Summary of Comments on MSA Actuarial Framework Exposure – July 26, 2021

- *See comment letters for full text.*

General Comments on Actuarial Approaches			Where/How Addressed in Framework
1	Washington	The NAIC should conduct a study to determine whether the "Minnesota" and "Texas" approaches mentioned in the MSA framework are consistent with the state laws and rules. Take our state as an example: we do not automatically calculate and discuss the "Minnesota" or "Texas" rate increase calculations. The proposed MSA rate review procedures are somewhat different from our current rate review, rules, and methodology. In our review, we also require carriers to clearly designate when policies were issued and whether the block is closed or still being sold. Carriers are also required to clearly demonstrate how the policies look in terms of rate stability requirements (e.g., the 58%/85%analysis) and the loss ratio requirements.	Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions. No further edits to framework.
2	American Academy of Actuaries *(May comment letter)*	We would first like to emphasize the importance of actuarial input from the beginning of any process involving the consideration, design, and evaluation of a potential long-term care (LTC) policy approach. Actuaries are uniquely qualified according to their professional standards and play a crucial role in the financing and design of LTC financing systems—from private long-term care insurance (LTCI) to public programs that provide LTC benefits. Actuaries have specialized expertise in managing the risk of adverse selection in insurance coverages, the ability to recognize and incorporate uncertainty into cost projections and premiums, and experience in evaluating the long-term solvency and sustainability of public and private insurance programs. An actuarial perspective can provide a basis for exploration of new and innovative review frameworks. We would refer the task force to two specific publications for examples of such perspective. One is an October 2018 Academy issue brief on considerations for treatment of past losses in rate increase requests for long-term care insurance. The second is a June 2016 Academy issue brief to enhance understanding of what is leading to significant rate increases, examine how the need for a rate increase is determined, discuss the effects of increases on various stakeholders, and explore alternatives to premium rate increases.	Actuarial considerations are important; however, other considerations factor into a state's decision. Actuaries vetted the MN & TX approaches for several years in public LTC pricing SG sessions. See subsequent comment letter. No further edits to the Framework.
3	American Academy of Actuaries *(May Comment Letter)*	The Long-Term Care Reform Subcommittee appreciates the NAIC's objective of "developing a consistent national approach for reviewing current LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner." The multi-state actuarial LTCI rate review ("MSA Review") proposed in the Framework has the potential to create a robust actuarial review, independent of state-specific considerations, to advance the stated objective. However, it will be critical to consider detailed proposals for Actuarial Review, Reduced Benefit Options, and Non-Actuarial	See subsequent comment letter. MN and TX approaches are included in the Framework. No further edits to the Framework.

		Considerations, which appear only as "placeholders" in the draft Framework. The subcommittee is reserving comment on Appendix B of the draft until its information requirements can be considered in context with exposure drafts of the placeholder sections. We suggest that the Framework include a description of the Minnesota and Texas approaches applied by the MSA Review team, or a citation to specific documents.	
4	ACLI/AHIP *(May Comment Letter)*	<u>Methodology Used in the MSA Team Recommendation</u> The Framework states that the MSA Team's review of rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. In addition, the MSA Team will apply the Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup's paper – "Long-term Care Insurance Approaches to Reviewing Premium Rate Increases", to calculate recommended, approvable rate increases. We suggest that the Actuarial Section of the final Framework document outline specific reasons for use of one method over another. In addition, the methodology used by the MSA Team in determining its recommendation must be actuarially sound and acknowledge an insurer's ability to achieve and preserve equity among policyholders in all states over the lifetime of the policy. Transparency in this piece of the process will result in greater consistency and confidence in outcomes, which is key to the Task Force achieving its charge.	Not intended to limit the MSA to only the MN or TX methods. Edits to V.A refer to either a blend of the two or other recommendation.
5	Academy	The actuarial review sections of the Framework address the necessary application of judgement in reviewing rate increase requests. The term is variously modified in the draft document as "regulatory actuarial judgment" or "regulatory judgment." Qualified actuaries performing an MSA Review would use their professional judgment as defined in Actuarial Standard of Practice (ASOP) No.1: (Actuarial Standards Board; Actuarial Standard of Practice No. 1, Introductory Actuarial Standard of Practice; March 2013.) 2.9 PROFESSIONAL JUDGMENT Actuaries bring to their assignments not only highly specialized training, but also the broader knowledge and understanding that come from experience. For example, the ASOPs frequently call upon actuaries to apply both training and experience to their professional assignments, recognizing that reasonable differences may arise when actuaries project the effect of uncertain events. We suggest that the Framework consistently adopt the term "professional judgment" when referring to the actuarial work of the MSA Review Team. The actuaries on the MSA Review	Edited to "professional judgement" throughout the Framework.

		Team may be guided by ASOP No.413 regarding appropriate communications and disclosures when issuing an actuarial opinion in an MSA Advisory Report. Specifically, disclosures may be necessary where material assumptions or methods are specified by applicable law (statutes, regulations, and other legally binding authority) or selected by another party.	
Decision Making Process / Transparency / Which Method Applies			
6	Academy	<u>Decision-making Process of the Multi-State Actuarial (MSA) Team:</u> The Framework outlines three main approaches to calculating a justified rate increase: 1) loss ratio approach (including the 58%/85% standard for rate-stabilized business); 2) Minnesota approach; and 3) Texas approach. Other than a statement that the 58%/85% standard would produce the maximum allowable increase for relevant blocks (which is consistent with rate stability regulation), it is unclear how the results from the different approaches will generate the rate recommendation of the MSA Review Team. We suggest that additional information be provided regarding the decision-making process of the MSA Review Team. Some questions and considerations that currently exist are: • What happens if the Minnesota and Texas approaches are in conflict whether a rate increase is justified or if the approaches produce materially different results? The two approaches differ in their structures, with the Minnesota approach looking at past and future impacts and including non-actuarial provisions through cost-sharing, while the Texas approach is geared toward ensuring only future impacts are captured.	See edits to Section V.A.
7	Academy	• The discussion of the Texas approach does not explicitly discuss the "catch-up" and "transition" provisions outlined as part of the Prospective Present Value approach in the NAIC LTC Pricing Subgroup document Long-term Care Insurance Approaches to Reviewing Premium Rate Increases, approved by the Long-Term Care Actuarial (B) Working Group in 2018. Was the omission of these provisions (outside of the last paragraph in Appendix C) intentional?	Catch up and transition are concepts applied after the TX PPV is calculated. See edits to Section V.A.
8	Academy	• In both the Minnesota and Texas approaches as specified, it is not clear how a company would account for a prior rate increase which was reduced and/or delayed due to lack of credible experience or for another reason. It can be very difficult in future filings to achieve a requested rate increase after a regulatory reduction in prior years. • How are past rate increase approvals considered across states? • Is the time value of money considered where two states may be at the same current rate level, but one approved prior increases many years earlier than the other state? • If the MSA Review provides a recommended rate increase (e.g., 40%) and a participating state approves a significantly lower increase (e.g., 10%), for how long may a company and/or a state regulator rely on the original MSA recommendation	MN approach allows a rate increase to be considered solely due to morbidity experience being more credible. Beyond the MSA, a company can work with a state to attempt to resolve the time value of money issue. See edits to Section V.A.

		when submitting or reviewing a follow-up filing to achieve the recommended rate level? o What is the process for the company to submit a follow-up filing for the remaining rate increase? o Does the follow-up rate increase request go through the MSA Review again? o Would the time value of money be considered in the review of the follow-up request?	
9	ACLI/AHIP	Our comments to this first exposure of the Actuarial Section of the MSSR Framework focus on transparency with respect to the methodologies used by the MSA Team. It is important to remember that not only will the MSRR process be used to recommend actuarially justified rate increases on existing legacy blocks of business; it will be applied to business that is being sold today. Insurers best protect their policyholders by fulfilling the obligations they made to them. This is accomplished when insurers have some level of predictability in their ability to manage their LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency within the MSA Review Process, specifically regarding the methodology used to calculate the increase recommended by the MSA Team. When insurers understand the methodology the MSA Team will use to calculate rate increases, they can make informed decisions about their business now that will ensure they can fulfill their obligations to policyholders years into the future. 1. Will the MSA Team apply just one method based on the characteristics of the block or will all methods be used in the calculation of a rate increase? • If all methods will be used, will the MSA Team recommend a blend of the results? • Or will they recommend the lowest percentage?	Both the TX and MN methods are run for each MSA rate increase submitted. The MSA team will not recommend the lowest percentage method just because it's the lowest percentage or the highest percentage method just because it's the highest percentage. Professional judgement will be applied for each rate submission based on the characteristics of the block to determine if one method is more appropriate than the other or if it will be a blend of the two methods. Prior rate increases, morbidity, blends of demographics are just a few of the factors considered. See these edits in Section V.A.
10	ACLI/AHIP	2. What public policy issue is each methodology designed to address (e.g. certain issues with aging or shrinking blocks)?	There is a balance of professional judgment that addresses some of the agreed upon policy issues, this includes a reduction in rate increase at later policy durations to address the shrinking block issue and elimination of rate increases related to inappropriate recovery of past losses. The Minnesota approach also considers adverse investment expectations related to the decline in market

			interest rates and a cost-sharing formula is commonly applied. The TX approach makes rate changes prospective. See edits to Section V.A.
11	ACLI/AHIP	3.How will each methodology address the inequity between policyholders in states that have routinely capped or delayed increases and those that have not?	Non-actuarial considerations are a topic for further discussion. No edits to the Framework.
12	ACLI/AHIP	4. The MSA's Actuarial Review standards/recommendations for participating states should include an acknowledgment that the recommendations for rate approvals do not reflect lifetime rate inequalities resulting from inconsistencies in the amount and/or timing of historical rate approvals between states, even on policies that offer identical coverage. We believe that the standards should encourage states to work with filing companies to address these inequities and that the MSA Team should continue to assess this issue to determine if more specific guidance is appropriate.	See edit to Section V.A. to point out that the catch-up increase only achieves current rate equity and not lifetime equity.
13	ACLI/AHIP	5.Will the MSA Team apply their "regulatory actuarial judgement" to recommend an increase percentage that is different (higher or lower) than that produced by the Minnesota or Texas approaches?	At this time the MSA recommendation, for the filed rate increase, could be what the Texas or Minnesota method generates, a blend of the two methods or using professional actuarial judgement the MSA Team may recommend a rate increase outside of these two methods. Other methods may evolve over time that the MSA Team may want to incorporate into the future process that may generate similar or unique results. See this edit to Section V.A.
14	ACLI/AHIP	6. In the example proposed (where there's less-than-credible older-age morbidity) what actions would the MSA Team take?	Use a balance approach if less than fully credible morbidity data. See edit to Section V.A.
Section V.A – MSA Team's Actuarial Review Considerations			
15	Academy	Section V.A indicates that assumptions in a rate increase filing may be "deemed unreasonable or unsupported" by the MSA Review Team. We suggest that the MSA Review Team contact the filing actuary to provide additional support for his or her actuarial assumptions, if necessary, prior to deeming them "unreasonable." If an actuarial	See added sentence to this bullet in Section V.A.

		assumption is deemed unreasonable or unsupported, it may have implications for the use of a similar assumption in a company's asset adequacy testing and/or Actuarial Guideline LI analysis.	
Section V.B. Loss Ratio Approach			
16	Academy	The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance: Section V.B.4(b) states that the loss ratio method results in "low incentive for responsible pricing." Practicing LTC pricing actuaries are responsible for compliance with all relevant actuarial standards of practice, and a company has incentives to price appropriately. Most companies would prefer to receive premium sooner rather than later. Additionally, there are the costs associated with filing and implementing a rate increase and the impact on policyholders of premium adjustments.	See edit to this bullet in Section V.B.4.b.
17	Financial Medic LLC	Addressing Actuarial Review, Loss Ratio Approach, Section B, point 4: The admission that past losses, known as premiums that were insufficient since inception, confirms our independent findings. We find evidence that some regulators reject the past loss theory without foundation of data science and accounting practices. We add that it is not merely the principle of past underpricing that is subject to recapture. The LRA is based on present value (PV) calculations, thus the shrinking number of policyholders (SNOP) are also charged interest based on the carrier's discount rates, as though signing an LTCI contract involved a hidden lending arrangements. Typical example (2021): A recent rate increase for a large carrier expands SNOP premium to 4.02x original premium though the book remains considerably underpriced using LRA (at an LLR of 111%). Through standard accounting procedures, the new premium is calculable and allocatable to 3 distinct components. We do not see recovery of principal and its interest being reported in narratives or financial statements from LTCI actuaries in carrier filings or regulatory final dispositions. This non-disclosure misleads all LTCI stakeholders. We note that the expanding pie in premium growth in rate filings 2020+ are mainly due to the two recovery components while Fair Pricing remains static. We ask how the industry came about the LRA method and not <u>Repriced in Accordance with Level Premium Precepts</u> (Fair Pricing) as the product was originally intended and sold to clients. The Actuarial Review raises fundamental questions as to the technical purity of rate adjudication methods yet the industry appears to be unduly focused on RBO. This is *cart before the horse logic* in our professional opinion.	MN & TX deal with the past loss issue, but in different ways. No edits to the Framework.

18	Academy	(Framework V.B.5) For rate-stabilized business, the draft states that the 58/85 test "would produce the recommended rate increase" if lower than the Minnesota and Texas approaches. Why would these approaches potentially override and reduce the recommended rate increase, when the rate stability model was already intended to address the issues with loss ratio regulation described in the preceding paragraph of the Framework?	Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions. No further edits to framework.
Sections V.C. Minnesota Approach and V.D. Texas Approach			
19	Academy	Section V.C.1(c) cites "concepts discussed in public NAIC LTC pricing subgroup calls from 2015 to 2019," which provides inadequate documentation to include in a regulatory procedure document. Rate filing actuaries may not be aware of the content of past calls. We suggest citation to particular documents, such as adopted summaries or minutes of the referenced calls, if available.	Added footnote in Section V.D. to NAIC Library for past proceedings.
20	Academy	The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance: • Section V.C.2(a) refers to "a direction that could be seen as misleading." Subparagraph (a) could be deleted entirely without affecting the definition of the Minnesota approach. • Section V.C.5, "anti-bait and switch adjustment," where we suggest a less pejorative term could be used. In the context of a rate increase review, see our comments above regarding industry standards and benchmarking. The concern regarding potential deliberate underpricing to boost market share, expressed in subparagraph 5(a)(iii), is best addressed in the context of an initial rate review by regulators.	Edited paragraph title. Topic under consideration for future discussion among actuary groups. No other specific changes to the Framework.
21	Academy	Section V.C.5(a) refers to "industry-average assumptions at the time of original pricing" for LTC products. • Where are these averages reliably to be found? • How are variations in product, carrier, distribution channel, and other factors taken into account? • What level of deviation from these averages (in one or more assumptions) would be considered "out of line" and trigger the use of "benchmark premium," rather than actual original premium, in the MSA Review Team's review process? • Recognizing that regulators who approved a company's original product and rate filings had the opportunity to review all relevant assumptions at the time of filing, and may not have enforced or suggested the use of industry averages at that time, it may not be appropriate to determine benchmark premiums with 20/20 hindsight uniformly for all product filings and company characteristics.	There was enough demand to eliminate incentive for bait & switch that a broad-brush approach was developed – not perfect but generally effective. Mortality, lapse, and investment returns are focus – able to look at average assumptions for each year of issue. Topic under consideration for future discussion among actuary groups. No edits to the Framework as these topics are more detailed than intended for the Framework.
22	ACLI/AHIP	7. The description of the Minnesota methodology includes a focus on underlying assumptions and indicates that the reviews are benchmarking to industry-average assumptions.	See response to Academy comment #21. Added "e.g., Moody's"

		• How are those assumptions calculated? • Will they be provided to companies? • Similarly, what is the "average corporate yield bond" index that will be used under the Minnesota method?	Remaining topics under consideration for future discussion among actuaries. No edits to the Framework as these topics are more detailed than intended for the Framework.
23	ACLI/AHIP	8. The "anti-bait and switch adjustment" under the Minnesota method appears to suggest the insurers intentionally underpriced LTC products. • How would the MSA Team make this determination? • How are the "industry-average assumptions at the time of original pricing" determined? • Are product and underwriting differences accounted for? • How far from the industry average is considered reasonable? • Wouldn't such assumptions only be considered unreasonable in hindsight considering the product was originally approved by the state insurance department?	Edited title of the subsection. Topic under consideration for future discussion among actuary groups. No edits to the Framework as these topics are more detailed than intended for the Framework.
24	ACLI/AHIP	9. The Minnesota Approach accounts for changes in interest rates; the Texas Approach explicitly does not. • How do these conflicting approaches achieve similar results? The same is true in cases of solvency concern – the document states that the cost-sharing formula in the Minnesota Approach can be adjusted. • How will the cost-sharing formula be adjusted? • How is solvency accounted for in the Texas Approach?	Solvency considerations are outside the calculation and are a consideration of individual states. See added subparagraph to Section V.A.
25	ACLI/AHIP	13. The Framework states that the MSA Team's review of rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. In addition, the MSA Team will apply the Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup's paper – Long-term Care Insurance Approaches to Reviewing Premium Rate Increases ("NAIC Pricing Subgroup's Paper"), to calculate recommended, approvable rate increases. In reviewing the methodologies, we noticed that specific components of the Texas method are not clearly included. In addition, there were changes or additions to adjustments made to the Minnesota method. The NAIC LTC Pricing Subgroup's paper was the result of a deliberate and collaborative effort on the part of regulators and industry in 2018, during which each method was fully vetted. We believe that any kind of change to the methods outlined in that document should occur only after the same robust discussion and review. For example:	Framework allows for flexibility when applying the MN, TX or any other approach to deal with unforeseen circumstances, data limitations, etc. Circumstances will be addressed on a case-by-case basis. Catch up and transition are concepts applied after the TX PPV is calculated. The base TX PPV amount applies to a typical case (across states). No edits to the Framework.

		a. Under the Texas method, the catch-up and transitional provisions are not clearly included. As outlined in the NAIC LTC Pricing Subgroup's Paper, we believe these are valid and important adjustments that should be considered when applying the Texas method. The catch-up provision is intended to account for necessary additional premiums in a new rate increase related to assumptions provided to the department at the time of a previous rate increase request that were not approved in conjunction with the prior filing(s). Likewise, the transition provision, for pre-rate stability products and other products where the last rate increase request was voluntarily reduced by the company, provides the ability to make a single filing to provide the full amount of premium necessary to meet the actuarial certification.	
26	ACLI/AHIP	13.b. With respect to the "anti-bait and switch adjustment" under the Minnesota method, we strongly disagree with the inclusion of this adjustment. We believe the name itself draws a legal conclusion and submit that any reference to this type of adjustment should be categorized as an "original assumption adjustment".	Edited title of the subsection.
27	Financial Medic LLC	Our firm agrees with what the Texas Approach is designed to address, Section D points 1 and 2. Point 3 describes a general methodology of looking at forward "deltas" (both present value premiums & claims, along with rate history) as the primary drivers of rate changes. Appendix C, Section B provides a formula that allows our firm to back test with a small code snippet to our LTCI processing subsystem that already had a forensic analysis capability. We encountered cases were the future claim "delta" was small relative to future premium "delta" such that a premium reduction would be called for. The Texas approach provides a useful filtering mechanism. (refer to the full comment letter for example). The claim "delta" was exactly zero, a perfect overlap, yet the regulatory agency granted a 40% increase. The stock language of the actuarial narrative based the increase on an expected deterioration of future claims. Accounting procedures refute the actuarial narrative but a simple picture tells the story even better absent professional formalities. The Texas proposal acknowledges that the methodology would not work for a first time increase as not "deltas' exist. Moreover, we discovered the formula by itself is not a complete specification. For example, when measuring future "deltas" form one filing to the next, the specification does not clarify the source of PVs to be used for the baseline (old) filing. In our experience, many rate requests are not granted in full thus the baseline filing would not be a good source of information unless there were a recalculation of PV futures as *adjusted by the actual rate increase*. A general concern is that the Texas Approach, being a mere draft or conceptualization, would have to be vetted to fit into the current environment. It is a dramatic change and one	MN & TX approaches address issue with past losses. No edits to the Framework.

		that would cause stakeholders to question why any methodological changes in being proposed, much less implemented, after significant economic harm. Our firm has received questions from clients, who (1) have lapsed, (2) paid more premium that they thought they should have, or (3) exercised an RBO – "have we been injured by the Loss Ratio Approach"? answering a resounding "yes"!	
Section V.F. Non-Actuarial Considerations			
28	Academy	The Framework contains various non-actuarial considerations that may be contemplated as part of the rate recommendation. We believe it is important to recognize that many of these considerations, while listed as non-actuarial, have actuarial aspects or implications. For example, the phase-in of a rate change over a period of years necessitates a higher cumulative rate increase to have the same financial impact as a single rate increase. Similarly, if limitations are imposed on when a company can file a future rate increase, such as a rate guarantee period, a future request may need to be higher due to the cost of waiting. Caps or limits on rate increase approvals that are not based on actuarial considerations likewise increase the size of future rate increases. In this situation, where necessary premium rate increases are delayed, policyholders pay higher premiums, and the ultimate necessary premium level increases due to the delays in approvals. It should also be noted that the Minnesota and Texas approaches, while primarily actuarial in presentation, already include decisions based on non-actuarial considerations, such as specific cost-sharing provisions and disallowing interest rate deviations as a reason for a rate increase. Finally, we believe that the MSA Review process may ultimately add little value if its actuarial conclusions are frequently overridden at the state level by non-actuarial considerations. The task force may wish to consider the degree of commitment demonstrated by Participating States when evaluating the success of the MSA Review program in meeting the NAIC's objective of "developing a consistent national approach for reviewing current LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner."	Non-actuarial considerations are topics for future discussion. No edits to the Framework.
29	Academy	We note that "Fair and reasonableness considerations" is listed in Section V.F (Non-Actuarial Considerations). This is a broad and not-well-defined category allowing wide latitude in regulatory decision-making regarding the results of an analysis, distinct from the justification of actuarial assumptions.	Fair and reasonableness refers to impact on policyholders. See edit to V.F. Non-actuarial considerations are topics for future discussion.

30	ACLI/AHIP	9. Will the MSA Team recommendation reflect any non-actuarial considerations or is the document simply acknowledging their existence? 10. A clear distinction needs to be made between non-actuarial considerations that should inform the MSA Team's recommendations (like company solvency) and non-actuarial considerations that states might apply to the MSA Team's recommendation (rate caps, phasing, age limits). The former should be a factor in the MSA Team's regulatory actuary judgment. To achieve The Task Force's goal of a consistent national approach to rate actions, the MSA Team should seek to discourage the latter (unless required by a clear state statutory mandate). 11. A primary goal of MSA Review Process is to achieve an adequate rate level for policyholders in all states. As proposed, the process gives states the discretion to continue to apply state-specific non-actuarial restrictions and caps on rate increase amounts. While we recognize the independence of each state's authority, we note that allowing states to impose artificial rate caps on what the MSA Team has determined to be an actuarially justified rate likely will perpetuate the historical discrepancies between states, which will not address cross-state inequities. It will also undermine the Task Force's charge to develop "a consistent national approach" to achieve "actuarially appropriate increases."	#9 – acknowledging their existence. Non-actuarial considerations are outside the MSA team's review. #10 - Solvency considerations are outside the calculation and are a consideration of individual states. See added subparagraph to Section V.A. #11 - States retain authority for final rate decisions. Non-actuarial considerations (caps, phasing, etc.) are topics for future discussion.
31	Washington	Can the rate changes recommended by the MSA team be implemented by all states and meet existing state laws and rules? If not, does this invalidate the actuarial work of the MSA team? Some states have capped an LTCI rate increase regardless of actuarial justification. If the MSA team recommends a higher rate increase than a particular state's capped rate increase, the actuarial assumptions may no longer be valid. Also, those states without a rate cap will be continuing to subsidize the states with a rate cap.	Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions. Non-actuarial considerations are topics for future discussion. No edits to framework.
Appendix D. Principles for RBOs associated with LTCI rate increases			
32	Vermont	On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads: *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.*	VT provided an additional sentence. *"In the case that an offering is tied to a rate increase, and involves the collection of consumer data, regulators should ensure that data collection and use is clearly disclosed and easily understood, that the consumer is made aware of any other available options, that the offer is not discriminatory, and that the rate impact is correlated to the offering. Consumer data should*

		Rate increases for long-term care policies typically add thousands of dollars to the annual premium paid for the policy. These types of rate increases are significant and may be a hardship to elderly consumers on fixed incomes. Consumers may not be able to consider their own best interest in the face of a significant change to annual expenses. Any offer associated with a rate action, and which involves the collection of data through artificial intelligence should clearly explain how information will be collected and used to avoid profiting and potential discriminator actions on behalf of the insurer. Also, any offer to an insured tied to rate increases should be supported with data showing why and how the rate impact is directly correlated to the offer. Consider this example: • A consumer on a fixed income receives notice that long-term care premiums will increase by $3,000 annually. • That consumer now faces $3,000 of new expenses. • If the consumer checks a box, they will receive a smart device that will collect data from their home and computer. • If they select this option, they will not have to pay any rate increase. The consumer may not be in the position to act in their own best interest and may not be able to consider these options carefully for several reasons. First, the consumer may not fully understand the technology proposed, the data to be collected, and the privacy implications. Second, the consumer may not realize that there may be several other options to modify their policy and reduce premiums besides accepting the new technology option. The technology option may seem like the only choice available. The MSA subgroup should consider keeping the wellness program offers separate from implementation of large rate increases (greater than 10%). Then, there would be no question that the consumer was coerced, rather than persuaded, to take part in any wellness program.	*not be collected to be monetized for profit or for advertising."* Referred VT comment letter to RBO Subgroup for input as the Subgroup is currently discussing wellness initiatives.
Appendix E. Guiding Principles for LTCI RBOs Options Presented in Policyholder Notification Materials			
33	Academy	There is a potential interaction between the NAIC's Reduced Benefit Options workstream and the MSA Review. Appendix E, "Guiding Principles on LTCI Reduced Benefit Options Presented in Policyholder Notification Materials," suggests that insurers should consider "disclosing all associated future planned rate increases approved by regulators" in their rate increase notification letters. • Will the existence of an MSA Review report with a recommended cumulative rate level impose any obligation on an insurer to disclose the likelihood of future rate increases to reach this level?	Goal is for MSA recommendation to be the final rate review unless the block's expectations deteriorate, or adverse morbidity experience becomes more credible.

		• How would any such disclosure apply to Participating and/or non-Participating states?	Disclosing all associated future planned rate increases approved by a state is already being applied in state's rate reviews. No edits to Framework.
34	ACLI/AHIP	We appreciate the subgroup's acceptance of many of our recommended changes now reflected into Appendix E. However, there are a few suggestions made in our May 24th letter that were not accepted by the subgroup. We welcome the opportunity to discuss further refinements to this document as the work evolves.	No edits to Framework.
Comments on the Operational Section of the Framework			
35	ACLI/AHIP	13. Finally, as mentioned in our previous comment letter, we encourage the subgroup to include a formal trigger to review and amend the Framework annually.	Process is expected to continually evolve and be evaluated. Responsibility for the Framework updates is addressed in section I.A and feedback from states in section III.E. No edits to the Framework.
36	Washington	Is this binding? If not, limited participation might impact goal of nationwide uniformity and defeat the purposes of MSA rate review. Several states have made it clear that they are not willing to participate in or accept the results of the MSA rate review, thus hampering the ability of MSA rate review to achieve its stated goal of nationwide uniformity. In order to achieve a more consistent rate review approach and minimize the differences across states, most states (if not all) need to participate in the MSA rate review program and make use of the final results mandatory. If the MSA rate review is not binding on participating states and is instead treated as a recommendation, state actuarial reviewers will use their own actuarial judgement to evaluate the MSA rate review and then apply state-specific laws and rules. The results will be different and therefore inconsistent. Enough state must bind themselves to the MSA rate review results in order for this approach to be effective. The current status of LTCI rate review at the Interstate Insurance Product Regulation Compact (IIRPC) informs this concern. At least a half dozen of the IIPRC states have opted out of IIPRC LTC review standards. This lack of uniformity is exacerbated by the IIPRC only being allowed to consider rate increases for policies that the IIPRC originally approved, and only for increases up to 15%. These challenges for the IIPRC suggest similar challenges may exist for MSA rate review.	Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions. Regarding benefits of MSA results, see edit to I.B & I.D of the Operational section second exposure draft.

37	Washington	Can the MSA Team review meet the proprietary or confidentiality requirements of the participating States? MSA rate reviews will be done by drawing on staff support from various state insurance departments. Can the MSA Team effectively maintain confidentiality and meet individual state's proprietary information law?	Edited throughout that confidentiality is based on each state's law. See edits to paragraphs I.E.3 & 4 of the Operational section second exposure draft.
38	Washington	Appendix A: MSA (Advisory) Report: The actuarial requirements in the report should not conflict with various state's laws, rules, and procedures. The report's wording will also need to be edited carefully whether it is just a recommendation or if there are conflicts with state regulations. The report should also address that actuarial standards and expectations still apply, since the team members are expected to contribute their actuarial expertise.	Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions. No edits to the Framework.
39	Academy	Appendix B: Information Checklist • Item A.1. should provide clarification for the desired issue state for group products (i.e., master group policy issue state or certificate issue state). • Some items from subsections A and B are at least partially duplicative. Specifically, items regarding attribution of rate increase, waiver of premium handling, and assumption comparisons to asset adequacy testing are repeated in both locations. • We encourage Participating States to agree that the listing of information for an MSA Review (as outlined in Appendix B) is exhaustive. If no further requests for information are needed as part of a specific state review, the filing process could be streamlined for both filers and reviewers.	The list of information was previously vetted at Health Actuarial (B) Task Force. Topic under consideration for future discussion among actuary groups. No edits to the Framework.