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V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections and other information provided by the insurer as outlined in Appendix B. The MSA Team will consider the following in performing their review, applying their expertise and judgement to the review as well as reviewing the actuarial formulas and results.

- Review company experience, company narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
  - Validate that the patterns of claims and premium projections over time match those reflected in the assumptions.
  - Adjust or request new projections of claims and premium to the extent any underlying assumptions are deemed unreasonable or unsupported by the MSA Team.
  - After verifying loss ratio compliance, apply the Minnesota and Texas approaches, which ensure remaining policyholders do not make up for losses associated with past policyholders.

In developing a recommendation, the MSA Team will apply regulatory actuarial judgment, for instance when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience.

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

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

B. Loss Ratio Approach

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

1. At policy issuance, pricing based on a lifetime loss-ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios.

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

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

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

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

C. Minnesota Approach

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

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

2. Cost-sharing formula that increases the company burden as cumulative rate increases rise.
   a. This addition to company burden moves rates away from a direction that could be seen as misleading. The company likely had or should have had more information on

the likelihood of large rate increases than the consumer had at the time the policy was issued.

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

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

5. Anti-bait and switch adjustment
   a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a "benchmark premium".
      i. This results in a lower rate increase.
      ii. This adjustment wears off over 20 years from policy issue.
         1. The rationale for the wearing off of this adjustment is the assumption that no company would intentionally underprice a product knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.

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iii. This adjustment is intended to prevent bait & switch, where, e.g., a company would underprice a product, gain market share, and then immediately request a rate increase.

D. Texas Approach

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

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

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

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

3. Data Requirements for Calculation:
   a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
      i. Present Value of Future Benefits (PVFB) under current assumptions.
      ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
      iii. Present Value of Future Premiums (PVFP) under current assumptions.
      iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
         - (Note that for all 4 projections above, the projection period is typically 40-50 years, although some companies project for 60 or more years.)

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

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

4. Assumptions

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

The formula used in TX approach is provided in Appendix C.

E. Reduced Benefit Options (RBO)

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

1. RBOs in MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal. The MSA Advisory Report will highlight how the company demonstrates the proposed RBOs’ reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more detailed assessment specific to their state’s requirements. As the MSA Review process develops and as the LTCI RBO (EX) Subgroup continues its work, this area of review may evolve.

2. Future RBOs

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

F. Non-Actuarial Considerations

The LTCI (EX) Task Force continues to review and consider non-actuarial considerations impacting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

- Caps or limits on approved rate changes
- Phase-in of approved rate changes over a period of years
- Waiting periods between rate change requests
- Considerations of prior rate change approvals and disapprovals

- Limits or disapproval on rate changes based solely or predominately on number of policyholders in a particular state
- Limits or disapproval on rate changes based on attained age of the policyholder
- Fair and reasonableness considerations
- Impact of the rate change on the financial solvency of the insurer

3. Considerations in MSA Advisory Report

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

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

2. Future Non-Actuarial Considerations

The MSA review process will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTCI (EX) Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations, as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

APPENDIX C—ACTUARIAL APPROACH DETAIL

A. Minnesota Approach

Details on the key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
    a. A combination of credible company experience, relevant industry experience, and regulatory judgment is applied.

2. If-knew premium and makeup premium aspects – aggregate application
    a. Makeup percentage
        i. {[PV (claims) / original LLR] - PV (past premium)} / PV (future premium) – 1
        ii. Premiums in the formula reflect the actual rate level.
    b. If-knew percentage
        i. [PV (claims) / PV (premiums)] / original LLR – 1
        ii. Premiums in the formula are at the original rate level.
        iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
    c. Definitions and explanations
        i. PV means present value
        ii. LLR means lifetime loss ratio
        iii. Interest rates underlying PVs and LLRs are based on:
            1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
            2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over 5 years of the current rate to a target rate (currently 4%) is assumed.
        iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate
        v. Company-provide premium and claim cash flows may be adjusted based on assumption review.
        vi. Makeup percentage is similar to that attained by the loss ratio approach

3. If-knew premium and makeup premium aspects – sample policy-level verification
    a. Over a range of issues years, issue ages, benefit periods, and inflation protection:
        i. Calculate an estimate of the original premium
            1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
            2. Apply first principles
                a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.

b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
c. Divide by the sum of the PV of an annuity of 1 per year
d. Multiply {b / c] times (1 + originally assumed profit percentage) to attain the original premium.
e. This premium provides the basis for comparison against the makeup and if-knew premium.

3. Replace the original premium with a benchmark premium
    a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) were out of line with industry-average assumptions at the time of original pricing.
    b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
    c. The benchmark aspect is intended to prevent bait & switch.

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

iii. Calculate an estimate of the if-knew premium.
1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.

b. Verifying the impact on expectation changes on rates
    i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
    ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
        1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
        2. Experience
        3. Impact on LLR of changes in expectations of morbidity.
        4. Industry information and trends (for reasonableness checks).

c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:

i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the company's aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.

ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations result in similar rate increase approval amounts.

1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.

iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the company (after initial attempts to resolve significant differences or gaps).

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

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

6. Cost-sharing formula that increases the company burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:

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

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

8. Summary
   a. Review current assumptions
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.
   f. Deduct past rate increases.
   g. Example – if:
      i. the original premium is $1,000
      ii. makeup premium is $3,000;
      iii. if-knew premium is $1,500;
      iv. 60% of policyholders remain;
      v. Past rate increases are 50%:
      vi. Blended amount is:
         1. $3,000 / $1,000 * .60 +
         2. $1,500 / $1,000 * .40
         3. – 1 =
         4. 180% + 60% - 1 = 240% - 1 = 140%.
      vii. Cost sharing is:
         1. 100% * .15 +
         2. 90% * .35 +
         3. 75% * .5 +
         4. 65% * .4 =
         5. 110%
      viii. Deduction for past rate increases results in:
         1. (1 + 1.1) / (1 + .50) – 1 =
         2. 40%.

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B. Texas PPV Formula

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

For rate stabilized policies:

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

Where:

- Δ indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.
- *C* is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then *C* = .5.

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

For pre-rate stabilized policies, we use .6 in place of .58 and .8 in place of .85:

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

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

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APPENDIX D—PRINCIPLES FOR REDUCED BENEFIT OPTIONS (RBO) ASSOCIATED WITH LTCI RATE INCREASES

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

A. Principles and Issues

As related to:

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

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

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

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

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

B. Widely Established RBOs in Lieu of Rate Increases

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

C. Less Common RBOs for Potential Discussion

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

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA review process will likewise develop and evolve to consider the reasonableness of these RBOs. The LTCI (EX) Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

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APPENDIX E—GUIDING PRINCIPLES ON LTCI REDUCED BENEFIT OPTIONS PRESENTED IN POLICYHOLDER NOTIFICATION MATERIALS

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

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

This document is intended to establish consistent high-level guiding principles for long-term care insurance reduced benefit options presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

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

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

A. Filing Rate Action Letters

Insurers should consider:

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

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

B. Readability and Accessibility

Insurers should consider:

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

C. Identification

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

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

D. Communication Touch and Tone

Insurers should consider:

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

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E. Consultation and Contact Information

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

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

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

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

F. Understanding Policy Options

Insurers should consider the presentation of the communication by:

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

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

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

Insurers should consider including disclosures regarding rate increase history:

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

Insurers should consider advising policyholders of their current benefits:

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

Insurers should consider personal needs decision-making by:

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

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

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

- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
    - What will happen if they take no action?
    - What will happen if they make no payment before the policy anniversary date?

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- If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
- If they elect the cash buyout, there could be tax implications.
- If they elect a paid-up nonforfeiture option, how long will the reduced benefit last if they had a claim?
- If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
- Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

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

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

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