

LONG-TERM CARE INSURANCE MULTI-STATE RATE REVIEW FRAMEWORK

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I. INTRODUCTION

A. Purpose

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

This framework is based upon the extensive efforts of the LTCI Multi-State Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (“Pilot Team”). As part of that pilot program, the Pilot Team reviewed seven LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals (“rate proposal”)² and producing an MSA Advisory Report for the benefit and use of all state insurance departments. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so that they will voluntarily rely upon that process’s recommendations when conducting their own state level reviews of in force LTCI rate increase filings³. Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

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

² “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase under the MSA Review process.

³ The term “filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance for a regulatory decision.

This document will be maintained by NAIC staff under the oversight of the LTCl (EX) Task Force and be revised as directed by the Task Force. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

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

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer's in force LTCl premium rate increase proposal is or has been issued.
- "Participating State" is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section I.E.1 below. Participation may include activities such as, but not limited to, receiving notifications of rate proposals in SERFF, participation in communication/Webinars with the MSA Team, and access to the MSA Advisory Report. Note that state participation may evolve in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an advisory report which state insurance departments may choose to rely on to make decisions on an insurer's rate increase filing or to supplement the state's own review process.

The MSA Review is conducted by a team of state's regulatory actuaries with expertise in LTCl rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff, the Interstate Insurance Product Regulation Commission ("Compact") staff, who will assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD⁴] States. The NAIC's electronic infrastructure, the System for Electronic Rates and Forms ("SERFF") will be used to streamline the rate proposal and review process. Although the administrative services of the Compact staff and SERFF's Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and advisory reports are prepared by the MSA Team.

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

The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply the Minnesota and Texas approaches to calculate recommended, approvable rate increases. While aspects of the Minnesota and Texas approaches may result in lower rate increases than resulting from loss ratio-based approaches and are outside the pure loss-ratio requirements contained in many states' laws and rules, the approaches fall in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will

⁴ Certain processes for Impacted vs. Participating States are yet to-be-determined (TBD).

document how the proposal complies with the regulatory approach utilized by the Team for Participating States. See Section V for more details on the actuarial review.

Through the MSA Review the MSA Team will communicate MSA information to the insurer and the MSA Team will address any questions from the insurer about the results of the review.

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

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. Participating States can either rely on the report or supplement their own state's rate review with it as described in the following Subsection I.D.

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

D. Benefits of Participating in the MSA Review

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

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

LTC insurers will likewise see multiple benefits in participating the MSA Review. First, by utilizing the MSA Review and through the receipt of MSA information from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increase requests. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, they have functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states. Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the

carrier's workload in developing often widely differing filings for states' review. Finally, the consistency of one uniform national system for reviewing rate proposals should lead to more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings.

E. Disclaimers and Limitations

1. State Authority over Rate Increase Approvals

The MSA Advisory Report is only a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state's laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state's regulatory authority, responsibility and/or decision-making. Each state remains ultimately responsible for approving, partially approving or disapproving any rate increase in accordance with applicable state law.

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

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

2. Information Sharing Between State Insurance Departments

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

3. Confidentiality of the Rate Proposal

Members of the MSA Team affirm and represent that any in-force LTCI rate proposal as discussed herein is protected from disclosure by the confidentiality provisions contained within their state's laws and regulations.

4. Confidentiality of the MSA Reports

Likewise, members of the MSA Team affirm and represent that any MSA Advisory Report(s) and MSA information provided to insurers as discussed herein is protected from disclosure by the confidentiality provisions contained within their state's laws and regulations.

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The NAIC LTCI (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed.

The LTCI (EX) Task Force may create one or more subgroups to carry out its oversight responsibilities.

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

II. Multi-State Actuarial LTCI Rate Review Team (MSA Team)

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

Membership must follow the requirements below and be approved by the Chair of the LTCI (EX) Task Force or the Chair of an appointed Subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

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

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or long-term care insurance
- Be recommended by the Insurance Commissioner of the state in which the actuary serves
- Have over five years of relevant LTCI insurance experience
- Hold an Associate of the Society of Actuaries (ASA) designation
- Currently participates as a member of the LTCI Multistate Rate Review (EX) Subgroup (or equivalent Subgroup appointed by the LTCI (EX) Task Force) and the LTC Pricing (B) Subgroup

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the LTCl (EX) Task Force or its appointed Subgroup

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

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (See Section IV for details of the MSA review and activities of a team member)
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs)
- Review and analyze materials related to MSA rate proposals
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein and protect from disclosure any confidential information received pursuant to the Master Information Sharing and Confidentiality Agreement
- Active involvement within NAIC LTCl actuarial groups
- Willingness to provide expertise to assist other states

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the Chair and Vice Chair of the LTCl (EX) Task Force, or its appointed Subgroup. Other interested regulators, e.g., domiciliary state insurance regulator, may be invited to participate on a call at the discretion of the MSA Team, or Chair or Vice Chair of the Task Force or its appointed Subgroup.

D. Conflicts, Confidentiality and Authority of the MSA Team

1. Authority of the MSA Team

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

2. Disclosures and Confidentiality Obligations, as Applicable

All members of the MSA Team acknowledge and understand that the MSA Review, any resulting advisory report, as well as all meetings, calls, correspondence, and all other materials produced in connection herewith are confidential and may not be shared, transmitted, or otherwise reproduced in any manner.

3. Conflict of Interest Avoidance Procedures and Certifications

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

E. Required NAIC and Compact Resources

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

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF.

III. REQUESTING AN MSA REVIEW

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

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

- Must be an in force long-term care insurance product
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders
- Includes any stand-alone LTCI product approved by states, not by the Interstate Insurance Product Regulation Commission (Compact)
- For Compact-approved products meeting certain criteria, the Compact Office will provide the first-level advisory review subject to the input and quality review of the MSA

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

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

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

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

B. Process for Requesting an MSA Review

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

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless request.
- Instructions containing a checklist for information required to be included in the rate proposal, as reflected in Appendix B, will be available to insurers through the Compact's webpage or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase request is or has been issued. Participating states will have access to view the insurer's rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [To Be Determined].
- Rate proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the impacted states upon receipt of the request with the SERFF Tracking No.
- The MSA Team may utilize a "queue" process for managing workload and resources for incoming requests through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team's review of objections and insurer responses are completed through SERFF.

C. Certification

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

Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

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

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

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

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

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

B. Completion of the MSA Review

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

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

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

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review and that a final MSA Advisory Report with recommendations will be communicated to state insurance departments within the next month which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and, 2) the insurer will receive MSA Review information for the insurer and the MSA Team will address questions from the insurer about the result of the review.

C. Preparation and Distribution of the MSA Advisory Report

Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF “reviewer notes” for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States.

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

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

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

The content and format of the MSA Advisory Report may be modified in the future under the direction of the LTCI (EX) Task Force, or appointed Subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback through this process.

D. Timeline for Review and Distribution of the MSA Report

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to, e.g., holidays or other unexpected events.

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

- Date to be determined by each state’s department of insurance – approval or disapproval of the rate increase filing submitted to in each state

E. Feedback to the MSA Team

At the direction of the LTCI (EX) Task Force, or appointed Subgroup, state insurance departments will be requested to periodically provide feedback on their state’s use of and reliance on the MSA Advisory Reports. State responses will be confidential pursuant to the Master Agreement and aggregated results of feedback surveys will not specifically identify state responses. This feedback will aid the Task Force in understanding the practical effects of the MSA Review process in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner. The feedback will also help refine the review process and improve future reports to better meet participants’ needs. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project.

VII. APPENDIX A—MSA ADVISORY REPORT FORMAT FOR REGULATORS

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

1. Executive Summary
 - a. Overall recommended rate increase, before consideration of different states’ history of approvals
2. Disclaimers
 - a. Purpose and intent of how states should use the MSA Advisory Report
 - b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer
 - c. Statement that the in-force rate increase request filed with the respective states shall be subject to the approval of each state, and each state’s applicable state laws and regulations shall apply to the entire rate schedule increase filing
3. Background on the MSA Rate Review process
4. Explanation of the Insurer’s Request
5. Summary of the MSA Team’s rate review analysis, including these aspects:
 - a. Actuarial review
 - b. Summary of consideration of differences in the history of state’s rate increase approvals
 - c. Non-actuarial considerations and findings
 - d. Financial solvency-related aspects and adjustments
 - e. Review for reasonableness and clarity of reduced-benefit options

- f. Summary information about the mix of business
6. Appendices
- a. Summary of the drivers of the rate increase request
 - b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal
 - c. Summary of rate proposal correspondence
 - d. Tables of recommended rate increases by state, after consideration of different state’s history of approvals
 - e. Frequently Asked Questions (FAQ)

VIII. APPENDIX B – INFORMATION CHECKLIST

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

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

A. Information Required for an MSA Review of a Rate Proposal

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

1. Identify all states for which the product associated with the rate increase request is or has been issued.
2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
 - a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.

⁵ https://www.naic.org/documents/committees_b_senior_issues_160609_ltc_guidance_manual.pdf

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

- b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios
3. Rate increase history that reflects the filed increase.
 - a. Provide the month, year, and percentage amount of all previous rate revisions.
 - b. Provide the SERFF MSA numbers associated with all previous rate revisions.
4. Actuarial Memorandum justifying the new rate schedule, which includes:
 - a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
 - i. The projection should be by year.
 - ii. Provide the count of covered lives and count of claims incurred by year.
 - iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies should be provided.
 - iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and impact on requested rate increase.
5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
 - a. Attribution analysis - present the portion of the rate increase allocated to and impact on the lifetime loss ratio from each change in assumption.
 - b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.
 - c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
 - d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate increase request.
6. Statement that policy design, underwriting, and claims handling practices were considered.
 - a. Show how benefit features, e.g., inflation and length of benefit period, and premium features, e.g., limited pay and lifetime pay, impact requested increases.
 - b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
 - c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.
7. A demonstration that actual and projected costs exceed anticipated costs and the margin.

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

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

10. Information from the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation Q&A: Morbidity, Lapse, Mortality, Interest*.
 - a. Comparison with asset adequacy testing reserve assumptions.
 - i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
 - ii. Additional reserves that the insurer is holding above NAIC Model Regulation 10 formula reserves should be provided, (such as premium deficiency reserves and Actuarial Guideline 51 reserves).
 - b. Assumptions Template in Appendix 6 of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation* (for policies issued after 2017, where applicable).
 - c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

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

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

- b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.
12. *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation* checklist items: summaries (including past rate adjustments); average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; reserve description.
13. Assert that analysis complies with actuarial standards of practice, including 18 & 41.
14. Numerical exhibits should be provided in Excel spreadsheets with active formulas maintained, where possible.
15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
16. Policyholder notification letter – should be clear and accurate.
 - a. Provide a description of options for policyholders in lieu of or to reduce the increase.
 - b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
 - c. Explain the comparison of value between the rate increase and policyholder options.
 - d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
 - e. How are partnership policies addressed?
17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

B. Supplemental Information

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

1. Benefit utilization:
 - a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
 - b. Explain how benefit utilization assumptions vary by maximum daily benefit.
 - c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.
2. Attribution of rate increase
 - a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, other.

- b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
 - c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.
 3. Reduced benefit options (RBOs)
 - a. Provide the history of RBOs offered and accepted for the block.
 - b. Provide a reasonability analysis of the value of each significant type of offered RBO.
 4. Investment returns:
 - a. Provide original and updated / average investment return assumptions underlying the pricing.
 - b. Explain how the updated assumption reflects experience.
 5. Expected loss ratio:
 - a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
 - b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.
 6. Shock lapse history: Provide shock lapse data related to prior rate increases on this block.
 7. Waiver of premium handling:
 - a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
 - b. Explain how counting is appropriate (as opposed to double counting or undercounting).
 8. Actual-to-expected differences: Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.
 9. Assumption consistency with the most recent asset adequacy testing: Explain the consistency or any significant differences between assumptions underlying the rate increase request and those included in Actuarial Guideline 51 testing.