ACLI
Financial Security for Life

October 2, 2025
Sent via email to HMarsh@naic.org
Market Conduct Annual Statement Blanks (D) Working Group

Dear Chair Joshua Guillory,

ACLI appreciates the opportunity to provide comments on the Long-Term Care (LTC) MCAS to the Market Conduct Annual Statement Blanks (D) Working Group. We hope that our feedback will aid in the development of useful improvements to the MCAS process for future responses. Below please find clarification questions and suggestions related to the Long-Term Care MCAS. We are happy to provide any further feedback or explanation.

Clarification Questions:

- **2-30** Number of complaints received directly from consumers.
  - The current definition of "complaint" does not appear to address complaints via social media. Should companies include complaints where the source of the complaint came from social media?
- **3-32** Number of claimants with pending claimant request determinations as of the beginning of the period and **3-33** Number of new claimants during the period.
  - Could you clarify if the counts in 3-33 do, or do not, include the counts in 3-32?
- **3-32** Number of claimants with pending claimant request determinations as of the beginning of the period and **3-34** Number of claimants with pending claimant request determinations as of the end of the period.
  - As of year-end, there are likely some requests that arise later in the year and are believed to be requests for claim determinations and are considered pending claimant request determinations under 3-34. However, upon review in the following year some of these pending requests are determined to be other requests that don't require claim determinations. Should the number of pending claimant requests at the beginning of the next year (under 3-32), be reduced by these that don't belong? Or should they be left in, so it matches the pending claims as of the previous end of the year (3-34)?
- **4-41** Definition "Claimant Request Denied or Not Paid because Benefit Eligibility Criteria Not Met"
  - How should companies handle the situation where an insured's benefit eligibility is denied in year X, but overturned on appeal in year X+1?
- **6-49** Number of benefit payment requests denied or not paid during the period.
  - How should companies handle the following situations:
    - In the example where a monthly bill includes an itemized list of expenses and most are approved, but one or more are denied as not covered under

the policy. Given the spirit of claim was approved do companies still need to account for the smaller denial(s)?

- In a situation where a claimant's bill exceeds the maximum benefit allowed for that time period and the company paid the maximum allowed. Are companies still required to identify as a denial the amount that was not paid due to being in excess of the maximum benefit?
- When a claim comes in that covers multiple months, can companies break that up into one decision for each month?
- If paperwork is received that is a duplicate of a previous claim already on record, is it appropriate for companies to exclude the duplicates? Similarly, if bills come in that are deficient in some manner so as not to be able to be adjudicated (i.e. claims that are "not in good order"), is it appropriate to exclude these items from the transaction counts? For example, suppose a bill comes in that does not identify a customer's name, so we do not know which policyholder is requesting payment. This type of bill cannot be paid nor denied. Is it acceptable to exclude this item from the counts of claims received and claims decisions made?

Language Suggestions & Feedback Concerning Data Elements for Consideration:

Interrogatories

- **Data Element Addition(s)**: "Direct written premium during the period." And "Direct written premium earned during the period."
  - If these additional elements are to be adopted, it would be helpful to have definitions for "direct written premium" and "direct earned premium" to promote consistency in response and expectations of questions related to premium. Further, it would be helpful to know whether licensees should assume that for premium all that would be required is just a number by state like other lines of business? If these elements would require more detailed breakdown than the number by state, there would be difficulties in licensee reporting that would not appear to provide substantial or helpful information to regulators.
- **Data Element Addition**: "Is there a reason that the reported LTC (Stand Alone, Life Hybrid, Annuity Hybrid) information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc)? If yes, provide explanation:"
  - **ACLI Comments**: We would like to better understand why this addition would be helpful or provide new information for regulators. Adding an element like this that necessitates narrative context from insurers creates a reporting burden that does not appear to benefit understanding of company activity. Further, this narrative request would likely not yield uniform results to compare across companies. We would suggest not adding this data element.
- **Data Element Addition**: "Number of class action lawsuits?"
  - **ACLI Comments**: It would be helpful to know how this data element would be relevant to MCAS. Litigation frequency does not appear to correlate directly with policyholder outcomes or MCAS metrics. Therefore, we would not suggest adding this data element.

General Information

- **Data Element Addition**: "Number of applications pending at the end of the period."
  - **ACLI Comments**: Because licensees use different systems or definitions for "pending" applications, the results of this data element may not provide helpful

information and could lead to inconsistency in data results that may not accurately represent the information being requested here. We would suggest striking this data element or providing a definition for "pending" to clarify whether pending includes applications still in the underwriting process or applications that have been approved but not issued yet.

- **Data Element Addition(s)**: "Related to data captured for cancellations" and "Related to data captured for complaints."
    - **ACLI Comments**: These added bullets under each heading would require extensive manual research to provide. Further, some of this information is already reported elsewhere (i.e. "*Number of policies terminated or cancelled by the insurer for reasons other than non-payment or free looks*" is already reported to regulators in the annual LTC Recission reports). To provide the level of detail requested in these added elements, licensees would be required to conduct a manual review step to identify and populate fields, especially in the case of appeals for data captured for complaints. The level of detail required for these questions would not match current MCAS reporting and could lead to confusion in reporting, inconsistent results, and a substantial amount of review for regulators in receiving this information. Further, as written, the "Related to data captured for complaints" section indicates binary choices for the first two and last two bullet points. Often, with appeals or external review, there can be a "split decision" wherein part of the denial is upheld and there is an overturn or agreement to approve the claim as of a given date. The current language for these data elements does not allow for this occurrence. If regulators feel the information requested in these sections is necessary for this MCAS, we would like to better understand what specific information is the most helpful and whether there is a way to capture the scope of the requested information in a less burdensome manner that would benefit regulators. We would suggest that these not be added as data elements and instead be reserved for a more appropriate follow-up inquiry or market conduct examination question.

Thank you for the opportunity to provide comments. We are happy to explain further or provide further feedback.

Thank you,

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