Market Conduct Annual Statement
Long-Term Care Hybrid Products Data Call & Definitions

Line of Business: Individual Long-Term Care Hybrid Products:
Life LTC Hybrid Products
Annuity LTC Hybrid Products

Reporting Period: January 1, 2019 through December 31, 2019

Filing Deadline: April 30, 2020

Product Identifier

1. **LifeLTC** **Life – Long-Term Care Hybrid Products**
2. **AnnLTC** **Annuity – Long Term Care Hybrid Products**

LifeLTC

LifeLTC Interrogatories

	Does the insurer have life long-term care hybrid data to report? Yes/No
	Did the insurer have a significant event or business strategy change that would affect the data for this reporting period? Yes/No
	If Yes above, explain:
	Has all or part of this block of business been sold; been closed; or been moved to another insurer during the reporting period? Yes/No
	If Yes above, explain:
	Additional state specific comments (optional)

LifeLTC Schedule 1—General Information

ID	Description
1 – 001	Number of policies in-force as of the beginning of the reporting period
1 – 002	Number of new business policies issued
1 – 003	Number of free look cancellations
1 – 004	Number of lapses
1 – 005	Number of rescissions
1 – 006	Number of policies in-force at the end of the reporting period
1 – 007	Number of internal replacements
1 – 008	Number of external replacements
1 – 009	Number of policies replaced where age of insured at replacement was <65
1 – 010	Number of policies replaced where age of insured at replacement was between 65 and 80
1 – 011	Number of policies replaced where age of insured at replacement was >80
1 – 012	Number of complaints received directly from consumers

LifeLTC Schedule 2—Claimants

ID	Description
2 – 001	Number of claimants approved for benefits as of the beginning of period
2 – 002	Number of claimants with pending claimant request determinations as of the beginning of period
2 – 003	Number of new claimants during the period
2 – 004	Number of claimants with pending claimant request determinations as of the end of period
2 – 005	Number of claimants approved for benefits as of the end of period

LifeLTC Schedule 3—Claimant Requests Denied/Not Paid

ID	Description
3 – 001	Number denied/not paid because claimant did not pursue (inactivity/death)
3 – 002	Number denied/not paid because of preexisting condition exclusion
3 – 003	Number denied/not paid because elimination/waiting period not met
3 – 004	Number denied/not paid because services provided not covered under the policy
3 – 005	Number denied/not paid because provider/facility not qualified under the policy
3 – 006	Number denied/not paid because benefits eligibility criteria not met
3 – 007	All other denied/closed without payment

LifeLTC Schedule 4—Claimant Request Determination Timeliness

ID	Description
4 – 001	Number made within 0 - 30 days
4 – 002	Number made within 31 – 60 days
4 – 003	Number made within 61 – 90 days
4 – 004	Number made beyond 90 days

LifeLTC Schedule 5—Benefit Payment Requests

ID	Description
5 – 001	Number pending as of the beginning of the reporting period
5 – 002	Number received during the reporting period
5 – 003	Number denied/not paid during the reporting period
5 – 004	Number pending as of the end of the reporting period

LifeLTC Schedule 6—Benefit Payment Request Timeliness

ID	Description
6 – 001	Number paid within 0 – 30 days
6 – 002	Number paid within 31 – 60 days
6 – 003	Number paid within 61 – 90 days
6 – 004	Number paid beyond 90 days
6 – 005	Number denied/not paid within 0 – 30 days
6 – 006	Number denied/not paid within 31 – 60 days
6 – 007	Number denied/not paid within 61 – 90 days
6 – 008	Number denied/not paid beyond 90 days

LifeLTC Schedule 7—Lawsuits

ID	Description
7 – 001	Number open as of the beginning of the reporting period
7 – 002	Number opened during the reporting period
7 – 003	Number closed during the reporting period—total
7 – 004	Number closed during the reporting period with consideration for the consumer
7 – 005	Number open as of the end of the period

AnnLTC

AnnLTC Interrogatories

	Does the insurer have annuity long-term care hybrid data to report? Yes/No
	Did the insurer have a significant event or business strategy change that would affect the data for this reporting period? Yes/No
	If Yes above, explain:
	Has all or part of this block of business been sold; been closed; or been moved to another insurer during the reporting period? Yes/No
	If Yes above, explain:
	Additional state specific comments (optional)

AnnLTC Schedule 1—General Information

ID	Description
1 – 001	Number of contracts in-force as of the beginning of the reporting period
1 – 002	Number of new business contracts issued
1 – 003	Number of free look cancellations
1 – 004	Number of lapses
1 – 005	Number of rescissions
1 – 006	Number of contracts in-force at the end of the reporting period
1 – 007	Number of internal replacements

1 – 008	Number of external replacements
1 – 009	Number of contracts replaced where age of insured at replacement was <65
1 – 010	Number of contracts replaced where age of insured at replacement was between 65 and 80
1 – 011	Number of contracts replaced where age of insured at replacement was >80
1 – 012	Number of complaints received directly from consumers

AnnLTC Schedule 2—Claimants

ID	Description
2 – 001	Number of claimants approved for benefits as of the beginning of period
2 – 002	Number of claimants with pending claimant request determinations as of the beginning of period
2 – 003	Number of new claimants during the period
2 – 004	Number of claimants with pending claimant request determinations as of the end of period
2 – 005	Number of claimants approved for benefits as of the end of period

AnnLTC Schedule 3—Claimant Requests Denied/Not Paid

ID	Description
3 – 001	Number denied/not paid because claimant did not pursue (inactivity/death)
3 – 002	Number denied/not paid because of preexisting condition exclusion
3 – 003	Number denied/not paid because elimination/waiting period not met
3 – 004	Number denied/not paid because services provided not covered under the contract
3 – 005	Number denied/not paid because provider/facility not qualified under the contract
3 – 006	Number denied/not paid because benefits eligibility criteria not met
3 – 007	All other denied/closed without payment

AnnLTC Schedule 4—Claimant Request Determination Timeliness

ID	Description
4 – 001	Number made within 0 - 30 days
4 – 002	Number made within 31 – 60 days
4 – 003	Number made within 61 – 90 days
4 – 004	Number made beyond 90 days

AnnLTC Schedule 5—Benefit Payment Requests

ID	Description
5 – 001	Number pending as of the beginning of the reporting period
5 – 002	Number received during the reporting period
5 – 003	Number denied/not paid during the reporting period
5 – 004	Number pending as of the end of the reporting period

AnnLTC Schedule 6—Benefit Payment Request Timeliness

ID	Description
6 – 001	Number paid within 0 – 30 days
6 – 002	Number paid within 31 – 60 days
6 – 003	Number paid within 61 – 90 days
6 – 004	Number paid beyond 90 days
6 – 005	Number denied/not paid within 0 – 30 days
6 – 006	Number denied/not paid within 31 – 60 days
6 – 007	Number denied/not paid within 61 – 90 days
6 – 008	Number denied/not paid beyond 90 days

AnnLTC Schedule 7—Lawsuits

ID	Description
7 – 001	Number open as of the beginning of the reporting period
7 – 002	Number opened during the reporting period
7 – 003	Number closed during the reporting period—total
7 – 004	Number closed during the reporting period with consideration for the consumer
7 – 005	Number open as of the end of the period

In determining what business to report for a particular state, all companies should follow the same methodology/definitions used to file the Financial Annual statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

General Instructions:

1. For purposes of the LTC Hybrid Product MCAS, "LTC Hybrid Product" means those products providing Long-Term Care insurance as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), as part of a Life-LTC hybrid insurance policy or Annuity-LTC hybrid contract. Such LTC hybrid benefits may be built into the life policy or annuity contract, or may be attached to such policy or contract by a rider. Do not report experience for stand-alone LTC products. Report experience for Life-LTC hybrid products separately from Annuity-LTC hybrid products in the schedules provided.

Report experience on individual LTC hybrid policies and contracts only. Do not report experience on group policies and contracts.

2. For Schedule 1, report experience for all policies or contracts with LTC hybrid benefits. For all data elements in Schedule 1, report the number of policies or contracts with Life-LTC hybrid or Annuity-LTC hybrid benefits and which meet the definition of the specific data element. For example, for data element 1-001 in the Life-LTC hybrid schedules, report the number of life insurance policies with LTC benefits in force at the beginning of the reporting period. For data element 1-001 in the Annuity-LTC hybrid schedules, report the number of annuity contracts with LTC benefits in force at the beginning of the reporting period. For data element 1-002, report the number of new business policies or contracts with LTC hybrid benefits.

3. For Schedules 2 through 6, report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, report experience for claimants, claimant requests denied/not paid, claimant request determination timeliness, benefit payment requests, and benefit payment request timeliness only for the LTC benefit portion of the LTC hybrid product.

4. Schedules 2, 3 and 4 refer to claimants and claimant requests. A claimant request is the initial request for LTC benefits under the policy or contract. The claimant request requires a determination by the insurer whether the claimant is entitled to LTC benefits under the policy or contract. Schedules 5 and 6 refer to individual benefit payment requests following the initial determination by the insurer that the claimant is entitled to LTC benefits under the policy or contract. The purpose of the schedules is to differentiate between initial coverage request activities (Schedules 2, 3 and 4) and benefit payment request activities (Schedules 5 and 6) once the insurer has affirmed the initial coverage requests.

5. Reporting for schedules 2 through 4 is to be done on a “per claimant” basis (counts each individual who makes one or a series of requests or demands for payment of benefits under a policy or contract.) [Model #641, Appendix E]

6. Reporting for schedules 5 and 6 is to be done on a “per transaction” basis (counts each benefit payment request pending and benefit payment paid or not paid/denied.) [Model #641, Appendix E]

7. For Schedule 7, report experience for those policies or contracts with some form of LTC hybrid benefit. Report lawsuit experience for all lawsuits related to the LTC hybrid product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.

Definitions:

Benefit Payment Request—A request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. (See Claimant Request and Claimant Request Determination, below.) Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment request. The data elements in Schedule 6 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes payment for an approved claimant (after satisfaction of the waiting or elimination period, if any). See general instructions 1, 3, 4 and 6.

Claimant—An insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests. See general instructions 1, 3, 4, and 5.

Claimant Request—A request or demand for payment made by an insured, or a representative of the insured, for a loss that may be included within the terms of coverage of the LTC hybrid policy or contract. It does not include events that were reported by the insured for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment.

If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date. See general instructions 1, 3, 4, and 5.

Claimant Request Determination—A determination as to whether an insured has met a contractual provision of a hybrid LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of this blank, the term applies to the initial claimant request, and captures the period of time from notice of claim to the claimant request determination date. For claimant requests that are denied/not paid, report the period of time from the date of notice of claim to the date the claimant was notified of the determination to deny or not pay the claim. See general instructions 1, 3, 4, and 5.

Claimant Request Denied/Not Paid because Benefit Eligibility Criteria Not Met—A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided. See general instructions 1, 3, 4, and 5.

Claimant Request Denied/Not Paid Because Claimant Did Not Pursue—A claimant made a request or demand for payment for the purpose of receiving a claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again (inactivity could be the result of death.) See general instructions 1, 3, 4, and 5.

Claimant Request Denied/Not Paid Because Elimination/Waiting Period Not Met—A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed. See general instructions 1, 3, 4, and 5.

Claimant Request Denied/Not Paid Because Services Provided Not Covered—Expenses incurred for services and support which are not eligible for reimbursement under the LTC benefit of a policy or contract, such as an expense incurred for home health care when the policy or contract only provides benefits for nursing home confinements. See general instructions 1, 3, 4, and 5.

Claimant Request Denied/Not Paid Because of Preexisting Condition Exclusion—A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services are subject to a restriction as a pre-existing condition for a period of time following the effective date of the claimant's LTC hybrid coverage. See general instructions 1, 3, 4, and 5.

Claimant Request Denied/Not Paid Because Provider/Facility Not Qualified—A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract. See general instructions 1, 3, 4, and 5.

Complaint—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose. See general instructions 1 and 2.

Denied/Not Paid—A request or demand for payment that is not paid for any reason.

Under Schedule 3, if a denial could be reported under more than one of the categories, report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant's request was denied, the denial should not be counted more than once.

Under Schedules 5 and 6, exclude denials for failure to meet the waiting or elimination period or because of an applicable preexisting condition.

The term does not include a request or demand for payment that is in excess of the applicable contractual limits. See general instructions 1, 3, 4, 5, 6 and 7.

Elimination Period—A period of time, as specified in the policy or contract, during which the insured incurs qualified long-term care services and support for which benefits are not payable until the end of such period.

Free Look—A set number of days provided in a policy or contract that allows time for the purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

Lapse—The termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for LTC hybrid products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought. See general instructions 1 and 7.

New Business Policy or Contract—A newly written agreement that puts LTC hybrid insurance coverage into effect under a policy or contract during the reporting period. See general instructions 1 and 2.

Replacement—Replacement of any life policy, annuity contract or LTC policy already in force with a new policy or contract with LTC hybrid insurance coverage.

- External Replacement—If the policy or contract to be replaced was issued by another insurer.
- Internal Replacement—If the policy or contract to be replaced was issued by you.

For Data Elements 1-007 (Number of Internal Replacements) and 1-008 (Number of External Replacements), report the number of policies included in data element 1-002 (Number of new business policies) which are replacements of any type of life, annuity or long-term care policies. See general instructions 1 and 2.

Rescission—Invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer , in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640). See general instructions 1 and 2.

Waiting Period—See definition of Elimination Period.