?

- **Annual Filings**
  - Issuers (for both QHPs and non-QHPs) offering a single risk pool plan in the individual or small group market for the 2024 plan year

- **Quarterly Filings**
  - Issuers can submit quarterly rate changes for the small group market if allowed by the State regulatory authority
  - Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change (or earlier State deadline)
What should issuers submit for Single Risk Pool Plans?

• If any plan within a filing includes a rate increase subject to review:
  – Part I – URRT
  – Part II – Written Description Justifying the Rate Increase
  – Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)

• If all plans within a filing have rate increases less than the subject to review threshold:
  – Part I – URRT
  – Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)

• If all plans within a filing are new, have no rate change(s), or have a rate decrease:
  – Part I – URRT
Filing vs. Product vs. Plan

- **A filing** is submitted by a specific company for a specific state in either the individual or small group market.
- **A product** is a discrete package of health insurance coverage benefits that are offered using a particular network type within a service area.
- **A plan** is the pairing of the health insurance coverage benefits under a product and a particular cost-sharing structure, provider network, and service area.
  - Plans within a product can vary based on cost sharing structure and service area. The combination of all service areas of the plans constitutes the total service area of the product.

<table>
<thead>
<tr>
<th>Acme Company – Individual Market Filing, Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product A</strong></td>
</tr>
<tr>
<td>Essential Health Benefits (EHBs) only</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>PPO</td>
</tr>
<tr>
<td>Plan A1 = bronze</td>
</tr>
<tr>
<td>Plan A2 = silver</td>
</tr>
<tr>
<td>Plan A3 = gold</td>
</tr>
</tbody>
</table>
**Renewing Plans**

- Issuers are able to designate plans as one (1) of three (3) options in the URRT: New, Renewing, or Terminated. Only “Renewing” plans are subject to the rate review provisions.

- Unless an issuer is brand new to the market, at least one (1) plan in the filing must be marked as “Renewing”; otherwise an issuer may be considered as having exited the market and may be subject to a 5-year ban.

- Issuers that replace an entire portfolio of products in a market with new products may avoid a 5-year ban if each newly offered product is cross-walked to a terminated product in the actuarial memorandum. An issuer must expect significant transfer of enrollment from one product to the other for this to be considered reasonable. The issuer should mark the newly mapped plan(s) as “renewing” and enter the current enrollment and current premium PMPM from the terminating plan(s) under the renewing plan(s) rather than in the terminating plan(s) columns.
Rate Filing Tips for PY 2024

• CMS intends to post preliminary single risk pool rate changes for all states on ratereview.healthcare.gov. Please remember the following:
  – New issuers and issuers with no rate changes will not be posted on the website.
  – The data from the most recent URRT and the most recent Actuarial Memorandum (or Redacted Actuarial Memorandum) entered into the system will be displayed on the website.
• Rate filing documents need to be submitted by the applicable deadline for proposed rates; they also need to be revised and resubmitted (as applicable) with the final rate information.
• State Based Exchanges that DO NOT use the federal platform have until the federal non-QHP deadline to finalize QHP rates in the URR Module.
URRT changes for PY 2024

• Lengthen Decimal Places in URR Template up to 16 characters, including decimal place, to improve calculation accuracy. Display will still only show two decimal places
• Update existing URR Template Rate Increase Formulas to round to 2 percentage decimal places
• Excel will no longer change “Paste” to "Paste Special, Values“
• Formulas will no longer disappear from cells when regenerating the URRT
• Move State & Market Field in the URRT from column J to column E for ease of reading
• Remove AV De Minimis range validations on URRT and URR Module
  • It will be the responsibility of the regulators to make sure the AV values are within permissible ranges. CMS will run internal error reports to notify regulators of issues that we find
• Return an error to users when documents fail to store
• Issuers in states that should be submitting through the SERFF to URR Transfer process will be blocked from access to the URR Module. This will prevent them from making changes that are not recorded in SERFF
• The transfer system connection is not applicable to States without an Effective Rate Review program, or states that do not utilize the SERFF system. The issuers in these states should continue to submit filings in the HIOS URR module directly.

• SERFF URR Transfer validation errors have been added for:
  – Issuer ID is incorrect
  – Product is not registered in HIOS
  – Effective Date is prior to the current year
  – Active Submission is already found in HIOS

• Allow SERFF to transfer CJN updates without a new URRT at or above threshold, and allow CJN documents for every filing
Step 1 – URRT Tab in SERFF

- All rate filing information for the individual and small group markets will be entered directly into SERFF under the URRT Tab. This includes:
  - Part I – URRT
  - Part II – Written Description Justifying the Rate Increase
  - Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)

- Once validated by the system, the information will be automatically transferred to the URR module of HIOS.

- The URRT information was set up on 4 TOIs within SERFF: H16G and HOrg02G (Small Group only) and H16I and HOrg02I rates. If the filing is created outside of these combinations, the URRT tab will not show.
Step 2 – Is the URRT required?

Once the user navigates to the URRT view, they will be asked if URRT is applicable to this rate filing:

The Unified Rate Review Template is required to be submitted by Issuers (for both QHPs and non-QHPs) offering a single risk pool plan in the individual or small group market. Issuers can submit quarterly rate changes for the small group market if allowed by the State regulatory authority. Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change (or earlier State deadline)

Note: These filings do not include Student Health or Excepted Benefit products, such as Stand-alone Dental products.
Step 3 – Adding the URRT

The second field is the template itself; additional items cannot be uploaded until the template has been added:

<table>
<thead>
<tr>
<th>Field</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified Rate Review Template</td>
<td>To download the latest version of the Unified Rate Review Template, please visit the CMS website at <a href="https://www.rhp-certification.cms.gov/s/Application%20Materials">https://www.rhp-certification.cms.gov/s/Application%20Materials</a>. Please upload the XML version of the template created by the 'Finalize' action and not the Excel file itself.</td>
</tr>
<tr>
<td>Actuarial Memorandum *</td>
<td>Can only be added after the Unified Rate Review Template is added.</td>
</tr>
<tr>
<td>Actuarial Memorandum - Redacted *</td>
<td>Can only be added after the Unified Rate Review Template is added.</td>
</tr>
<tr>
<td>Consumer Justification Narrative</td>
<td>Only needed if URRT is above the threshold. Can only be added after the Unified Rate Review Template is added.</td>
</tr>
<tr>
<td>Other Supporting Docs</td>
<td>Can only be added after the Unified Rate Review Template is added.</td>
</tr>
</tbody>
</table>
Step 4 – Validation of the URRT

Once the template has been uploaded, it will be sent to CMS for validation and a message appears to the issuer:

Unified Rate Review Template *

To download the latest version of the Unified Rate Review Template, please visit the CMS website at https://www.qhpcertification.cms.gov/s/Application%20Materials. Please upload the XML version of the template created by the 'Finalize' action and not the Excel file itself.

In Progress: URRT validation with CMS is in progress. Check back later for validation success or failure.

1urrttemplatevalidationsuccess.xml

Replace File
Once the validation request has been processed, the message will update accordingly. If the validation is successful, SERFF also displays the regenerated Excel file:

Unified Rate Review Template *
To download the latest version of the Unified Rate Review Template, please visit the CMS website at https://www.qhpcertification.cms.gov/s/Application%20Materials. Please upload the XML version of the template created by the 'Finalize' action and not the Excel file itself.

Success: CMS URRT validation was successful.

1urrttemplatevalidationsuccess.xml

Replace File

validated.xls
Step 6 – Actuarial Memorandum

Issuers will be required to upload the Actuarial Memorandum and Redacted Actuarial Memorandum:

**Actuarial Memorandum**

*The Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Unified Rate Review Template. The document should contain actuarial reasoning and assumptions, justifications and methodologies that support the entries in the URRT. This document must be a PDF.*

Select .pdf File

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**Actuarial Memorandum - Redacted**

*Upload a redacted version of the Actuarial Memorandum. This redacted document will be made available to the public on the CMS website. It should not contain any information that is a trade secret or confidential commercial or financial information. This document must be a PDF.*

Select .pdf File
Step 7 – Consumer Justification Narrative

Issuers can upload the Consumer Justification Narrative (CJN) if not above threshold, but if the CJN is required, issuers will be required to upload the CJN and the user interface indicates this new requirement:

Consumer Justification Narrative
You must have at least one plan that meets or exceeds the threshold to require a Consumer Justification Narrative. This document must be a PDF.

Threshold criteria, One or more plans that meet all three criteria:

- Has 'Metal' level of Platinum, Gold, Silver, Bronze, or Catastrophic
- Has a 'Plan Category' of Renewing
- Has a 'Cumulative Rate Change %' (over 12 months prior) equal or greater than 15%

Select .pdf File

Consumer Justification Narrative is required for the URRT uploaded.
Step 8 – Supporting Documentation

There is an Additional Supporting Documentation section where up to 30 files can be uploaded.

Other Supporting Documents
Additional documentation relevant to the URRT submission. These documents must be PDFs.

Select .pdf Files
Step 9 – Other SERFF Functions

Upon Submission of the filing, the information from the URRT tab will be submitted to the state but also sent to CMS. The template and supporting URR items can also have the following SERFF functions applied, but these functions will not be transferred to the URR module of HIOS:

- Request Confidentiality
- Objections/Objections Letters
- Change Schedule Items
- Response Letters
- Amendment Letters
- State Public Access
Step 10 – State Determinations

Once the state review is complete, the state will mark the URRT as complete as their determination. If the filing contains only plans below the threshold:

**Acknowledge Review**

**URRT Reviewed**

**HIOS ID**

12345

**URRT Documents**
Step 10 – State Determinations

If the filing contains at least one plan above the threshold:

Select URRT determination *

Comments *

Send _ to CMS
Once a state regulator enters a final determination, the following information will be displayed. The URRT determination and the comments will be sent to the URR Module of HIOS and displayed on ratereview.healthcare.gov. Once a determination has been sent to CMS, there can be no further action on the URRT tab from the issuer or the state.

State URRT Review

URRT Determination
Not Unreasonable

Comments
This is the reviewers comments about the URRT.
Important Reminder

Filings that are submitted through the SERFF transfer process can no longer be reopened after they are in a final status. If a change needs to be made to a filing, it will need to be deactivated by a member of the CCIIO staff in HIOS and then a new submission will need to come through SERFF.
Rate Review Inbox

• Send questions about the content of URR submissions to ratereview@cms.hhs.gov
• Include submission tracking number, State, Health Insurance Oversight System (HIOS) ID, and issuer legal name
• When there is an error or issue with the template:
  – Include screenshots or attach template
  – List steps taken that produced the error
• Please read the instructions before emailing ratereview@cms.hhs.gov
Resources

- Instructions for the URRT, Actuarial Memorandum and Redacted Actuarial Memorandum

- CMS Regulations and Guidance
Open Q&A Session
Combination Products

Jan M. Graeber, ASA, MAAA
Senior Actuary
ACLI
jangraeber@acli.com

December 5, 2022
Combination Products

- Market Landscape
- General Product Types
- Benefit Structures
- Indemnity and Reimbursement Models
- Combination Product Regulation
- LIMRA Data on Combination Products
Financing Long-Term Care Needs

- Medicare
- Medicaid
- Self-Funding
- Private Insurance Solutions
Private Insurance Solutions to Addressing Long-Term Care Needs

- Traditional Stand-Alone Long-Term Care Insurance
- Combination Products
  - Life Insurance Policies with Long-Term Care Benefits
  - Life Insurance Policies with Chronic Illness Benefits
General Combination Product Basics

• Typically, less expensive than stand-alone LTC
• Death benefit is accelerated if LTC benefits or chronic benefits are used
• Death benefit preserved if LTC benefits or chronic illness benefits are never used
• Some policies allow for:
  • Restoration of the Death Benefit
  • Extension of the LTC or chronic illness benefit
• Many contain no up-front or explicit premium for the accelerated benefit
• Tax benefits typically received through:
  • IRC 7702B - Tax-Qualified LTC, or
  • IRC 101(g) - Chronic Illness ADB
Combination Products
Indemnity and Reimbursement Models

General Structure of Benefits:

- Indemnity benefits – benefit amount is paid once the policyholder qualifies for benefits
- Reimbursement benefits – benefits will only be reimbursed for the expenses incurred once the policyholder qualifies for benefits
LTC Combination Product Terms

- LTC Acceleration of Benefit rider (ADB)
- LTC Extension of Benefits Rider (EBR)
- Some refer to products that bundle ADB plus EBR as “hybrids” or “linked benefit products”
LTC Combination Products

Companies that wish to market or offer their combination products as Long-Term Care coverage must comply with the LTC Model Regulation or applicable state LTC law.
LTC Combination Products and HIPAA

• Qualified LTCI will be subject to favorable tax treatment under the Federal Income Tax Code, similar to accident and health insurance products.

• Benefits paid by a tax-qualified policy will not be counted as taxable income to the policyholder under most circumstances, and premiums paid can be counted as a non-reimbursed medical expense for those itemizing their deductions for tax purposes.

• Almost all policies sold today are TQ policies, although non-TQ policies continue to be available.
Chronic Illness Combination Products

- Provides an acceleration of the death benefit for chronic illness care needs.
- At most, the benefit payout is 100 percent of the death benefit.
- Some products apply a charge at issue for the chronic illness rider.
- Some do not apply a charge at issue and discount the benefit amount at time of claim.
- Receive tax benefit under Section 101(g) of the Internal Revenue Code.
- Cannot be marketed as LTC insurance.
- When benefits are paid, the life policy face amount is commonly reduced dollar-for-dollar up to 100% of the face amount of the life policy.
- Acceleration benefit options typically range between two years and four years, or range from 1% to 5% of the face amount per month.
REGULATORY FRAMEWORK AND GUIDANCE

- NAIC Long-Term Care Model Regulation (640)
- NAIC Accelerated Benefits Model Regulation (620)
- Interstate Insurance Compact Uniform Standards
LIMRA Data
Combination Products
Market Share by Type of Combination Product

2021 New Policies

- Life/LTC: 207,283
- Life/CI: 351,512
- ILTCI*: 90,752

Market Share by New Policies

- Life/LTC: 54%
- Life/CI: 32%
- ILTCI*: 14%

*Based on participants in LIMRA's 2021 Annual Individual Long-Term Care Sales Survey.
Market Share by Type – LTC Combination Products

Policy Market Share by Type
- Acceleration — LTC: 6%
- Acceleration — CI: 22%
- Linked Benefits: 72%

Premium Market Share by Type
- Acceleration — LTC: 27%
- Acceleration — CI: 14%
- Linked Benefits: 59%
## LTC Combination Products

### LTC Extension Benefit Duration

<table>
<thead>
<tr>
<th>Benefit Duration</th>
<th>Share</th>
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<tbody>
<tr>
<td>2-Year</td>
<td>27%</td>
</tr>
<tr>
<td>3-Year</td>
<td>4</td>
</tr>
<tr>
<td>4-Year</td>
<td>22</td>
</tr>
<tr>
<td>5-Year</td>
<td>7</td>
</tr>
<tr>
<td>6-Year</td>
<td>20</td>
</tr>
<tr>
<td>7-Year</td>
<td>1</td>
</tr>
<tr>
<td>8-Year</td>
<td>*</td>
</tr>
<tr>
<td>Lifetime</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
</tbody>
</table>

* Less than 1/2 of one percent

### LTC Extension Inflation Protection Provisions

<table>
<thead>
<tr>
<th>Benefit Duration</th>
<th>Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>3% simple</td>
<td>5%</td>
</tr>
<tr>
<td>3% compound</td>
<td>47</td>
</tr>
<tr>
<td>5% simple</td>
<td>7</td>
</tr>
<tr>
<td>5% compound</td>
<td>9</td>
</tr>
<tr>
<td>None</td>
<td>32</td>
</tr>
</tbody>
</table>

### LTC Extension Couples Discount

<table>
<thead>
<tr>
<th>Couples Discount</th>
<th>Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included</td>
<td>77%</td>
</tr>
<tr>
<td>Not included</td>
<td>23</td>
</tr>
</tbody>
</table>
Market Share by Type – Chronic Illness Combination Products

**Chronic Illness Policy Market Share**
- 8% Additional Rider Premium at Issue
- 92% No Additional Premium

**Chronic Illness Premium Market Share**
- 9% Additional Rider Premium at Issue
- 91% No Additional Premium
SOCIETY OF ACTUARIES
RESEARCH UPDATE TO
HATF

December 5, 2022

ACHILLES NATSIS, FSA, MAAA
Health Research Actuary
Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.
Emerging Long-Term Impact of COVID 19 on Health Care Costs
Background

- This research follows upon previous work:
    - [https://www.soa.org/resources/research-reports/2021/covid-19-cost-model/](https://www.soa.org/resources/research-reports/2021/covid-19-cost-model/)
  - Funded by the Robert Wood Johnson Foundation, using Wakely Commercial Data
    - 11 Million lives (mostly Large Group and ACA). Data from Jan 2019 – July 2021.
    - Examined Monthly PMPM costs for members with a COVID-19 diagnosis
    - Member cohorts listed below
      - Severely Hospitalized members (ICU Stay)
      - Non-Severely Hospitalized Members (No ICU)
      - Non-Hospitalized Members with underlying conditions
      - Non-Hospitalized Members without underlying conditions

- Highlighted at an SOA Webcast on July 28th: Emerging Long Term COVID-19 Trends
- Research to be published in early 2023.
## Change in Monthly PMPM Costs

<table>
<thead>
<tr>
<th>Population</th>
<th>Percent of Total Population</th>
<th>Pre-COVID 6+ months</th>
<th>Month of COVID-19 Diagnosis</th>
<th>Post-COVID 6+ months</th>
<th>Post- vs. Pre-COVID % Cost Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP Admits: Severe COVID</td>
<td>0.2%</td>
<td>$1,904</td>
<td>$168,095</td>
<td>$2,824</td>
<td>48%</td>
</tr>
<tr>
<td>IP Admits: Non-Severe COVID</td>
<td>2.2%</td>
<td>$1,647</td>
<td>$43,711</td>
<td>$2,015</td>
<td>22%</td>
</tr>
<tr>
<td>All IP Admits</td>
<td>2.4%</td>
<td>$1,668</td>
<td>$53,811</td>
<td>$2,051</td>
<td>23%</td>
</tr>
<tr>
<td>Non-Admitted COVID with &gt;0 HCCs</td>
<td>33.2%</td>
<td>$1,256</td>
<td>$7,273</td>
<td>$1,814</td>
<td>44%</td>
</tr>
<tr>
<td>Non-Admitted COVID with no HCCs</td>
<td>64.5%</td>
<td>$249</td>
<td>$870</td>
<td>$322</td>
<td>29%</td>
</tr>
<tr>
<td>All Non-Admitted COVID</td>
<td>97.6%</td>
<td>$603</td>
<td>$3,034</td>
<td>$868</td>
<td>44%</td>
</tr>
<tr>
<td>All Members</td>
<td>100.0%</td>
<td>$626</td>
<td>$4,229</td>
<td>$899</td>
<td>44%</td>
</tr>
</tbody>
</table>

- Members with more severe outcomes correlated with higher pre-COVID costs.
- Post-COVID costs rose significantly, especially for Severely Hospitalized members and non-hospitalized members with chronic conditions.
- Vast majority of commercial members not hospitalized, most with no chronic conditions.
Summary of Monthly PMPM Costs Pre and Post-COVID

- Members with COVID-19 diagnosis
- Inpatient is main driver of PMPM cost changes
- Several month ramp-down and ramp-up of costs
- Post-COVID costs higher than Pre-COVID-Costs
Study Conclusions

• Results varied significantly by Severity of COVID and underlying conditions
  • Members with most severe outcomes had higher average base costs
  • Higher severity outcomes had more interim period distortions
• Claims took up to 6 months to settle at ‘New Normal’ levels
  • Hospitalized and Severely Hospitalized patients took the longest to come back down
  • Non-Hospitalized patients with no prior HCCs came back down almost immediately
• Significant ramp-up of claims prior to COVID Diagnosis
  • Greater ramp-ups for hospitalized and ‘severely hospitalized’ patients
  • Causes may be due to resumption of deferred services and pre-diagnosis COVID claims
• Comparison of Pre-COVID vs. Post-COVID claims can be significantly impacted by the base period chosen
  • Need to interpret & choose Pre-COVID claims levels carefully to reflect accurate results
  • Incorporating more recent months in the base can reduce the Pre- vs. Post-COVID PMPM claims differences
• Significant long lasting higher claims
  • Strong overall signal that COVID-19 diagnosis is correlated with significant increases in PMPM costs
  • Long COVID showing up in claims 6+ months post-COVID diagnosis
  • Further study needed to extend the post-COVID period and to examine the impacts of other variants
Additional Health Research
## Practice Research & Data Driven In-house Research

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
<th><a href="https://www.soa.org/resources/research-reports/2022/2023-gretzen-model-update/">Link</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>2023 Getzen Model</td>
<td>This research examines is a model that does long term medical trend projects. In addition, there is a write-up which describes how each of the assumptions were chosen.</td>
<td>12/15/2022</td>
<td><a href="https://www.soa.org/resources/research-reports/2022/2023-gretzen-model-update/">https://www.soa.org/resources/research-reports/2022/2023-gretzen-model-update/</a></td>
</tr>
<tr>
<td>Wall Street Journal Future of Health Summary</td>
<td>This research will summarize a recent &quot;Future of Health&quot; online event sponsored by the Wall Street Journal.</td>
<td>12/15/2022</td>
<td><a href="https://www.soa.org/resources/research-reports/2022/wall-street-journal-health/">https://www.soa.org/resources/research-reports/2022/wall-street-journal-health/</a></td>
</tr>
<tr>
<td>Health and Health Care Inequalities: Research</td>
<td>A summary of the challenges involved in conducting research that requires health or health care data and protected personal information. Includes considerations for future research.</td>
<td>1/6/2022</td>
<td></td>
</tr>
<tr>
<td>Challenges and Considerations</td>
<td></td>
<td>12/15/2022</td>
<td></td>
</tr>
<tr>
<td>Risk Adjustment White Paper</td>
<td>Interview Risk Adjustment SMEs and create a white paper that will address recent concerns brought up by political leaders about the use of Risk Adj through an actuarial user's guide to its past and future applications.</td>
<td>12/15/2022</td>
<td></td>
</tr>
<tr>
<td>Emerging Impact of Long COVID on Healthcare Costs and Medical Conditions</td>
<td>A study that will examine the impact of a COVID 19 diagnosis on patient claims and medical conditions.</td>
<td>12/15/2022</td>
<td></td>
</tr>
<tr>
<td>Social Physical and Cultural Determinants of Health</td>
<td>Qualitative SDOH research project</td>
<td>12/15/2022</td>
<td></td>
</tr>
<tr>
<td>State Based Public LTC Catastrophic Research</td>
<td>Study the feasibility, possibilities and potential options for a state specific public product for Catastrophic LTC protection.</td>
<td>1/6/2022</td>
<td></td>
</tr>
<tr>
<td>Group Life Waiver of Premium Valuation Tables</td>
<td>Develop valuation tables for claim mortality and recovery on Group Term Life policies with Waiver of Premium benefits.</td>
<td>1/31/2023</td>
<td></td>
</tr>
<tr>
<td>HCCI Quick Hit - Specialty Pharmacy Trends</td>
<td>This research will examine some key specialty drugs to look at how increases in uptake in drugs worth between 10K and 200K are driving current pharmacy trend.</td>
<td>1/31/2023</td>
<td></td>
</tr>
</tbody>
</table>
About the American Academy of Actuaries

The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy and its boards also set qualification, practice, and other professionalism and ethical standards for actuaries credentialed by one or more of the five U.S.-based actuarial organizations in the United States.
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The Academy, through its public policy work, seeks to address pressing issues that require or would benefit from the application of sound actuarial principles. The Academy provides unbiased actuarial expertise and advice to public policy decision-makers and stakeholders at the state, federal, and international levels in all areas of actuarial practice.
Health Practice Council—Key Policy Priorities for 2022

- Health Equity
- COVID-19: Implications for Health Care Utilization and Spending
- Insurance Coverage
- Long-Term Care
- Medicare Sustainability
- Payment and Delivery Reform
- Climate Change and Health
Health Equity

- Issue Briefs:
  - *Data Collection for Measurement of Health Disparities* (forthcoming)
  - *Health Care and Health Insurance System Risk Assessment and Risk Adjustment in the Context of Health Equity* (August 2022)
- Comment Letters:
  - Comment letter to CMS on Medicare Advantage, focused on the health equity aspects of the questions posed within the CMS’s RFI. (August 2022)
- Presentations:
  - Presentation to the NAIC Special (EX) Committee on Race and Insurance, Workstream Five by Annette James (August 2022)
COVID-19: Implications for Health Care Utilization and Spending

- Articles:

- Webinars:
  - “Health Spending Projections in the Wake of COVID-19” (May 2022)
Health Insurance Coverage

- Issue Briefs:
  - Drivers of 2023 Health Insurance Premium Changes (and infographic) (June 2022)
  - Medicaid Managed Care State-Directed Payments (September 2022)

- Comment Letters:
  - Comments on Cost-Sharing Reduction Premium Load Factors (September 2022)
  - Comments on Family Glitch Proposed Rules (June 2022)

- Virtual Briefings, Webinars, and Presentations:
  - “Considerations for Calculating Cost-Sharing Reduction Load Factors” (November 2022)
  - Academy Annual Meeting Breakout Session, “Regulating the Affordable Care Act: What’s New for 2023?” (November 2022)
  - “Drivers of 2023 Health Insurance Premium Changes” (July 2022)
Long-Term Care Insurance (LTCI)

- Issue Brief:
  - *Value of Reduced Benefit Options in Long-Term Care Insurance Rate Increases* (LTC Actuarial Equivalence) (June 2022)

- Webinar:
  - “*Value of Reduced Benefit Options in Long-Term Care Insurance Rate Increases*” (LTC Actuarial Equivalence) (June 2022)
Medicare Sustainability

- **Issue Brief:**
  - *Medicare’s Financial Condition: Beyond Actuarial Balance* (June 2022)

- **Essential Elements:**
  - “*Medicare’s Long-Term Sustainability Challenge*” (June 2022)

- **Capitol Forum Webinar:**
  - “*Social Security and Medicare Trustees’ Reports: A Deep-Dive Discussion With the Programs’ Chief Actuaries*” (June 2022)
## Payment and Delivery Reform

### Issue Briefs:
- *Addressing High Insulin Spending: Moving Beyond Copay Caps* (forthcoming)
- *Issue brief on Gene Therapy Drug Costs* (forthcoming)
- *Implications of Hospital Price Transparency on Hospital Prices and Price Variation* (March 2022)

### Webinars and Presentations:
- *Annual Meeting Breakout Session*, “Health Care Workforce Shortages” (November 2022)
- “*Hospital Prices: Can Greater Price Transparency Drive Lower Prices and Reduce Price Variation?*” (April 2022)
- “*Health Spending Projections in the Wake of COVID-19*” (May 2022)
Climate Change and Health

- Climate Change Joint Task Force:
  - In November 2021, the Academy launched the Climate Change Joint Task Force. Membership is comprised of members from the health, casualty, life, and pension practice areas and is organized under the Risk Management and Financial Reporting Council (RMFRC).
  - The task force has submitted numerous comment letters to federal agencies on climate-related disclosures and financial risks.

- Presentations:
  - Annual Meeting Session, “Climate Change and Health” (November 2022)
Group Life Waiver Valuation Table Work Group—submitted report on updating AG 44 for the NAIC (Report)(Tables). (June/July 2022)

Joint project between the Academy and Society of Actuaries Research Institute (SOARI).

Presentation to NAIC HATF in May 2022.

Status: The revised AG 44 and associated tables have been adopted by B Committee and will now be considered for adoption by Executive & Plenary at the NAIC Fall National Meeting (final step).
HPC NAIC Workstreams—HRBC

- Health Risk-Based Capital (E) Working Group (HRBC)
  - Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula.
    - July 2021—Academy comment letter.
    - January 2022—Academy report.
    - July 2022—Timeline letter.
    - November 2022—Academy Health Underwriting Risk Factors Analysis Work Group commences work.
    - December 2022—next update is scheduled to the NAIC HRBC at the Fall National Meeting.
HPC NAIC Workstreams—LTCAWG

- NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG)
- Long-Term Care Insurance Mortality and Lapse Study
  - Original request from the NAIC LTCAWG
    - Developed by the Long-Term Care Valuation Work Group of the Academy and SOARI.
  - Presentation to NAIC HATF in November 2021.
  - Update presentation to NAIC LTCAWG in June 2022.
  - Exposed by the NAIC LTCAWG until Sept. 5, 2022.
  - Status: LTCAWG is to draft changes to VM 25 and to adopt tables within the report (TBD).
“Envision Tomorrow: 2022 Annual Meeting” in Washington, D.C.
November 2–3, 2022
Health-specific breakout sessions:
• Health Care Workforce Shortages
• Climate Change and Health
• Regulating the Affordable Care Act: What’s New for 2023?
Health Practice Council—Key Policy Priorities for 2023

- Health Equity
- COVID-19 and Other Public Health Challenges
- Insurance Coverage and Benefit Design
- Health Care Costs and Quality
- Medicare Sustainability
- Long-Term Services and Supports (LTSS)
- Financial Reporting and Solvency
- Professionalism
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Under the Public Policy tab, access Academy:

- Comments and letters
- Issue briefs
- Policy papers
- Presentations
- Reports to the NAIC
- Testimony
Thank You

Questions?

Contact: Matthew Williams, JD, MA
Senior Health Policy Analyst, Health
williams@actuary.org