LONG-TERM CARE INSURANCE (B) TASK FORCE

Long-Term Care Insurance (B) Task Force Aug. 13, 2024, Minutes
- Long-Term Care Actuarial (B) Working Group Aug. 12, 2024, Minutes (Attachment One)
  - Long-Term Care Actuarial (B) Working Group July 2, 2024, Minutes (Attachment One-A)
    - America's Health Insurance Plans (AHIP) and the American Council of Life Insurers Comment Letter (ACLI) (Attachment One-A1)
      - Virginia State Corporation Commission's Bureau of Insurance Comment Letter (Attachment One-A2)
    - Genworth Life Insurance Company Comment Letter (Attachment One-A3)
    - Washington Office of the Insurance Commissioner Comment Letter (Attachment One-A4)
    - Robert Darnell Comment Letter (Attachment One-A5)
  - Washington State Office of the Insurance Commissioner Comment Letter (Attachment One-B)
  - American Academy of Actuaries (Academy) Comment Letter (Attachment One-C)
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  - Genworth Life Insurance Company and GLIC of New York Comment Letter (Attachment One-E)
  - American Council of Life Insurers (ACLI)/America's Health Insurance Plans (AHIP) Comment Letter (Attachment One-F)
  - Single LTCI Multistate Rate Review Approach Presentation (Attachment One-G)
- Education Project on Reduced Benefit Options (RBOs) in LTCI (Attachment Two)
- Presentation on the Results of the RBOs and Consumer Notices Research Project (Attachment Three)

Draft Pending Adoption

Draft: 8/19/24

Long-Term Care Insurance (B) Task Force
Chicago, Illinois
August 13, 2024

The Long-Term Care Insurance (B) Task Force met in Chicago, IL, Aug. 13, 2024. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri and Dusty Smith (AL); Barbara D. Richardson (AZ); Ricardo Lara represented by Ahmad Kamil (CA); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro (DE); Gordon I. Ito represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); Sharon P. Clark represented by Shaun Orme (KY); Timothy J. Temple represented by Crystal Lewis and Frank Opelka (LA); Kevin P. Beagan (MA); Robert L. Carey represented by Marti Hooper (ME); Chlora Lindley-Myers represented by William Leung and Amy Hoyt (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); D.J. Bettencourt represented by Michelle Heaton and Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Scott Kipper represented by Jack Childress (NV); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by Alex Cheng (OR); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise represented by Brian Fomby (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented by R. Michael Markham and Debra Diaz-Lara (TX); Jon Pike represented by Tomasz Serbinowski, Ryan Jubber, Shelley Wiseman, and Tanji J. Northrup (UT); Scott A. White represented by Julie Fairbanks (VA); Kevin Gaffney represented by Isabelle Keiser and Marcia Violette (VT); Mike Kreidler represented by John Haworth (WA); Nathan Houdek represented by Darcy Paskey (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Spring National Meeting Minutes

Haworth made a motion, seconded by Bailey, to adopt the Task Force's Spring National Meeting minutes (*see NAIC Proceedings – Spring 2024, Long-Term Care Insurance (B) Task Force*). The motion passed unanimously.

The Task Force also met June 20 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.

2. Heard an Update on LTCI Industry Trends

Andersen said several factors impacting long-term care insurance (LTCI) company solvency and premium rates are being monitored. The rising cost-of-care inflation, particularly the impact on inflation-protected products, results in a higher portion of maximum daily benefits being utilized. This is a highly impactful trend, especially in home health care. Partially offsetting this trend is increased investment returns due to higher interest rates. There is still uncertainty in morbidity and morbidity incidence improvements. In certain circumstances, companies are allowed to model future rate increase approvals as part of reserve adequacy testing. Efforts to understand state insurance regulators' rate reviews and approvals, including what insurers plan to request, will help to ensure the modeling is correct. Another monitored area is the performance of assets supporting LTCI blocks of business, including insurers' investments in alternative complex assets. Finally, wellness initiatives and their impacts on long-term care (LTC) events are viewed as positive; however, the impact on net financial gains or losses from decreases in LTC events is still unknown.

3. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Andersen said the Long-Term Care Actuarial (B) Working Group met Aug. 12. During this meeting, the Working Group discussed replacing the current LTCI multistate rate review approach with a single methodology within the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). The Working Group received comments from state insurance regulators and interested parties on the methodology and agreed action needed to be taken. As blocks of business age for policyholders who have had policies for 20 or more years, are over the age of 80, and have faced cumulative rate increases of 400% or more (85/25/400 issue), there are concerns about these policyholders receiving future rate increases. There is consensus at the Commissioner, Task Force, and Working Group level that the 85/25/400 issue should be addressed. The Working Group exposed two alternative approaches from Minnesota and Missouri for a 45-day public comment period ending Sept. 27.

Serbinowski said the 85/25/400 issue is a policy issue for the Task Force rather than an actuarial issue. Lombardo said the cost-sharing aspect of the approach is included in the current LTCI MSA Framework, so the intent is not to introduce a new concept. He said many Commissioners have indicated the issue of cumulative rate increases should be addressed. In order to lower the slope of the cumulative rate increases at the 25-year duration, rate increases at earlier durations increase. The Working Group is cognizant that LTC policies are issue-age-rated, not duration-rated. The Working Group does not want to create a discrimination issue. Lombardo said this is a way to adjust the current methodology and develop an approach that Commissioners have been calling for. He said he and Andersen have had many conversations and given presentations to Commissioners on this issue and have not heard objections. He said he recognizes this issue is not actuarial but that actuaries work on policy issues as part of their daily role. Any proposal from the Working Group to update the LTCI MSA Framework would go through the Task Force, Health Insurance and Managed Care (B) Committee, and Executive (EX) Committee and Plenary.

Commissioner Navarro made a motion, seconded by Fix, to adopt the report of the Long-Term Care Actuarial (B) Working Group, including its Aug. 12 and July 2 minutes (Attachment One). The motion passed unanimously.

4. Received an Overview of Consumer Education on RBOs

Commissioner Navarro said Delaware recently implemented an education project on reduced benefit options (RBOs) in LTCI (Attachment Two). He said this presentation was well received by local media, the Alzheimer's Association, and other aging associations in Delaware. Genworth Life Insurance Company provided training for Delaware staff. The Delaware Department of Insurance (DOI) developed a new website. The first point of contact for consumers is the Delaware Medicare Assistance Bureau (DMAB). The next level of contact is the Delaware Consumer Services Division, and then the deputy attorney general that is assigned to the DOI. The DOI cannot offer financial advice but can explain LTCI and RBOs. The new website contains additional information links. Lombardo said he looks forward to hearing more from Delaware at a future meeting about how the new program is working.

5. Received a Presentation on the Results of the RBOs and Consumer Notices Research Project

Brenda Rourke (NAIC) provided an overview of the research project being conducted by the Center for Insurance Policy and Research (CIPR) on RBOs, consumer notices, and consumer choices (Attachment Three). Rourke said that, in summary, the study results indicated that participants were more likely to accept the rate increase over an RBO if they:

- Received a prior rate increase.
- Thought the letter was clear and easy to read.
- Thought the RBO options were clear.
- Said they had enough information and were in control of their choice.
- Had confidence and belief in their knowledge and skills.
- Believed their loved ones and others with LTCI would make the same choice.

- Had more financial knowledge.
- Were less likely to take risks.
- Believed they are likely to need LTC.

Rourke said the letter to consumers about the rate increase and RBOs alone did not impact consumers' choices. Rourke said the next steps for the study include: 1) continuing to model the data using multivariate analysis; 2) studying the perception of clarity of the letters and if there are ways to improve the current RBO checklists; and 3) discussing ways to better educate policyholders about their choices.

Lombardo said the CIPR will be asked to present the results of future work on this project during a future Task Force meeting.

Having no further business, the Long-Term Care Insurance (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/LTCI TF/2024 SummerNM LTCI TF/LTCITF 081324 Minutes.docx

Draft: 8/15/24

Long-Term Care Actuarial (B) Working Group
Chicago, Illinois
August 12, 2024

The Long-Term Care Actuarial (B) Working Group of the Long-Term Care Insurance (B) Task Force met in Chicago, IL, Aug. 12, 2024. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sanjeev Chaudhuri (AL); Sarah Bailey (AK); Thomas Reedy (CA); Stephen Flick (DC); Weston Trexler (ID); Scott Shover (IN); Josh Carlson (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); Margaret Garrison (NE); Jennifer Li (NH); Bill Carmello and Neil Gerritt (NY); Laura Miller (OH); Andrew Schallhorn (OK); Timothy Hinkel (OR); Glorimar Santiago (PR); R. Michael Markham (TX); Tomasz Serbinowski (UT); Allan L. McVey and Joylynn Fix (WV); and Rebecca Rebholz (WI).

1. Adopted its July 2 and Spring National Meeting Minutes

Lombardo said the Working Group met July 2 and March 15. During its July 2 meeting, the Working Group took the following action: 1) discussed comments received on the exposure of the Minnesota approach with any suggested adjustments as a candidate for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews and 2) exposed the Minnesota approach with any suggested adjustments to the cost-sharing formula to address large rate increases for policyholders at roughly age 85 with a policy duration of 25 years (85/25 issue) as a candidate for a single LTCI multistate rate review approach for a 30-day public comment period ending Aug. 1.

Dyke made a motion, seconded by Fix, to adopt the Working Group's July 2 (Attachment One-A) and March 15 (*see NAIC Proceedings – Spring 2024, Long-Term Care Insurance (B) Task Force*) minutes. The motion passed unanimously.

2. Heard an Update on and Discussed a Single LTCI Multistate Rate Review Approach

Lombardo presented comments received on an exposure of the Minnesota approach with any suggested adjustments to the cost-sharing formula to address large rate increases for policyholders at roughly age 85 with a policy duration of 25 years (85/25 issue) as a candidate for a single LTCI multistate rate review approach. He said comments were received from the Washington State Office of the Insurance Commissioner (Attachment One-B), the American Academy of Actuaries (Academy) (Attachment One-C), the Missouri Department of Commerce and Insurance (Attachment One-D), Genworth Life Insurance Company and Genworth Life Insurance Company of New York (Attachment One-E), and the American Council of Life Insurers (ACLI)/America's Health Insurance Plans (AHIP) (Attachment One-F). Jan Graeber (ACLI) said the combination of implicit and explicit cost-sharing elements in the Minnesota approach makes it challenging to accurately quantify the level of cost-sharing that will result and can also mask the level of rate increase that is needed. She said ACLI/AHIP want to ensure that an adopted single approach is transparent and consistently applied.

Andersen said that in the past few MSA filing reviews, the MSA team has provided a metric using the dollar amount impact on financials for the block of business before and after the MSA recommended increase that can be used as a method to quantify actual cost-sharing rather than percentages.

Andersen gave a presentation (Attachment One-G) with background on the Minnesota approach and a proposal for revising the approach's current cost-sharing formula to address the 85/25 issue, as well as cumulative rate increases greater than 400%. He said the current formula is no haircut for the first 15% of the cumulative rate increase, 10% for the portion of the cumulative rate increase between 15% and 50%, 25% for the portion of the cumulative rate increase between 50% and 100%, 35% for the portion of the cumulative rate increase between 100% and 150%, and 50% for the portion of the cumulative rate increase in excess of 150%. He said his proposal is a 5% haircut for the first 100% of the cumulative rate increase, 20% for the portion of the cumulative rate increase between 100% and 400%, and 80% for the portion of the cumulative rate increase in excess of 400%. He said this is intended to reduce rate increases for policyholders around the 85/25/400 area.

Lombardo said he and Andersen think the proposal is a first draft to reach some level of compromise between insurers and policyholders while addressing the 85/25/400 issue. He said the proposal will impact different companies in different ways. He said he, Andersen, and others do not believe there is a single solution that every company and regulator will support. Lombardo said the proposal will be exposed for public comment, and the Working Group intends to work toward presenting a final proposal for amending the MSA framework to use a single approach to be voted on for adoption by the Working Group at the Fall National Meeting. He said any changes will only affect the MSA review process under the MSA framework and will not change states' ability to conduct their own rate increase review processes.

Leung said he is concerned that the proposal does not address very large rate increases that will still be considered unreasonable, even after applying the proposed cost-sharing. He said he is also concerned that the formula will treat companies that have received no rate increases in the past differently than companies with past cumulative rate increases. He said he thinks the cost-sharing modifications proposed in the Missouri Department of Commerce and Insurance comment letter address these concerns. Andersen said the implicit cost-sharing through the blending of the if-knew and makeup premiums in the Minnesota approach will likely resolve any issues with exorbitant rate increases prior to the application of the proposed explicit cost-sharing factors. He said he does not think it is likely that there will be a mature LTCI block that has not had any rate increases in the past requesting a large rate increase. Andersen said the Minnesota approach has been successfully used for over 250 rate increase filings and for nine MSA filings.

Serbinowski said the proposed cost-sharing factors produce results similar to those from the informal 300% cap on rate increases that the Utah Insurance Department implemented in 2016. He said the 300% cap is no longer enforced. He said the cost-sharing factors are the most arbitrary element of the Minnesota approach, are non-actuarial in nature, and he is not sure that the Working Group is the best forum to address a policy issue rather than an actuarial one. He said he is also concerned that two similarly situated companies may end up being granted far different rate increases depending on whether they filed for an increase before or after the implementation of the proposed new cost-sharing factors. He said he finds it difficult to support the proposal.

Fix said regulators need to do something to address the current issues with LTCI rate increases and that all regulators can find reasons to not support the proposal. She said states will not give up their rights to final approval of rate increases under the MSA process. She said that if an unforeseen rate increase request situation occurs and the MSA process does not appropriately address it, the process does not need to be used. She said that since consistent application of the process is a concern for regulators and industry, perhaps the MSA team can create a training program to teach regulators exactly how to conduct a rate increase review using the MSA process. She said West Virginia fully supports the MSA process using the Minnesota approach as a single LTCI MSA review approach methodology. Lombardo agreed that whatever single approach is ultimately adopted, there should be training for regulators in the application of the MSA process so there is a complete

understanding among states as to how each state is applying the methodology. He said MSA training can help address industry concerns about inconsistent application of the MSA process. Andersen said the MSA framework includes a structure for an MSA associate program, and this can be used to train the states on the application of the MSA process.

Chaudhuri said having an adopted MSA framework that uses a single approach and that also includes non-actuarial aspects, such as cost-sharing, will be helpful for commissioners and others because it can be used as a starting point for making policy decisions based on non-actuarial elements.

Miller said she agrees there should be an MSA process training program so that regulators can fully understand the process before deciding whether to adopt it. She said she is not confident that she understands how all the elements of the process work and is not comfortable voting for adoption without this knowledge. She asked why 85, 25, and 400 were chosen as points where action needs to be taken.

Lombardo said that a vote will not be called today, and there will be further exposure of changes to the Minnesota approach for comment. Andersen said that age 85 and duration 25 are not meant to be defined cutoff points, but many of the rate increase complaints received are from policyholders generally at that age and duration. He said that after examining various LTCI block component averages, cumulative rate increases at a threshold of 400% tend to happen for policyholders at age 85, duration 25. He said his proposed cost-sharing factor changes the focus to more on the 400% threshold but benefits age 85, duration 25 policyholders as a by-product of their application. He said the focus of the changes is to reduce higher cumulative rate increases regardless of a policyholder's age or duration. Miller said she supports having a framework that will allow regulators to explain rate increase evaluations to their commissioners, even if portions of it are non-actuarial.

Graeber said she is concerned that under the MSA process, rate increase evaluations will be interpreted as actuarial when elements, such as cost-sharing, are policy-driven. She said she thinks the actuarially justified rate increase needs to be disclosed and what policy decisions were applied that reduced the actuarially justified increase. Miller asked Graeber if she thinks the Working Group is not the appropriate venue for making cost-sharing recommendations. Graeber said in the past, the Working Group only dealt with actuarial issues, and she believes the Long-Term Care Insurance (B) Task Force was formed to consider policy-related issues at a commissioner level. Lombardo said the MSA process, a single approach, and addressing the 85/25 issue have been discussed with many commissioners, and they all approve of the Working Group developing potential solutions to these issues. He said the cost-sharing elements are already part of the Minnesota approach as used in the MSA framework, and the Working Group is only proposing modifications to cost-sharing factors that have been in use to reflect the LTCI block cohorts that commissioners have expressed concerns about. He said before any factor modifications can be implemented, they will need to be approved at the commissioner level through the Executive (EX) Committee and Plenary.

Commissioner McVey said he thinks the MSA process will work to help regulators solve the issues they face with LTCI rate increases. He said regulators are at a point where something must be done to address the issues, and the Working Group has been tasked with developing the best alternative. He said insurers need to work with regulators to develop the best solution possible. Graeber said she understands the Working Group is acting on direction from commissioners, and she wants to ensure that the MSA process is transparent by stating the actuarially justified rate increase and also the reasons why cost-sharing was applied to reduce the increase. She said that she wants it to be clear that commissioners are ultimately the ones making the policy decisions applied to a rate increase request.

Lombardo said the final decision on the level of rate increase lies with the commissioner of any given jurisdiction. He said that nothing in the MSA process changes this. He said commissioners need to be able to explain the complicated details of an LTCI rate increase to policyholders in a way they can understand, and the MSA framework helps accomplish this. Lombardo said having a single approach to be used in the MSA process eliminates the complications of explaining why multiple approaches were used and how their weights were assigned in developing the rate increase. He said more consistency is needed among states so there can be more predictability in the LTCI market that will hopefully attract new insurers to offer LTCI products. He said that the MSA framework is intended to be subject to revision over time, and whatever the Working Group presents at the Fall National Meeting is not necessarily the final version of the MSA approach.

3. Exposed Proposals for Modifications to Minnesota Approach Cost-Sharing Factors

Lombardo said modifications to the cost-sharing factors used in the Minnesota approach as proposed by Andersen and Leung will be exposed for a 45-day public comment period ending Sept. 27.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Member Meetings/B CMTE/HATF/2024_Summer/8-12-24 LTCAWG/LTCAWG Minutes 08-12-24.docx

Draft: 7/16/24

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
July 2, 2024

The Long-Term Care Actuarial (B) Working Group of the Long-Term Care Insurance (B) Task Force met July 2, 2024. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sarah Bailey (AK); Stephen Flick (DC); Lilyan Zhang (FL): Scott Shover (IN); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); David Yetter (NC); Michael Muldoon (NE); Jennifer Li (NH); Neil Gerritt (NY); Craig Kalman and Laura Miller (OH); Jim Laverty and Shannen Logue (PA); Aaron Hodges and R. Michael Markham (TX); Tomasz Serbinowski (UT); Rebecca Rebholz (WI); and Joylynn Fix (WV). Also participating was: Julie Fairbanks (VA).

1. Discussed Comments on a Single LTCI Multistate Rate Review Approach

Lombardo presented comments received from America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI) (Attachment One-A1), the Virginia State Corporation Commission's Bureau of Insurance (Attachment One-A2), Genworth Life Insurance Company (Attachment One-A3), the Washington Office of the Insurance Commissioner (Attachment One-A4), and Robert Darnell (Attachment One-A5) on the exposure of the Minnesota approach with any suggested adjustments as a candidate for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews.

There was discussion on Virginia's comment that the MSA recommendation provide catch-up percentages separate from the overall rate increase. Yetter said he prefers seeing the rate increase plus the catch-up.

Jan Graeber (ACLI) said the ACLI Long-Term Care Insurance Committee will meet later this month to discuss potential ideas to ensure consumers continue to receive valuable long-term care coverage while addressing affordability concerns fairly and soundly. She said ACLI is dedicated to finding a solution that will address the Working Group's concerns. In response to the assertion in the ACLI/AHIP comments that a single methodology cannot work in all cases and that the Minnesota approach results in insufficient rate increases for older blocks of LTCI, Andersen said feedback from the Working Group is that it results in excessive rate increases for older blocks. He asked if this is what ACLI/AHIP views as the main weakness of the approach or if they have identified other weaknesses. Graeber said ACLI/AHIP thinks there are cases where the cost-sharing aspect of the Minnesota approach results in insufficient increases, and they have not identified any specific concerns with it, but they want to preclude any adjustments to the methodology that are non-actuarial in nature.

Andersen said he appreciates the cost of delay issue raised in Genworth's comments, and the MSA team is relying on a decision made at the commissioner level on the balance between fairness to consumers and preventing insurer financial distress, as well as bringing rates to similar levels among states. He said there is nothing in the MSA Framework that would prevent a state from working out a solution for a cost of delay issue with an insurer.

Andersen said the Minnesota and Texas approaches have a long history, have both been publicly vetted over the past eight years, and both were adopted as part of the MSA Framework. He said the Minnesota approach has been used to review over 250 filings and seems to have worked well. Andersen said it has also worked well for many filings in the pilot and adopted versions of the MSA Framework. He said the MSA team has heard from regulators that the Minnesota Approach yields increases that are too large, and insurers have said it yields increases that are not large enough. He said he thinks no single methodology will completely satisfy both parties.

Andersen said an issue that has emerged is large rate increases for policyholders at roughly age 85 and policy duration 25, which is referred to as the 85/25 issue. In Minnesota, he is exploring state adjustments to the Minnesota approach to mitigate these larger increases and proposes that the MSA Framework also do so in a way that does not create discrimination issues. He and Lombardo have had many discussions with commissioners and regulatory actuaries, and the response has been unanimous that this issue should be pursued. Advantages to the Minnesota approach as a candidate for a single methodology are that it is well-understood and documented, has been in use for over eight years, and that simple adjustments to weightings for the cost-sharing factors could address the 85/25 issue. He said there may be benefits to reducing the insurer's cost-sharing in earlier policy durations, as it may reduce financial distress for younger blocks in years to come and prevent large rate increases for older aged policyholders later in the block's life. He said a possible solution would be to reduce insurer cost-sharing for policyholders with lower cumulative rate increases and increase insurer cost-sharing for policyholders with higher cumulative increases. He said this will provide two levers to mitigate the 85/25 issue, one currently and the other later in the life of the block.

Lombardo said the Working Group and the Long-Term Care Insurance (B) Task Force have established the goal of adopting a single methodology for use in the MSA Framework by the end of this year and to address the 85/25 issue in the process. He said the MSA Framework will always be open for revision, and the Working Group and MSA Team will remain open to considering modifications that will produce better results for all stakeholders. He said even if the Working Group and Task Force adopt a single methodology and a way to address the 85/25 issue, these issues and others will continue to be worked on in the future. He said this is a necessary two-step process that needs to occur to have a better opportunity for more regulators to understand the concept of using a single methodology in the MSA Framework and to potentially get more regulator support going forward.

Fix said she agrees with Andersen and Lombardo and thinks that a change must be made. She said a modified Minnesota approach for use as a single methodology provides a balanced solution to the majority of the issues regulators are facing. Miller said she also agrees and thinks that regulators need to not only consider the actuarial aspects of rate increase review, but also consider the harm that can come to consumers from the way insurers price these products. She asked why age 85 and duration 25 were singled out and if the intent is to have a single cost-sharing modification for policyholders at or greater than age 85, duration 25, or if the modification will vary by age and duration. Andersen said under his proposal, there will not be anything explicit at age 85, duration 25, but it will reflect the ages and durations in a block where larger cumulative increases are seen. He said these policyholders will be the ones who benefit from the adjustment. Lombardo said 85 and 25 were chosen as an easy way to describe the issue and are not meant to apply exclusively to such policyholders. Miller suggested reducing duration 25 to a smaller number. Logue said Pennsylvania recognizes these issues are problematic and that there is no perfect solution to them. He supports the Working Group's efforts toward implementing a single approach.

2. Exposed a Single LTCI Multistate Rate Review Approach for Comment

Lombardo said the Working Group will expose the Minnesota approach with any suggested adjustments to the cost-sharing formula to address the 85/25 issue as a candidate for a single LTCI multistate rate review approach methodology for use in MSA filing reviews for a 30-day public comment period ending Aug. 1. He said the Working Group will discuss comments received during its Aug. 12 meeting.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2024_Summer/7-2-24 LTCAWG/LTCAWG Minutes 07-2-24.docx

May 3, 2024

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Paul and Fred,

The American Council of Life Insurers (ACLI)[1] and the America's Health Insurance Plans[2] (AHIP) appreciate the opportunity to comment on the NAIC Long-Term Care Actuarial Working Group (LTCAWG) exposure titled "Recommendation on a single MSA actuarial approach after regulator feedback Document."

ACLI and AHIP recognize the challenges you face in responding to some legislators and consumers facing a large rate increase on LTC policies. In addition, we commend the significant effort by the LTCAWG trying to create an acceptable uniform approach to review LTC rate increase filings with the goal of bringing consistency and efficiency to the process.

At this stage, there are differing opinions regarding the most suitable methodology for the multi-state rate review (MSRR) team. Moreover, many states are hesitant to adopt the MSRR approach over their own methods and the likelihood of a substantial number of states adopting the MSRR recommendation is uncertain.

The diversity among the various blocks of business within the industry makes it challenging for a single approach to effectively cater to all. Factors such as variations in block average ages and durations, initial pricing adequacy, and historical rate adjustments requested and approved indicate that a "one size fits all" approach will not appeal to a broad segment of the market. The current MSRR methodology, aimed at achieving consistency in rates, disproportionately disadvantages older blocks with a history of denials and delays in review. Introducing the proposed changes would likely worsen this situation.

As stated in our prior communications, our primary concern is the inclusion of non-actuarial factors in the rate filing review process. As an industry, we cannot endorse anything that effectively alters the terms and conditions of policies regarding an insurer's ability to adjust future premium rates arbitrarily. Allowing political or social considerations to override sound actuarial principles sets a risky precedent, potentially leading to unintended consequences in the future. We worry that such unintended consequences could possibly include some insurers seeking legal/regulatory recourse.

Finally, any limitations being considered by the NAIC should be done via model statute or properly promulgated regulations rather than guidelines or as part of the MSRR framework. An NAIC model regulation (Model #641) aimed at strengthening the pricing of LTC insurance already exists and could be amended if necessary.

[1] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

Based on these concerns, we question the success envisioned by the NAIC in 2019 when they adopted the charge of developing a consistent national approach for reviewing LTC insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, can truly be achieved. A possible outcome is a continued assortment of approaches that fail to satisfy insurers, regulators, or policyholders.

We remain open to exploring alternative solutions that address rate increase filings, policyholder concerns, and highlight the continued value of policies even with premium rate increases. As illustrated in the recommendation section of this letter, highlighting the continuing value of the policies even with premium rate increases can be an effective tool to help address concerns raised by legislators and consumers.

Executive Summary

As insurers, we have a fundamental obligation to ensure the financial sustainability of the products we provide to consumers. Actuarially sound rates are essential to achieving this goal, and deviating from these principles would compromise our ability to fulfill our contractual obligations.

We understand your concerns for consumer protection; however, we must also recognize that insurance products inherently involve risk and personal responsibility. In the case of LTC insurance, policyholders may face premium increases that are necessary to ensure the insurer's financial sustainability. While many policyholders may be able to adjust their benefits or premiums to manage costs, there may always be some who are unable to afford the increases and must lapse their coverage. It is essential to remember that LTC insurance products are designed to provide a safety net, not a guaranteed benefit.

We also understand that affordability is a critical issue, particularly for older age policyholders. However, arbitrarily prohibiting large rate increases on targeted segments of the LTC market may not be the most effective solution.

The section below provides a potential framework for a solution, which highlights the value of LTC coverage.

ACLI and AHIP Recommendation

When evaluating LTC products, it's essential for all stakeholders to consider the value they provide to consumers. Consumer protection efforts should strike a balance between safeguarding consumers and allowing for consumer choice, acknowledging that LTC products can play a vital role in supporting individuals' LTC needs.

Pricing LTC coverage involves complex actuarial assumptions and calculations. Rather than delving into technical details, we recommend sharing the importance and value of LTC coverage with policymakers and lawmakers. This approach enables them to understand the benefits and make informed decisions that support consumers' needs. By taking a nuanced approach, we can ensure that consumers have access to valuable products that meet their needs while also being protected from unintended consequences.

Rather than imposing benefit caps or restricting premium increases, we suggest focusing on measures that promote consumer education, flexibility, and choice. This could include:

- Clear and transparent communication about premium increases and benefit adjustments
- Options for policyholders to adjust their benefits or premiums to manage costs

- Support for policyholders who are struggling to afford their premiums

Below are several illustrations, based on realistic policy information, which demonstrate the value that LTC insurance can provide.

Scenario 1

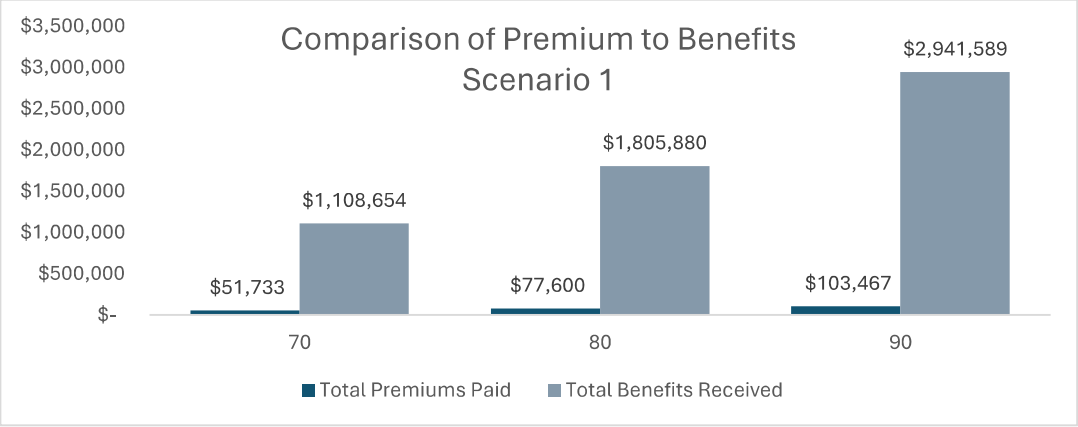
To illustrate the potential value, consider a policyholder who purchased the policy at age 50, with an original monthly maximum benefit of $6,964 and 5% compounded annual inflation protection. The elimination period is 90 days, and the benefit period is 5 years. The annual premium at issue is $2,587. The following table provides a comparison of potential premium paid to benefits received, assuming age at claim of 70, 80, and 90 years, and claims continue for 5 years.

Assumptions:

- Premiums are paid annually
- Inflation protection is 5% compounded annually
- Benefit period is 5 years
- Elimination period is 90 days
- No Premium Increases

Age at Claim	Total Premiums Paid	Total Benefits Received	Benefit-to-Premium Ratio
70	$ 51,733	$1,108,654	21.43
80	$ 77,600	$1,805,880	23.27
90	$ 103,467	$2,941,589	28.43

Note: The benefit-to-premium ratio increases significantly over time due to the compounding effect of inflation protection.



Scenario 2 – Same as Scenario 1 with Premium Increases

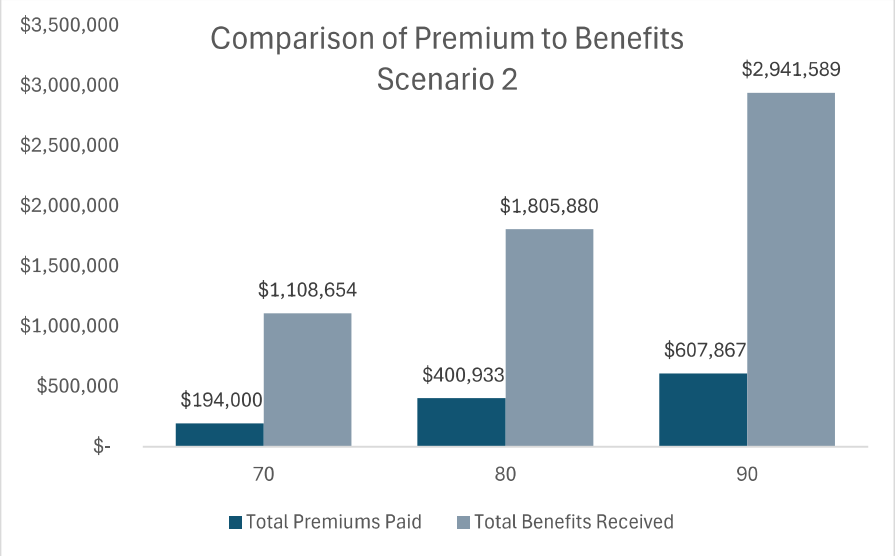
The policyholder purchased the policy at age 50, with an original monthly maximum benefit of $6,964 and 5% compounded annual inflation protection. The elimination period is 90 days, and the benefit period is 5 years. The initial annual premium at issue is $2,587. Rate increases of 100%

are filed in years 6, 11, and 16. The following table compares the potential premium paid to benefits received, assuming age at claim of 70, 80, and 90 years, and claims continue for 5 years.

Assumptions:

- Policy purchased at age 50
- Original monthly maximum benefit: $6,964
- 5% compounded annual inflation protection
- Elimination period: 90 days
- Benefit period: 5 years
- Initial Annual Premium: $2,587
- Premium increases by 100% each year at years 6, 11, and 16
- Claims continue for 5 years

Age at Claim	Total Premiums Paid	Cumulative Premium Increase	Total Benefits Received	Benefit-to-Premium Ratio
70	$194,000	700%	$1,108,654	5.71
80	$400,933	700%	$1,805,880	4.50
90	$607,867	700%	$2,941,589	4.84



In contrast to Scenario 1, the initial annual premium increases 700%. While this is a significant amount, it's essential to consider the value of the coverage provided and the potential benefits received. In this scenario, depending on age at claim, the policyholder could receive over 5 times the total premiums paid in benefits, highlighting the importance of actuarial soundness in setting insurance premiums.

Considerations for Consumers

If the insurance company announces a 100% premium increase, the policyholder should carefully consider the following factors when deciding whether to keep or drop the coverage:

1. Affordability: With a 100% premium increase, the initial annual premium would double to $5,173 in year 6, and would double again in years 11, and 16. The policyholder must assess whether they can afford such a significant increase.
2. Inflation Protection: The 5% compounded annual inflation protection may be higher than the increase in cost of care. The policyholder should assess whether a reduction in inflation protection could be appropriate for their situation.
3. Policy Terms: Review the policy terms to understand flexibility in adjusting benefits to help mitigate the increase in premiums.
4. Financial Situation: Assess the policyholder's current financial situation, income, and expenses to determine if they can absorb the increased premium costs.
5. Health Status: Consider the policyholder's current health status and potential future care needs, weighing the importance of maintaining coverage against the increasing costs.

By carefully evaluating these factors, the policyholder can make an informed decision about whether to keep the coverage, adjust the benefits, or explore alternative solutions.

Scenario 3 – Same as Scenario 2 with Premium Increases and Benefits Capped

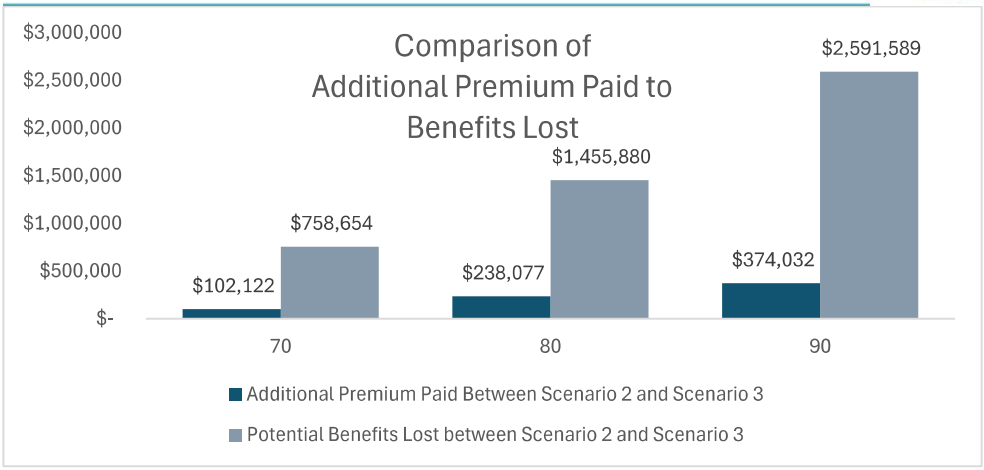
The assumptions are the same as Scenario 2; however, rather than approving the actuarially justified 100% increase in premium in years 6, 11, and 16, assume that premium increases were capped at 40% per year in years 6, 11, and 16. In addition, assume that the company became financially unsustainable and the policies were assumed by the state guaranty fund, which caps total benefits at $350,000.

Assumptions:

- Policy purchased at age 50
- Original monthly maximum benefit: $6,964
- 5% compounded annual inflation protection
- Elimination period: 90 days
- Benefit period: 5 years
- Initial Annual Premium: $2,587
- Premium increases by 40% each year at years 6, 11, and 16
- Total benefits received capped at $350,000

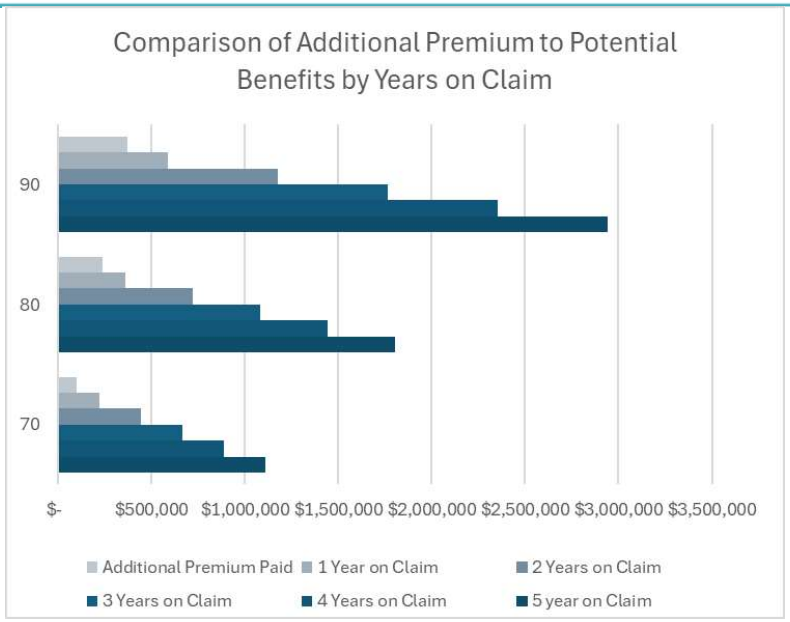
Age at Claim	Total Premiums Paid	Cumulative Premium Increase	Total Benefits Received	Benefit-to-Premium Ratio
70	$ 91,878	174%	$350,000	3.81
80	$ 162,857	174%	$350,000	2.15
90	$ 233,835	174%	$350,000	1.50

Age at Claim	Additional Premium Paid Between Scenario 2 and Scenario 3	Potential Benefits Lost between Scenario 2 and Scenario 3	Benefits Lost/Additional Premium Paid
70	$ 102,122	$ 758,654	7.43
80	$ 238,077	$ 1,455,880	6.12
90	$ 374,032	$ 2,591,589	6.93



This above table highlights that without a benefit cap (but with high premium increases) actually provides more consumer protection because it:

- Empowers consumer choice: Without a benefit cap, consumers have the flexibility to reduce their benefits (and corresponding premiums) if they feel the premium increases are too high.
- Avoids forced benefit cuts: By not capping benefits, consumers are not forced to accept reduced benefits due to regulatory restrictions on premium increases and guaranty fund limits.
- Encourages personal responsibility: Consumers can take ownership of their long-term care planning and make informed decisions about their benefits and premiums.
- Supports actuarial sustainability: The table without a benefit cap assumes actuarially justified rate increases, ensuring the insurer's financial sustainability and our ability to fulfill our contractual obligations.
- Empowering consumers to make their own choices about benefits and premiums can be a more effective way to allow policyholders to protect their interests.



Summary

Consumers facing significant rate increases on LTC policies must have the ability to make informed decisions that align with their financial circumstances and risk tolerance. Factors such as financial situation, health status, policy features, and future care needs should be carefully considered before deciding whether to maintain coverage, adjust benefits, or lapse the policy.

Actuarial justification plays a crucial role in ensuring the financial stability of insurers and protecting the interests of consumers. Deviating from actuarial principles may lead to inadequate premiums, jeopardizing insurer stability and consumer protection.

Furthermore, delaying approval of actuarially justified rates poses significant risks to insurers and policyholders alike. Proactive oversight and timely approval of actuarially justified rate adjustments are essential to maintain market confidence and protect consumers from sudden premium hikes or lapses in coverage.

While addressing affordability issues for older age policyholders is important, it is crucial to maintain a focus on actuarial soundness and fairness in setting premiums. Empowering consumers with knowledge, flexibility, and support can help strike a balance between consumer protection and insurer stability.

In conclusion, we urge regulators to prioritize actuarially justified rate increases and policies that empower consumer choice within the insurance market. By doing so, we can ensure the long-term viability and sustainability of insurance products while promoting fair outcomes for consumers.

Thank you for considering these important issues.

Sincerely,

Jan Graeber
Senior Actuary, ACLI

Ray Nelson
Consultant for AHIP

From: Julie Fairbanks
To: King, Eric
Cc: White, Scott A.; Blauvelt, Julie; Smith, Greg; Chupp, Craig
Subject: FW: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due May 3
Date: Monday, May 6, 2024 3:36:22 PM
Attachments: image001.png
Single actuarial approach_comments_recom_022024.pdf

Good afternoon Eric,

VA's comments are below. I apologize for submitting them a few days late.

Virginia is supportive of the development of a single MSA actuarial approach based on the concepts outlined in the attachment. In regards to the recommendations that the WG is planning to incorporate into the single actuarial method, VA would like to provide the following suggestions:

Regarding #4 and the catch up provision for attaining a similar rate level upon states, VA would prefer that the MSA team continue to provide recommended rate increases for approval and separately provide catch up percentages for individual states. This will allow the states to evaluate the specifics of previous rate increase approvals and whether to apply catch up percentages .

Regarding # 8, we agree with having a solvency provision for state consideration but it should be separate from the basic analysis.

In addition to the recommendations in the attached, it would be helpful for states to have a clear understanding of how the MSA team arrives at a recommended increase so that each state can determine whether the recommendation complies with their regulatory requirements and have the ability to apply the same approach to other filings to ensure consistency. This would be especially helpful when considering multiple filings from the same insurer.

Thank you,
Julie

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Confidential

From: King, Eric <EKing@naic.org>
Sent: Sunday, March 17, 2024 10:36 AM
To: King, Eric <EKing@naic.org>
Subject: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due May 3

To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties

The Working Group requests comments on the Minnesota Approach with any suggested adjustments as a candidate for a Single LTCI Multistate Rate Review Approach. The Minnesota Approach is described here: https://content.naic.org/sites/default/files/documents/ltci-msa-framework.pdf

Suggested adjustments should be related to the concepts contained in the attached recommendation on a single MSA actuarial approach after regulator feedback document.

Please provide comments to eking@naic.org by Friday, May 3.

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Genworth Life Insurance Company & Genworth Life Insurance Company of New York
Response to MSA Single Method Exposure Draft
May 3, 2024

Executive Summary

The promulgation of a single MSA methodology, if accompanied by detailed and comprehensive implementation guidance, provides the opportunity for additional clarity and predictability for both industry and regulators in how to manage inforce business going forward.

This submission of comments on the Exposure Draft does not constitute either agreement with the principles of the current Minnesota Method, nor endorsement of the Minnesota Method as the final single methodology. Our purpose is to provide feedback based on Genworth Life Insurance Company's and Genworth Life Insurance Company of New York's (collectively, "Genworth" or the "Company") experience, to request clarification where needed, and to recommend adjustments that may benefit all stakeholders.

While Genworth appreciates the opportunity to provide specific methodology suggestions, lack of sufficient detail in the existing MSA Framework guidance makes it difficult to create a reliable baseline from which to establish any modeling or quantification of impact. While the Company continues to believe that a single methodology or "one size fits all" approach is not suitable for addressing all LTC rate filings across the industry, the suggestions and improvements described below would create a more predictable and sustainable methodology and provide clarity for insurers that are contemplating use of the MSA process.

If the Actuarial Working Group (AWG) intends to move to a single approach based on the Minnesota Method, it is imperative that the MSA standardize application of that method.

Genworth has experienced significant variability in approach from regulators attempting to use the Minnesota Method in recent years, as a result of guidance that has either changed over time, is unclear in its intended implementation, or otherwise introduces subjectivity that leads to widely varying results. We recommend standardization of the following components of the Methodology:

- **Weighting**. Genworth believes a single, unified weighting factor may be the most direct and transparent approach to achieve the intended cost-sharing. A comprehensive weighting should account for advanced attained ages, the age of the block, and solvency considerations.
- **Cost-Sharing**. Genworth agrees with the need for an adjustment to the final increase to provide relief for solvency considerations. The current additional cost-sharing approach, waived entirely for unspecified solvency concerns, penalizes insurers when higher increases are necessary while rewarding states that have been slow to approve past requests, both of which only exacerbate solvency risks. Introducing various types of cost-sharing at different steps in the process with undefined determinants results in adding risk to the ongoing management of inforce blocks of business due to unpredictable rate increases.
- **Solvency.** The current guidance does not provide clearly defined objective criteria for when an adjustment for solvency should be made, resulting in an unknown and arbitrary threshold when

such an adjustment is permitted or otherwise is deemed no longer necessary. The current approach could be modified to more directly address solvency considerations, such as need for future rate increases to support margin sufficiency in Cash Flow Testing (CFT).

- **Implementation Date**. The current guidance does not provide clarity on the use of an assumed implementation date for when a rate increase may take effect. As the time value of rate increases can significantly impact the value to the company, an explicit adjustment should be allowed, especially when rate reviews continue for an extended period of time past the valuation date of the projected cash flows.
- **Aggregate vs. Sample Policy Methods.** The current Framework does not describe the decisions for when each method should be used, and when circumstances would prohibit use of the Aggregate Method. As there are also no examples of how the Sample Policy Method should be applied, we have generally seen the Aggregate Method used in all situations where regulators have utilized the Minnesota Method. In absence of specific guidance, the presence of the Sample Policy Method creates the appearance of a separate methodology without clarity for when either approach is the limiting factor.
- **Discount Rate.** For current Present Values (PVs), the "average corporate bond yields" are not defined, which has led to various approaches in application. Since rate increases are requested in an effort to support margin sufficiency, use of investment returns assumed in CFT should be permitted.
- **Waiver of Premium**. The inclusion or exclusion of Waiver of Premium (WOP) benefits should be consistent with original pricing methodology. If a company included WOP as a claim benefit and grossed up premiums when setting original rates which were approved for use by a regulator, such an approach should be permissible in subsequent rate increase calculations.

If an additional modification is deemed necessary for higher attained ages, we prefer that modification occur at an aggregated, or "block," level.

The most equitable approach to providing premium increase relief for policyholders at higher attained ages is through a block-level adjustment based on an average (or median) age of the policyholders within that block, rather than differentiating rate increases based on an arbitrary attained age.

While cross-state premium equity may be desirable, a universal rate level target ignores the cost of delay and may not always be the best solution for ongoing management of a block of policies.

We encourage the focus on rate equivalence, but recognize that equal treatment of policyholders may not entail identical nationwide rate levels. We believe it's important to leave the issue of rate history and potential adjustments on the table for future discussion.

Phased approvals over multiple years when granting the full requested increase, as opposed to frequent filings with smaller approvals, best balances insurer needs with policyholder transparency.

Genworth understands the potential impact to policyholders of large increases implemented in a single year; however, timely implementation remains the most prudent approach to ensuring continued claims-paying ability, and reduces the need for additional future increases. Phased increases can frequently result in higher future increase needs, due to reduction in expected premiums combined with the aging

of the block. That being said, “pre-approving” multiple increases phased in over multiple years can at least provide some additional transparency to the policyholder when compared to smaller increases approved one at a time.

The “wait-and-see” approach of approving increases well below requested and justifiable amounts, especially when such approvals are phased, puts undue pressure on insurers and endangers the viability of the industry. So while phasing of increases can be reasonable in certain circumstances, it is not necessarily prudent universally.

Genworth Response to MSA Single Method Exposure Draft

Genworth and its predecessor companies have been issuing Long Term Care insurance policies since 1974. Through the first quarter of 2024, the Company has paid over 370,000 claims totaling $30B. Through the processing of these claims, the Company has gained significant knowledge and understanding of claim behavior.

While pursuing rate increases necessary to sustain financial viability, the Company continues to invest in people and resources to support our policyholders, with initiatives that enhance customer experience and overall well-being of our policyholders:

- Our **Stable Premium Options** offer meaningful coverage while mitigating significant portions of the rate increases, while providing a rate guarantee upon election (in some cases, offering a lifetime rate guarantee).
- Our **Coverage Needs Estimator** is an online tool that helps policyholders evaluate their potential costs of care and compare those costs to their policy benefits.
- Our **Live Well | Age Well** program offers personalized support to policyholders who may be nearing claim eligibility, with the goal of helping policyholders live healthier longer at home.
- Our **CareScout Quality Network** is a network of high-quality caregivers that offers preferred pricing for policyholders. This network is expected to be available nationwide by year-end.

Ultimately, premium rate increases remain the strongest lever available to address LTC liability experience pressures. As an industry, we must recognize that the extremely long lead time between underwriting and credible claims experience (30+ years) may result in large adjustments in premium requirements. Such experience uncertainty is exactly why LTC policies are permitted to be written as guaranteed renewable, which expressly contemplates that rates may be changed in the future due to actual experience emerging different than original pricing assumptions. Insurance pricing relies on a multitude of assumptions regarding policyholder behavior, the costs of future heath care, and future market conditions, including the interest rate environment, all of which change drastically over such long time horizons. Given the long-tail nature of the product and the guaranteed renewable regulatory framework, it is neither reasonable nor logical to impute to an insurer at the time of original pricing knowledge of how experience would unfold many years in the future.

Below please find direct responses to your eight recommendations.

1. Generally have lower rate increases for those at very advanced ages with high-duration policies that have had substantial past rate increases.

Genworth Perspective: Genworth appreciates the concern for older policyholders and recognizes that premium rate increases can be challenging for some individuals. To provide relief, the Company has developed and made available numerous policyholder alternative options that offer policyholders the ability to mitigate the impacts of a premium increase while maintaining meaningful coverage. Since 2022, rate increase requests in most cases are differentiated by both Benefit Increase Option (BIO) and Benefit Period (BP), to align the highest increases with the benefit features facing the most adverse experience.

Charging different premiums to policyholders with the same benefit features who differ only by attained age would be incredibly onerous to implement. Our systems are not built to add a new risk class not part of the original pricing, like attained age, and to differentiate premiums along these constraints. It would be costly, time-consuming, and add risk to our processes to try to add such functionality at this point in our history.

Proposed Solution: Genworth supports using Product Block as a differentiating feature that can provide relief to advanced age policyholders. As product blocks typically have finite issue years and consistent marketing, the makeup of the policyholders within a block should provide sufficient comparability that would enable an approach to targeted rate increases.

2. Do not dismiss aspects of proposals labeled as "non-actuarial" by the ACLI.

Consider all proposals made thus far regarding incorporation into a single actuarial approach.

Genworth Perspective: Genworth is committed to adhering to sound actuarial practice, as promulgated in official industry regulations as well as standard industry practice. When evaluating a methodology, it is critically important to distinguish fundamental actuarial concepts (premium sufficiency, regulation limitations on increases, rate increase impacts on solvency, etc.) from non-actuarial considerations (consumer protection, annual approval caps, cost sharing, etc.). Conflating the two perspectives can lead to misunderstandings by broader audiences about the actuarial justification or financial basis for a rate increase.

3. Balance between consumer protection and preventing further financial distress for insurers.

Genworth Perspective: Genworth appreciates the balance regulators seek to achieve as they navigate their dual mandate to protect consumers by approving fair premiums while also ensuring the claims-paying ability of insurers. We believe insurer solvency is the ultimate form of consumer protection and remains an essential part of any discussion on rate increases. And while Genworth appreciates the opportunity to comment on the current MSA methodology, the Company would like to reiterate that this response does not imply agreement with any method that employs the use of an if-knew premium for purpose of determining a rate increase that should be approved.

Genworth also understands the desire to increase the insurer's burden as cumulative rate increases rise, however, significant cost-sharing is achieved through the inherent blending with if-knew premium increases. Per requirements, assumption changes must be supported by changes in experience. Insurers are precluded from additional requests if experience doesn't change. However, if experience emerges differently than expected, this is the very circumstance for which the rate increase was intended. Through the current cost-sharing, insurers are also not permitted the full amount of the increase if experience is too unfavorable, which results in double penalty. The current cost-sharing provision also increases the insurer's burden in states that have been slower to approve past increase requests.

There is also concern for the "hidden cost-sharing" where past increases are backed out after the blending occurs. In situations where past increases are higher than the If-Knew calculation, backing out such increases after blending creates an implied negative rate increase for the If-Knew portion

(effectively a premium *reduction*). As this effect is not explicitly addressed in the MSA Framework, it becomes an additional source of unintended cost-sharing. Given that the reason for beginning the rate increase exercise is due to deteriorating experience, anything that implies a premium reduction is counterproductive and potentially invalidates the foundation of the methodology.

Proposal: Combine all types of cost-sharing into a single step to provide clarity, ease of calculation, and improved standardization. The three main concerns addressed by cost-sharing include: percentage of block remaining; attained age of policyholders; and relative solvency of the insurer. All three of these components can be combined to create a unified cost-sharing result that achieves a balance between the If-Knew portion of the rate increase and the makeup portion of the rate increase.

The current guidance lacks definition or criteria for when a carrier is eligible for unique consideration due to its solvency or financial position. Genworth believes that clear criteria, and perhaps a quantitative solvency assessment, may help achieve a more objective solution to address the dual mandate. These criteria ought to contemplate the amount of assumed future rate increases needed to support asset adequacy margin sufficiency. Additionally, criteria should be developed for when a carrier that previously received this unique consideration is no longer eligible. The impact of the solvency considerations in the current framework can be significant, and without clear guidance for gaining or losing this eligibility, carriers have significant uncertainty about the outcome of the method.

Additionally, it should be noted that the requirement of the 58/85 test as described under Rate Stabilization guidance is an additional limiter that ensures a certain level of cost sharing, where applicable. The current Framework guidance does not recognize the existing regulations on this topic.

Finally, to address the impact of the "hidden cost-sharing," past increases should be backed out of the If-Knew and Makeup portions before blending. If past increases are higher than the If-Knew increases, then the If-Knew contribution should be floored at 0%, as it is not reasonable for any methodology to suggest that a rate decrease is appropriate when regulations and experience demonstrate an increase is needed.

4. Continue including a catch-up provision in a single actuarial approach for attaining a similar rate level between states.

Align with actuarial soundness, consumer fairness, insurers' financial sustainability, and regulatory considerations.

Genworth Perspective: Genworth supports the goal of achieving cross-state premium equity. Premium equity entails, at a minimum, moving states to a similar (if not entirely equivalent) rate level. However, in some cases, it is reasonable to consider the timing and amount of past approvals across states in determining equitable premiums. If a state has had higher premiums than another state for an extended period of time, it would not always be equitable for both states to simply proceed at an equal revised future rate level going forward, as policyholders in the more proactive state would end up paying higher lifetime premiums for equal coverage. We appreciate that this is not always practical and therefore we encourage the focus to remain on rate equivalence as a first step. However, we believe it's important to leave the issue of rate history and potential adjustments on the table for future discussion. Differing rates of approvals can create a hindrance to progress, where states do not want to feel like they are

burdening their constituents when other states have been slow to approve, without the possibility of ultimate equity.

5. Continue to encourage buy-in from states on the MSA actuarial approach.

Perhaps LTC Task Force leadership could have individual meetings with states that tend to approve the lowest rate increases, providing information and addressing questions.

Acknowledge that some states that perform detailed reviews of state filings will tend to review and consider their own method and compare with the MSA recommendation; some states are committed to following the MSA recommendation. States that aren't able to perform detailed reviews are more likely to rely on the MSA.

Genworth Perspective: Genworth has seen a variety of interpretations of what states call the "Minnesota Method" with little to no consistency. The guidelines, as detailed in the MSA Framework (and AWG White Paper before it), leave room for interpretation that has led to vastly different results depending on the reviewer and their degree of subjective assessment. Guidelines should be issued with sufficient specificity such that the results of a single rate increase request filing would be equivalent no matter who reviewed it. The current approaches leave insurers with little clarity regarding the end result, which adds another layer of complexity and uncertainty to ongoing management of the policies.

For Rate-stabilized products, regulators often use the Margin for Adverse Experience (MAE) as an additional form of optional cost-sharing (similar to the solvency consideration). Multiple states have removed MAE from the calculation to determine the approved increase. If the single MSA method is intended to take the place of rate stabilization guidance when assessing rate increases, the guidance should explicitly address the inclusion of margin.

Proposal: Provide additional guidance in specific areas where subjectivity has been, or can be, introduced.

- **Margin**: develop clear guidelines on when additional margin should be included in projections. Per rate stabilization guidelines, an MAE should be included in applicable policies.
- **Waiver of Premium**: create a universal requirement to either include or exclude WOP. If a product was priced with the inclusion of WOP as a benefit, future pricing exercises should continue to include it. Removing WOP in subsequent pricing of increases creates an additional aspect of implicit cost-sharing.
- **Discount Rate**: For current PVs, the "average corporate bond yields" are not defined, which has led to various approaches. The most common approach is to use the same rate for both "original PV" and "current PV", defaulting to the rate used in original pricing for all discounting. If a different rate is in fact a requirement, a more specific and relevant rate should be permitted. Since rate increases are requested in an effort to support margin sufficiency, use of investment returns assumed in Cash Flow Testing should be permitted to meet such requirement.
- **Aggregate vs. Sample Policy Methods**: The current Framework does not describe when each method should be used. No examples of how the Sample Policy method should be applied are included in the Framework. As a result, the Aggregate Method is the only method we've seen used (including in our most recent MSA filing submission). Within the Sample Policy Method, the concept of "profit" is not fully defined and provides no guidance on how it could be derived. If

there are unique situations when such a method should be deemed necessary, the implementation guidance should spell out such criteria and illustrate with examples.

- **Implementation Date**: As detailed in the White Paper, "delays in implementing actuarially justified rate increases due to either a carrier failing to file a needed rate increase, or delays in the regulatory approval of a needed rate increase, can pose a potential solvency risk." Insurers should be permitted to use a likely implementation date in the projections, and update the implementation date for prolonged rate review timelines to avoid additional financial strain and more closely mimic the impact of the rate increases.

  The following example, based on a recent filing, uses the MSA Framework Template to Illustrate the impact of moving the implementation date (valuation date discounting) forward one year. In our experience, the lag between the data used in a given filing to the ultimate approval and implementation of the rate increase is well over the single year shown in this simplified example. As demonstrated below, the impact of a 1-year delay in implementation has a material impact on the result of the calculation. Such adjustments should be explicitly permitted within the MSA guidance.

MSA Framework Methodology Steps	2022 Implementation	2023 Implementation
(1) If-Knew Rate Increase (Since Issue)	127.20%	127.20%
(2) Make Up (Standard Solve)	1185.60%	1305.80%
(3) Percentage of Issued Policies Inforce	56.80%	56.80%
Blended RI = {2} * {3} + ({1} * (1-{3}))	**728.70%**	**797.00%**
Include Cost Sharing Provision	**492.70%**	**537.10%**
- Cumulative Rate Increase to Date	239.20%	239.20%
LTC MSA Framework Blended If Knew With Cost-Sharing	**74.70%**	**87.8%**

6. Pre-approve and phase in rate increases over a reasonable period of time as opposed to requiring annual re-filings.

Part of the reason is pre-approved phased-in rate increases transparently enable policyholders to make well-informed decisions about their LTC policy based on the most likely future rates.
Also, pre-approved phase-ins eliminate work effort for companies and regulators that often provides little value.

Genworth Perspective: For larger increases, Genworth believes it is sometimes reasonable, though not always preferable, to phase increases in over a number of years (usually two to three years) if the regulator chooses to approve on that basis. This approach works best when there is agreement between the company and regulator that future filings are not planned, meaning a sufficient approval is being granted to prevent an immediate refiling. Otherwise, phasing causes unnecessary delays in future filings, driving up the ultimate level of increase needed to achieve a similar financial impact if implemented immediately.

7. If-knew weighting and additional cost-sharing considerations

Study impacts on rates and solvency of various weights (including the Utah proposal) as well as the potential effects of eliminating an explicit cost-sharing provision.

Proposal: To provide a clear and consistent approach, we recommend a combined cost-sharing calculation that accounts for age of the block, attained age of the policyholders, and solvency considerations. The current weighting methodology results in an immediate and drastic convergence between the much lower If-Knew premium level based solely on the aging of the block. This adjustment should be made more gradual, and combined with an adjustment for higher attained ages, since the two concepts are also frequently highly correlated. A final adjustment can be made for solvency considerations, where a rate increase is adjusted either up or down based on the value of future rate increases needed to support margin.

Genworth would appreciate the opportunity to model various scenarios and approaches and propose more concrete formulas. However, additional clarity on the baseline Framework are necessary before modeling such approaches.

8. Maintain the flexibility of having a solvency provision but continue having the application be very rare.

Proposal: While a solvency provision can provide relief for insurers that rely heavily on future rate increases for financial sustainability, a subjective assessment for when such a provision applies creates a challenging position for management of the block. A more consistent, fair, and predictable approach would be to embed an adjustment for solvency considerations into the unified cost-sharing calculation. Applying such a factor based on objective financial criteria avoids a sudden impact when the provision is deemed no longer applicable based on a subjective assessment that can vary from one review to the next, and creates a fairer environment for an adjustment that can be used consistently across all insurers.

Recommendation on a single MSA actuarial approach after regulator feedback:

Recommendations based on apparent consensus:

1. Generally have lower rate increases for those at very advanced ages with high-duration policies that have had substantial past rate increases.

   Appropriate implementation to avoid administrative and discrimination concerns may be to adjust the method for older blocks (which tend to have older policyholders that have been subject to substantial past rate increases) instead of differentiating rate increases by age within a block.

   Recognize that high-duration policyholders have:

   - tended to have the most benefit from what proved to be underpricing due to the number of underpriced premiums paid;
   - tended to have been the most surprised by the magnitude of cumulative rate increases compared to any that could have been expected when the policy was issued.

2. Do not dismiss aspects of proposals labeled as "non-actuarial" by the ACLI.

   Consider all proposals made thus far regarding incorporation into a single actuarial approach.

3. Balance between consumer protection and preventing further financial distress for insurers.

   Further analysis may be necessary to assess certain attractive proposal aspects how they maintain this balance.

4. Continue including a catch-up provision in a single actuarial approach for attaining a similar rate level between states.

   Align with actuarial soundness, consumer fairness, insurers' financial sustainability, and regulatory considerations.

5. Continue to encourage buy-in from states on the MSA actuarial approach.

   Perhaps LTC Task Force leadership could have individual meetings with states that tend to approve the lowest rate increases, providing information and addressing questions.

   Acknowledge that some states that perform detailed reviews of state filings will tend to review and consider their own method and compare with the MSA recommendation; some states are committed to following the MSA recommendation. States that aren't able to perform detailed reviews are more likely to rely on the MSA.

6. Pre-approve and phase in rate increases over a reasonable period of time as opposed to requiring annual re-filings.

Part of the reason is pre-approved phased-in rate increases transparently enable policyholders to make well-informed decisions about their LTC policy based on the most likely future rates.

Also, pre-approved phase-ins eliminate work effort for companies and regulators that often provides little value.

Recommendations, but split views among regulators:

7. If-knew weighting and additional cost-sharing considerations

   Study impacts on rates and solvency of various weights (including the Utah proposal) as well as the potential effects of eliminating an explicit cost-sharing provision.

8. Maintain the flexibility of having a solvency provision but continue having the application be very rare.

Long-Term Care Insurance
An Actuarial Approach to Rate Increases

The MSA "method" has an overriding fatal characteristic: it is non-actuarial. This has been documented a number of times by the American Academy of Actuaries ("**AAA**").

This article refers to Long Term Care ("**LTC**") insurance policies. The primary objective is to use actuarial methods to determine if a rate increase is justified. Regulations are based on Loss Ratios. We should also realize that a policy form will probably have several classes. Classes need to be split if the selections are optional. The intent is to make sure the less expensive classes are not subsidizing the more expensive classes.

Whether Pre-Rate Stability or Post-Rate Stability, separate classes exist depending on the:

A) Policy Form: the initial rate filing defines the loss ratio ("**L/R**") for the entire form, but a policy form is usually not a single class. Loss ratios for different classes within a policy form will need to be calculated.

B) Premium Classes
   I) Premium-paying-period: L/R's differ by paid-up option, for example: Single-Pay, 10-Pay, Paid-up at Age 65, and Lifetime Pay are four different classes
   II) Survivorship: premium classes differ based on the Survivorship option; for example: lifetime-pay with survivorship and lifetime-pay without survivorship are two different classes
   III) Number of lives: single-life and joint-life are two different classes.

C) Benefit Classes
   I) Federal tax qualified ("**TQ"**): Yes, No and Pre-TQ are three different classes
   II) Coverage: Facility-only, Home-Care only and Comprehensive are three different classes
   III) Indemnity vs. Reimbursement: these are two different classes
   IV) Restoration of Benefits ("**ROB**"): with and without ROB are two different classes (note: commercial valuation systems assume all policies have ROB, thus, the liabilities for policies without the ROB benefit are often overstated).

D) Benefit Options
   I) Unlimited (or Lifetime) Benefit Period: benefit periods of 10 or more years could be merged with the Unlimited Benefit Period
   II) 5% Compound Inflation Protection option.

   These two classes are generally the most expensive options. Segregation of these classes allows the reviewer to ascertain that these two classes are not heavily subsidized by less expensive classes.

E) Rate Increase: Classes are separated by their initial filing and any approved rate increase.

All combinations of A) through D) should be considered separate classes if the choices are optional.

Initial Points Re: Rate Increase Filings

I) Pre-Rate Stability: The L/R for any rate increase filing cannot be less than the prior rate increase filing.
II) Post-Rate Stability: The L/R for any rate increase filing cannot be less than the prior rate increase filing or 85%.

First Rate Increase: Intro

Classes should be calculated individually and in total (for the form). With the first rate increase, two initial L/R's should be calculated for each class:

I) The expected L/R based on the assumed distribution of sales
II) The expected L/R based on the actual distribution of sales.

The minimum initial L/R should be the greater of these two. This prevents a company from intentionally misrepresenting the expected L/R, or, more likely, not getting the distribution they were hoping for.

The Margin for Adverse Experience ("**MAE**") (minimum of 10%) should be included with all initial filings to help avoid rate increases. The MAE should not be added to any rate increase filings.

For a rate increase filing: in-force policies that are paid-up (that is, the policies for which no further premium is due) should not be included. Paid-up policies are now the responsibility of the company and any premium deficit of paid-up policies cannot be charged to the premium-paying policyholders.

For each policy form, if any class has less than 5% of the total number of in-force policies, that class is immaterial. The rate increase for any immaterial class should be determined by the similar material class.

First Rate Increase

For the first rate increase and for each class, there will be two projected premium streams: the initial premium and the premium for the rate increase. The initial premium will have a historical portion and a projected portion. Similarly, claims will have historical claims and two pieces for the projection: claims that were initially projected and the additional claims from the new assumptions. For the Active Life Reserves (**ALR**), most companies do not change their reserve factors, yet the reserves will still change due to: 1) the new projection, 2) if the requested rate increase is adjusted, and 3) policyholder behavior.

From the projected premiums and claims, new L/R's may be calculated for each class and in total. A new maximum L/R may be calculated using:

1) the original loss ratio and the anticipated premium from the original premium
2) the projected rate-increase premium and its associated L/R (this L/R will not be less than 80% for pre-Rate Stability and 85% for post-Rate Stability).

Overview

For any rate increase, there will probably be several classes. For each class, there will be separate premium streams for the initial premium and each rate increase. Each premium stream will have its own loss ratio requirement, so each premium stream must be kept separate. The loss ratio is determined by the filing (initial or rate increase). From rate-increase filing to rate-increase filing, the L/R cannot decrease. To keep rate increases to a minimum, rate increases should not be delayed – this is the company's responsibility.

For all premium streams: the proposed rate increase will be affected by policyholder behavior. Policyholder behavior will lead to additional lapses and reduced premiums and liabilities due to benefit reductions.

For each premium stream (initial, first rate increase, second rate increase, …) the accumulated premium and L/R may be used to calculate the overall loss ratio. For each class and the total: if, after the requested rate increase, the loss ratio is too low, the requested rate increase may need to be adjusted downward.

L/R Calculations for the Rate Increase

Within each material class, there will be premium streams associated with the initial premium and each rate increase. For each prior rate increase there is a historic L/R and a new L/R associated with the current rate increase. Applying these L/Rs to each associated premium stream provides the minimum loss ratio for the class. The rate increase may be adjusted downward if the L/R after the proposed rate increase is too low.

Calculations for Surplus

For each class, the "surplus" (ALR + PVF Premium – PVF Claims – PVF Expenses) (**PVF** = Present Value of Future) may be calculated, and summed for all classes. Overall surplus for the product may be analyzed to determine if the rate increase needs further adjustment.

Each premium stream will be divided by historical and projected. The projected premiums will be impacted by the proposed rate increase with expected shock lapses and expected benefit reductions. ALR should be calculated before the rate increase, after the rate increase, and after the adjusted rate increase (Note: the ALR before and after the rate increase are usually the same as companies do not usually change the ALR factors due to the rate increase – the ALR is usually changed only due to policyholder behavior, and policyholder behavior changes only: 1) due to the rate increase and 2) any adjustment that is made to the rate increase). These will be used to calculate the surplus for each class, and in total for the filing.

ALR

New assumptions affect the premium and should also impact the ALR. However, most companies do not change the ALR factors due to a rate increase. The thought is that the new premiums and the current ALR should be sufficient for the block of business. However, in many cases, the present value of the premium and the ALR is not sufficient for the block of business. This should be analyzed to determine if the rate increase needs to be larger (perhaps as large as the requested rate increase, but not larger than the requested rate increase) to make the block sufficient.

L/R's Cannot Decrease

A decreasing L/R is somewhat related to Bait and Switch. What would be easier than to sell a product with a high L/R and then rate increase the policies to a low L/R as policyholders attain age 80 -- forcing policyholders to lapse just before the average age of claim.

Similarly, some companies may have a high expected L/R and give a "partial" rate increase to lower the L/R and then give another rate increase to further lower the L/R. This process is unfair to the policyholder as the final rate is higher than if the first rate increase had been given. If a policyholder must lapse due to inability to afford, they should have early knowledge so that they can lapse sooner rather than later.

Post-Rate Stability

During the 1990's, a number of agent-owned companies were selling LTC benefits. Many of these companies began their sales in Florida, with an aging population. Often, these companies utilized quick issuance and paid their claims rapidly: features often advertised to the public. These actions encouraged the public to apply for their policies. One of the more prominent carriers was known for approving applications that had been disapproved by non-agent owned companies. The initial premium rates were very competitive. This company began a habit of giving a rate increase in the second policy year, and paying a first-year commission on the rate increase. Many agents accepted this policy, feeling fully compensated because they were paid a full commission on the initial premium and the premium increase. Unsuspecting policyholders were surprised by the rapid rate increase. Understandably, these rapid rate increases led to many complaints at various state Departments of Insurance ("**DOI**").

Rate Stability was enacted to solve this issue. The primary impact was the minimum 85% L/R requirement for any rate increase. Long-term care is an expensive product for companies to administer. With a loss ratio of 85%, an expense ratio of 10 - 12% and premium taxes of 2-3%, companies could have little expectation of making a profit on their LTC product. Thus, to make a profit, a company could not have an initial 'loss leader' premium and follow that with a large rate increase to create the profit.

Initial Premiums Prior to "Rate Stability" Regulations

In the early days of LTC, there was very little experience to draw upon for expected claim costs. Most experience assumptions came from Medicare policies. With hindsight, we now realize that Medicare policies understated the claim period and overstated the lapse and mortality rates. As data was collected from LTC policies, these differences were recognized – and the data improved over time. The needs for LTC data updates continues.

In the 1990's average issue ages were often in the 70's. As tax-qualification was approved, carriers were aware that lapse rates appeared to be overstated, and claims were beginning to look higher than expected. Unfortunately, the carriers delayed rate increases because they did not want to give rate increases to the elderly without being assured of the adverse data trends. By the time that Rate Stability became regulations, the need for rate increases was formally realized by most carriers. As the carriers began to file rate increases, the state DOI's also were against raising rate for the elderly. Thus, rate increases were doubly delayed, leading to larger rate increases due to their late filings and later approval. Today, there are cumulative rate increases that exceed 500%.

Actuarial Equivalency

LTC policies build a large ALR. The ALR is calculated with the initial policy premiums is funded with policyholder premiums (and not with the company's monies).

Generally, lapses are regarded as being due to policyholder circumstances. However, as rate increases become very large, policyholders cannot be expected to continue to afford the rate increases. On the positive side, policyholders continue to realize the value of their policy and try to keep them in-force, although often with lowered benefits as they cannot afford the premium for the benefits they originally purchased. When the policyholders lower their benefits, their ALR is reduced as well. However, since the policyholders funded the reserve, the reserve should belong to the policyholders. When policyholder benefits are lowered, the decrease in reserve should be used to fund the benefits that remain (termed "actuarially equivalent"). Today, this is not required in the model regulations (although some states may require the reserve decrease to be used for the remaining policyholder benefits). In states where Actuarial Equivalency is not required, companies are permitted to do whatever they want with the reserve decrease.

An example of Actuarial Equivalency is when a policyholder is allowed to lower their Inflation Protection option going forward (the current benefit level is not reduced), and accept a lower Inflation Protection interest rate going forward . . . and their premium is not increased. An example is:

> A block of business has a 5% Compound Inflation Protection interest rate and an ALR of a billion dollars. An offer to lower the Compound Inflation Protection interest rate (going forward) from 5% to 3% might be made so that the policyholder's premium does not increase. This is generally termed a Landing Spot (where the going forward inflation protection interest rate is lowered from the original interest rate to a "Landing Spot" [in this example, the 5% initial Inflation Protection Interest Rate is lowered, for future policy years, to 3%]). For all policyholders with the 5% inflation protection interest rate, the current reserve is a billion dollars. If all the policyholders choose the Landing Spot, the reserve is lowered from $1,000,000,000 to $600,000,000. Without Actuarial Equivalency, the decrease in the reserve ($1,000,000,000 - $600,000,000 = $400,000,000) is given to the company to do whatever they want with the $400,000,000. With Actuarial Equivalency, the initial reserve for the Landing Spot should be the current reserve of $1,000,000,000.

In the example, Actuarial Equivalency increases the Landing Spot from 3.0% to 3.5%, the carrier's reserve did not change, and the policyholders were able to use the entire reserve (that they funded with their prior premiums). Similarly, for any group that reduces their benefits, the accompanying

reserve reduction could be used to decrease the benefit reduction, giving the policyholder the benefit of their prior funding of the ALR.

At a minimum, for Actuarial Equivalency, the company should hold the reserve reduction as a separate amount. The amount should increase with investment earnings and be used to lower any future rate increase.

Today's Regulatory Environment

LTC carriers are removing themselves from the LTC marketplace. There were some early mistakes (no LTC data, carrier delay of filing a rate increase). But these have, for the most part, been rectified. However, some states continue to delay rate increase approval. Although carriers see the need for the product as the population ages, they tend to view LTC as a product where they cannot make a positive return. Thus, many, if not most carriers, are no longer accepting new sales. It appears there are no new carriers entering the marketplace.

Rate Increase Variance by State

State differences in regulations and definitions affect premium rate increase filings. Past history of some states approving all or a majority of rate increase filings versus states that either deny or approve only a small portion of the requested rate increase has resulted in large variances in premiums on a state by state basis. Policyholders in one state could be paying significantly more or less than policyholders with the exact same coverage in a different state. Companies are striving to achieve the same L/R in all states taking into consideration prior rate increase filings and the large variances that are the result of state approvals or disapprovals. The goal to achieve level rates across all state is neither reasonable nor actuarial.

Solutions to a Necessary, but Rapidly Dying, Product

We need insurers – but they are a dying breed. Consumers need a way to pre-fund potential long-term care services and expenses. We should work towards a solution that works for both the public and the carriers.

Arscott, Erin

From: Gaines, Ned (OIC) <Ned.Gaines@oic.wa.gov>
Sent: Thursday, July 18, 2024 12:52 PM
To: King, Eric
Cc: Kropelnicki, Jenny; Kreidler, Mike (Cmrs. Private)
Subject: RE: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due August 1

Hi Eric,

On behalf of Commissioner Kreidler please see Washington's comments below. Please let me know if you have any questions.

Regarding the Minnesota Approach with adjustments to haircut percentages or cumulative rate increase ranges of the cost-sharing formula; we don't have an issue with the percentages outlined in the MSA rate review proposal. Our concern is that the Minnesota approach considers some recoupment of past losses via rate increases for current policyholders. Past losses are almost entirely from people who are on claim and thus not paying premiums. Charging current policyholders for those losses puts the burden on the wrong people and appears to violate actuarial standards.

Thank you.

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

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From: King, Eric <EKing@naic.org>
Sent: Tuesday, July 2, 2024 11:53 AM
To: King, Eric <EKing@naic.org>
Subject: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due August 1

External Email

To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties:

The Working Group requests comments on the Minnesota Approach with adjustments to haircut percentages or cumulative rate increase ranges of the cost-sharing formula as a candidate for a Single LTCI Multistate Rate Review Approach. The adjustments are intended to increase cost-sharing burden for the company where cumulative rate increases are very high (which tends to be the case for higher-age policyholders, higher-duration policies) and potentially decrease cost-sharing burden for the company for lower-duration policies.

The Minnesota Approach, including the current cost-sharing formula, is described here:
https://content.naic.org/sites/default/files/documents/ltci-msa-framework.pdf

Please provide comments to eking@naic.org by Thursday, August 1.

July 23, 2024

Fred Andersen, Co-Chair
Paul Lombardo, Co-Chair
Long-Term Care Actuarial (B) Working Group (LTCAWG)
Long-Term Care Insurance (B) Task Force
National Association of Insurance Commissioners (NAIC)

Via email: eking@naic.org

Re: Minnesota Approach as a Candidate for a Single Long-Term Care Insurance (LTCI) Multistate Rate Review Approach

Dear Co-Chairs Andersen and Lombardo,

On behalf of the American Academy of Actuaries' (Academy)[1] Long-Term Care (LTC) Committee (Committee) we offer the following comments in response to your July 2 request for comments on the Minnesota approach by the NAIC's LTCAWG:

> The Working Group requests comments on the Minnesota Approach with adjustments to haircut percentages or cumulative rate increase ranges of the cost-sharing formula as a candidate for a Single LTCI Multistate Rate Review Approach.[2] The adjustments are intended to increase cost-sharing burden for the company where cumulative rate increases are very high (which tends to be the case for higher-age policyholders, higher-duration policies) and potentially decrease cost-sharing burden for the company for lower-duration policies.

Non-Actuarial Considerations

In evaluating the Minnesota approach, the Committee notes that the method includes both actuarial and non-actuarial considerations. The April 2022 LTCI Multistate Rate Review (MSA) Framework includes several paragraphs regarding non-actuarial considerations in Section V.F. ("Non-Actuarial Considerations"):

> The Long-Term Care Insurance (EX) Task Force continues to review and consider non-actuarial considerations affecting 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:

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

[2] https://content.naic.org/sites/default/files/documents/ltci-msa-framework.pdf

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1. Caps or limits on approved rate changes.
2. Phase-in of approved rate changes over a period of years.
3. Waiting periods between rate change requests.
4. Considerations of prior rate change approvals and disapprovals.
5. Limits or disapproval on rate changes based solely or predominately on the number of policyholders in a particular state.
6. Limits or disapproval on rate changes based on attained age of the policyholder.
7. Fair and reasonableness considerations for policyholders.
8. The impact of the rate change on the financial solvency of the insurer.

As these items are based on pragmatic considerations, rather than mathematical principles of actuarial science, defining them as "actuarially justified" seems inappropriate. Of particular concern to the Committee are comments cited in the minutes of the February 20, 2024, LTCAWG Virtual Meeting:

> (Co-Chair) Andersen said the general consensus received from Working Group members and regulators is to not dismiss aspects of proposals labeled as "non-actuarial" by the American Council of Life Insurers (ACLI), and that the Working Group should consider all proposals made thus far regarding incorporation into a single actuarial approach. Lombardo said he has received feedback from regulators that these should be considered new actuarial techniques and not necessarily non-actuarial. He said going forward, such things can be considered actuarial in nature even if historically they were not.

The Committee would be very interested in learning more about any new actuarial techniques being proposed for use in LTC rate regulation. However, we do not believe that applying retrospective modifications to existing rate regulation of in-force policies, solely for the purpose of reducing actuarially determined rate increases on certain subsets of insureds, can be considered a purely actuarial approach. It is not clear which specific subsets of insureds will be affected, or whether these represent appropriate classes of insureds under the filed premium rate structure of the policies. Overall, we believe that designation of an item as being "actuarial" in nature should be based on mathematical principles of actuarial science, not policy or pragmatic considerations.

As stated in our October 8, 2021, comment letter,

> We believe that the Minnesota approach embeds implied policy decisions that are not actuarial in nature. While the calculations themselves may require actuarial methods, … the approach embeds non-actuarial considerations that seek a "fair and reasonableness consideration," the level of which is not clearly defined. Also, as the approaches labeled "if-knew / makeup approach" and "cost-sharing formula" are public policy decisions that are not specified in adopted model law, defining them as "actuarially justified" seems inappropriate.

It is not clear how moving to a single approach will address the above concerns. The MSA Review is a recommendation only, as an individual state retains the ability to perform additional analyses after receiving the report. Should a single approach be adopted for the MSA Review, it is the Committee's strong recommendation that the approach be based on actuarial fundamentals. Should an approach that entails comparing multiple methods be used, clear guidance that helps guide regulators to determine the best method for a given filing must be developed.

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Working Group Recommendations

As the Committee reviewed the February 2024 exposure, "Recommendation on a single MSA actuarial approach after regulator feedback," we offer the following comments on considerations No. 1 to No. 7:

RECOMMENDATION BASED ON APPARENT CONSENSUS:

1. **Generally have lower rate increases for those at very advanced ages with high-duration policies that have had substantial past rate increases.**

   Appropriate implementation to avoid administrative and discrimination concerns may be to adjust the method for older blocks (which tend to have older policyholders that have been subject to substantial past rate increases) instead of differentiating rate increases by age within a block.

   Recognize that high-duration policyholders have:

   - **tended to have the most benefit from what proved to be underpricing due to the number of underpriced premiums paid;**
   - **tended to have been the most surprised by the magnitude of cumulative rate increases compared to any that could have been expected when the policy was issued.**

Committee Comments: It is not clear exactly how the Minnesota Approach would be adjusted to get to the "appropriate implementation." We recommend that any concrete proposal take into account the provisions of ASOP No. 12, *Risk Classification*.

2. **Do not dismiss aspects of proposals labeled as "non-actuarial" by the ACLI.**

   Consider all proposals made thus far regarding incorporation into a single actuarial approach.

Committee Comments: Please see our comment above regarding Non-Actuarial Considerations.

3. **Balance between consumer protection and preventing further financial distress for insurers.**

   Further analysis may be necessary to assess certain attractive proposal aspects how they maintain this balance.

Committee Comments: We recognize that the method and framework may include both actuarial and non-actuarial components to address consumer protection concerns and prevent further financial distress for insurers. Please see our comments above regarding Non-Actuarial Considerations.

4. **Continue including a catch-up provision in a single actuarial approach for attaining a similar rate level between states.**

   Align with actuarial soundness, consumer fairness, insurers' financial sustainability, and regulatory considerations.

Committee Comments: We agree that a catch-up provision is appropriate to address disparities across states. However, using a catch-up provision which looks solely at current rate equity does not consider historical state regulatory decisions. This would include scenarios where a company may have filed for an appropriate rate increase and the request was denied or limited in approval. By considering only the current rate, an unintended consequence could result that encourages states to delay approving rate increases.

5. **Continue to encourage buy-in from states on the MSA actuarial approach.**

   Perhaps LTC Task Force leadership could have individual meetings with states that tend to approve the lowest rate increases, providing information and addressing questions.

   Acknowledge that some states that perform detailed reviews of state filings will tend to review and consider their own method and compare with the MSA recommendation; some states are committed to following the MSA recommendation. States that aren't able to perform detailed reviews are more likely to rely on the MSA.

Committee Comments: We agree with the goal to encourage buy-in from states, leading to greater consistency and predictability of LTC rate regulation across more jurisdictions. It is not clear from the description how much state regulatory buy-in will increase by limiting the MSA Review to a single methodology. As noted in our previous comments on the MSA from October 2021:

> Insurers may want to file rate increase requests in non-participating states concurrently with the MSA Review filing so that the insurer does not needlessly delay the filing and review process in non-participating states. It is unclear if and how insurers will know which states are Participating States in the MSA Review, and whether states will decide on participation in the MSA review each time any rate increase request is submitted.

A growing number of states now ask about the Texas/PPV and Minnesota Methods in their own reviews. If the LTCAWG introduces additional policy decisions into the methodology, it is possible that this will have a more significant impact beyond filings submitted through the MSA and participating states alone. This reinforces the need for clear guidance about what is a non-actuarial/policy decision, so that these states know this when asking for information outside of an MSA rate review.

6. **Pre-approve and phase in rate increases over a reasonable period of time as opposed to requiring annual re-filings.**

   Part of the reason is pre-approved phased-in rate increases transparently enable policyholders to make well-informed decisions about their LTC policy based on the most likely future rates.

   Also, pre-approved phase-ins eliminate work effort for companies and regulators that often provides little value.

Committee Comments: We agree with these comments. The Committee would note, as we did in our July 26, 2021, comment letter, that phasing-in a rate increase should ordinarily result in ultimate rates higher than if a single actuarial equivalent rate increase were implemented. Additionally, it is not clear, under a phased-in approach for an increase with the catch-up provision, which would take precedence: ensuring similar rate levels or actuarial equivalence of the proposed rate increase. If the latter, the ultimate rate level would be higher for states where the catch-up provision has been applied.

RECOMMENDATIONS, BUT SPLIT VIEWS AMONG REGULATORS:

7. **If-knew weighting and additional cost-sharing considerations**

   Study impacts on rates and solvency of various weights (including the Utah proposal) as well as the potential effects of eliminating an explicit cost-sharing provision.

Committee Comments: It is not clear exactly how the weights or cost-sharing in the Minnesota Approach would be adjusted. We recommend that any concrete proposal take into account the provisions of ASOP No. 12, *Risk Classification*.

*****

The Committee welcomes the opportunity to speak with you in more detail and answer any questions you have regarding these comments on finding a single MSA approach. If you have any questions or wish to discuss these comments further, please contact Matthew Williams, the Academy's senior health policy analyst (williams@actuary.org).

Sincerely,

Andrew Dalton, MAAA, FSA
Chairperson, LTC Committee
American Academy of Actuaries

CC: Eric King, Health Actuary, NAIC

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RE: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due August 1

Reply | Reply All | Forward

LW Leung, William <William.Leung@insurance.mo.gov>
To King, Eric
Cc Rehagen, John; LeDuc, Jo; Murrah, Chris; Lombardo, Paul; Andersen, Fred

Thu 7/25/2024 4:27 PM

You replied to this message on 7/25/2024 6:23 PM.

Single Formula example 2.xlsx
.xlsx File

Good afternoon Eric,

Missouri is supportive of the development of a single MSA actuarial approach exposed and believe the following adjustments will be appropriate:

a) The cumulative rate increase should be no more than 600% after all the adjustments and cost sharing.

b) Each rate increase filing should not increase the cumulative rate increase by more than 100% from that of the current rate.

Adjustment a) can be achieved by increasing the cost sharing when cumulative rate is more than 500%. For example, increase the cost sharing from 50% to 90% when CRI exceeds 500% and further increase to 95% when CRI exceeds 1000%. The cost sharing is increased to 100% when CRI exceeds 5000%.

Potential Cost-Sharing Formula for Typical Circumstance Cumulative Rate Increase (CRI) since issue date is haircut by:								
		Current				Propose		
		100000%				100000%		
CRI	Hair cut	Applicable CRI	with Hair cut		CRI	Hair cut	Applicable CRI	with Hair cut
15%	0	15%	15%		15%	0	15%	15%
50%	10%	35%	32%		50%	10%	35%	32%
100%	25%	50%	38%		100%	25%	50%	38%
150%	35%	50%	33%		150%	35%	50%	33%
300%	50%	150%	75%		300%	40%	150%	90%
500%	50%	200%	100%		500%	50%	200%	100%
1000%	50%	500%	250%		1000%	90%	500%	50%
5000%	50%	4000%	2000%		5000%	95%	4000%	200%
100000%	50%	95000%	47500%		100000%	100%	95000%	0%
CRI allowed		100000%	50042%		CRI allowed		100000%	557%

Below is an example of the result from a recent filing where the blended cumulative rate increase was 3811%:

		Propose	
		3811%	
CRI	Hair cut	Applicable CRI	with Hair cut
15%	0	15%	15%
50%	10%	35%	32%
100%	25%	50%	38%
150%	35%	50%	33%
300%	40%	150%	90%
500%	50%	200%	100%
1000%	90%	500%	50%
5000%	95%	2811%	141%
100000%	100%	0%	0%
CRI allowed		3811%	497%

Incidentally, the adjustment above also lowers the hair cut from 50% to 40% when the cumulative rate increase is >150% and <=300%. This is one of the desired feature in the request attached to the exposure.

Adjustment b) is demonstrated below using the details in the development of the maximum allowable rate increase from a recent MSA filing.

Minnesota (Blended if-Knew/Make-up) Approach	current	Propose
Loss ratio at the original premium level	61.5%	61.5%
Minimum loss ratio applicable to the form	60%	60%
If Knew Increase	142%	142%
Make-up increase	10153%	10153%
Remaining policyholders percentage	37%	37%
Blended increase	3811%	3811%
Cost sharing increase	1947%	1947%
Past rate increase	514%	514%
Cumulative rate increase limited to 100% ORI		614%
Rate Increase under MN approach in % of CR	233%	16%
Max Justified Rate Increase = (1+MUI)/(1+PRI)-1	1571%	1571%
Maximum allowable rate increase	233%	16%

These two changes fit in very well with the current framework.

The examples used are real life examples. I can change the numbers if you see there is any potential confidentiality conflicts.

An excel spread sheet is included for easy testing of or modification to these changes.

Genworth Life Insurance Company & Genworth Life Insurance Company of New York Response to Request for Comment on Rate Increase Cost-Sharing August 1, 2024

The Working Group requests comments on the Minnesota Approach with adjustments to haircut percentages or cumulative rate increase ranges of the cost-sharing formula as a candidate for a Single LTCI Multistate Rate Review Approach. The adjustments are intended to increase cost-sharing burden for the company where cumulative rate increases are very high (which tends to be the case for higher-age policyholders, higher-duration policies) and potentially decrease cost-sharing burden for the company for lower-duration policies.

As outlined in the letter submitted May 3, 2024, Genworth believes that additional clarity and detail is needed regarding the existing MSA Framework to properly consider a proposal for a single methodology. Specifically, the areas regarding weighting, cost-sharing, solvency, discount rate, and the use of the sample policy method vs. the aggregate method lack sufficient detail to properly assess the methodology as a predictable and reliable approach. Genworth appreciates that discussion is ongoing for many of these open items and submits the following comments on the current exposure as a continuation of our previous comments.

Genworth would like to further demonstrate the impacts of the various elements of cost-sharing with an example, and a proposed refinement. Below is a walkthrough of a theoretical example of a pre-Rate Stability product with a history of past rate increases. These examples demonstrate the impacts of the various elements of cost-sharing with the use of two different approaches to dealing with prior cumulative rate increases, which has been a source of confusion in applying the MN method historically. It is Genworth's intention that these examples will highlight the extent to which differing interpretations of these various factors can affect the final outcome, emphasizing the need for the requested clarity in the method.

The below assumptions and cash flow modeling approaches are key components that influence the outcome of the Minnesota method. Genworth has historically handled these components as follows and many regulators have accepted this interpretation as an acceptable application of the Minnesota Method.

- Discount Rate: A 4% discount rate is utilized, consistent with the Statutory Valuation rate a typical pre-Rate Stability block might see during issuing years and loss ratio regulation guidance, to not receive additional rate increase relief due to changes in interest rates.
- Margin for Moderately Adverse Experience (MAE): As the example shown is based on a pre-Rate Stability (RS) product, the projections do not include margin for MAE. MAE would be expected to be included on all post-RS products, as expressly required by model regulation.
- Aggregate Method: While the MSA Framework details two potential approaches, it is our experience that the Aggregate Method (as opposed to the Sample Policy Method) is more straightforward and widely understood. We do not believe that the Sample Policy Method is sufficiently explained in the MSA Framework, and therefore have utilized the Aggregate Method.
- Waiver of Premium (WOP): In this example, we have not removed either the premium or benefits associated with waived premium, which is consistent with the pricing of our products. Removal of WOP benefits during a rate increase exercise without adjusting the original pricing targets could amount to an additional form of cost-sharing.
- Rate Increase Implementation Date: These examples assume the make-up rate increase will be implemented after considering the time necessary for the preparation and submission of a filing,

regulator review and approval, and the administrative work required to implement the approval. Some interpretations of the MN method have assumed the approval would be implemented on the valuation date, which is not a realistic assumption.

Example A: MSA Framework Method of Handling Prior Rate Increases

Steps	Description	Rate Increase Result	Lifetime Loss Ratio
	Prior Cumulative Rate Increases	*325%*	
	Best Estimate Projections		*95%*
	Since Inception If-Knew	*127%*	
1	Make-Up Cumulative Justified Rate Increase	2042%	
2	MSA Blended Cumulative Rate Increase	1215%	
3	MSA Blended Cumul RI - with Add'l Cost-Sharing	649%	
4	MSA Blended RI - backout Prior Rate Increases	76%	84%

- Step 1: The cumulative rate increases needed to get the block back to a lifetime loss ratio of 60%. Note that the incremental increase above the already implemented rate increases would be only 404%.
- Step 2: Blending the If-Knew rate increase with the make-up increase
- Step 3: Applying the cost-sharing factor to the blended amount
- Step 4: Backing out prior cumulative rate increases of 325%

Example B: Backing Out Prior Rate Increases Before Additional Cost-Sharing

Steps	Description	Rate Increase Result	Lifetime Loss Ratio
	Prior Cumulative Rate Increases	*325%*	
	Best Estimate Projections		*95%*
	Since Inception If-Knew	*127%*	
1	Make-Up Justified Rate Increase	404%	60%
2	Blended Rate Increase (Floored If-Knew)	229%	70%
3	Blended RI with Add'l Cost-Sharing	156%	76%

This is an alternative approach to the steps outlined in the MSA Framework examples that we believe better applies the intended principles in a format that is transparent, easy to replicate, and makes reasonable adjustments such as eliminating instances where rate decreases are suggested.

- Step 1: The prospective rate increase needed to get the block back to a lifetime loss ratio of 60% (can be calculated by removing the 325% prior cumulative rate increases from the 2042% make-up cumulative increase in Example A)
- Step 2: Since the prior cumulative rate increases are greater than the If-Knew result, it is most reasonable to back out the prior rate increases and floor the If-Knew portion of the calculation at 0%, less the methodology suggest a rate *decrease* is appropriate (which is illogical given the exercise was initiated by a deterioration in experience). If the If-Knew portion were not floored at 0%, the result would be a Blended Rate Increase of 209%, implying an If-Knew contribution of (47)%.

- Step 3: The resulting rate increase is then reduced by the additional cost-sharing provision

As seen in the above examples, a 404% prospective increase is justified and supported by regulations. Cost-sharing is applied in a variety of ways:

1. Blending with If-Knew, a hypothetical rate increase that relies on historical fictional premiums which cannot be collected by the company to pay actual claims.
2. Not flooring the If-Knew contribution at 0% when it is lower than prior justified and approved cumulative increases. In Example B, not flooring the if-knew contribution at 0% would mean that a (47)% rate increase was being used in the weighting, driving down the blended increase from 229% to 209%.
3. Additional cost-sharing. As seen in Example B, the LLR is driven up to 71% before the additional cost-sharing factors are applied, well above the 60% to which the block was originally priced. This does not suggest that a 71% LLR is always a reasonable target for a block of LTC, but an 11% increase in the LLR is a significant level of cost sharing already being produced.
4. Backing out cumulative increases after applying the additional cost-sharing. As shown in Example B, the highest amount that could be requested is 404%, but applying the additional cost-sharing provision to the calculation prior to backing out prior increases applies a haircut based on a much higher percentage (in Example A, based on 1215%). The difference resulting from backing out the cumulative increases before vs. after the additional cost-sharing is a reduction in the rate increase from 146% and LLR of 77% (derived from Step 2 Example B, not shown) to a rate increase of 76% while driving the LLR up to 84% (Step 4 of Example A). For older blocks of business, this blended amount will typically be quite large, and therefore the additional cost-sharing will have a natural pull to a 50% haircut given the low and narrow cost-sharing bands.
5. Implementation delay. As the MSA Framework examples are silent on use of realistic implementation date in the calculations, use of the cash flow valuation date as the implicit assumed rate increase date results in an increase to the LLR due to the natural lag from valuation date to actual implementation date.

Conclusion

The end result of these various haircuts and elements of cost-sharing in this example is that the LLR goes down from 95% to 85% when following the MSA Framework as currently described (and applying the modeling components mentioned above). In a more transparent and intuitive stepwise approach, the LLR may go down to 76%, though still far above the pricing LLR of 60%, representing significant cost-sharing. On older blocks, the results of the MSA Framework approach to cost-sharing are much more severe and can result in an LLR above 100%. Any further impacts from universal removal of WOP (as has been suggested), exclusion of margin for MAE from Rate Stability products, changing the discount rate, use of the Sample Policy method, arbitrary lifetime rate caps, or attained age limitations all serve to further deteriorate the financial position of LTC carriers. The additional cost-sharing provision, not grounded in any specific actuarial or analytical methodology, is already arbitrary, applied after blending with the non-actuarial If-Knew rate increase, and rewards states that have been slow to approve past rate requests, further driving cross-state premium inequities.

August 1, 2024

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Paul and Fred,

We appreciate the opportunity to provide comments on the ongoing discussions and exposures related to the potential adoption of the Minnesota Method as the single Long-Term Care Insurance (LTCI) Multistate Rate Review (MSRR) approach and addressing policyholders who may have seen significant rate increases at later attained ages. ACLI and AHIP members are committed to adhering to sound actuarial practices and support efforts to achieve clarity and predictability in the MSRR process. This has been a challenging process, and we truly appreciate regulators' efforts.

The current exposure requests comments *"on the Minnesota Approach with adjustments to haircut percentages or cumulative rate increase ranges of the cost-sharing formula as a candidate for a Single LTCI Multistate Rate Review Approach."*

We appreciate the efforts made by the NAIC Long-Term Care Actuarial Working Group to standardize the MSRR process for LTC rate filings. Our comments below aim to enhance transparency regarding existing cost-sharing levels and to address some concerns with the Minnesota Method.

Concerns with the Adoption of the Current Minnesota Method

Our concern with the formal adoption of the current Minnesota Method as the single approach without addressing clarifications and refinements are described below. We believe that by keeping the door open for further discussion and refinement, we can develop a methodology that aligns with actuarial principles and provides the necessary clarity and predictability for both insurers and regulators.

Areas of concern include:

- Cost-Sharing Implications: The current Minnesota Method contains multiple cost-sharing aspects, including the "if-knew" premiums, blending approaches, and cost-sharing factors. It is important to acknowledge and address these elements when considering additional limitations on rate increase levels.
- Transparency and Complexity: The cost-sharing aspects in the current Minnesota Method are embedded within multiple calculations, making it challenging to quantify the actual level of cost sharing that currently exists.
- Lack of Detailed Guidance: The existing MSRR framework lacks sufficient detail (e.g. treatment of waiver of premium, inclusion of moderately adverse experience, decisions regarding use of aggregate vs. sample policy methods), making it challenging to establish a

reliable baseline for modeling or quantifying impacts. This has resulted in varied interpretations and inconsistent application of the Minnesota Method across states and insurers, leading to different outcomes based on subjective assessments. This inconsistency adds complexity and uncertainty for insurers.

- Unique Characteristics of LTC Blocks of Business: The prescriptive cost sharing table within the current Minnesota Method lacks flexibility to address the unique circumstances of different LTC blocks, products, and policyholder demographics.
- LTC Blocks Should be Self-Sustaining: The Minnesota Method can produce results that may not be self-sustaining (i.e. the method can produce rate increases that result in a lifetime loss ratio in excess of 100%), which may result in insufficient rates.

Request for Clarifications and Further Engagement

We were hoping that the clarifications raised in earlier comment letters would be addressed before proceeding with the adoption of the Minnesota Method as the single MSRR approach. It is crucial to address these issues before any formal adoption, including:

- Address Open Questions from May 3 Comments
    - We encourage the working group to provide detailed responses to the questions and concerns raised in the May 3 comment letters submitted by various stakeholders. This will help ensure that the methodology is fully understood, transparent, and consistently applied.
- Provide Transparency on Cost Sharing Mechanisms
    - Ensure that there is a clear understanding by all stakeholders of the existing cost-sharing mechanisms embedded in the Minnesota Method, including how any potential adjustments would impact both insurers and policyholders.
- Facilitate Discussion on Clarification of Certain Aspects of the MSRR and Methodological Refinements to Increase Transparency and Uniformity
    - We encourage a thorough review of potential refinements to the current Minnesota Method to address regulatory concerns of large cumulative rate increases at later durations and attained ages.
    - Provide clarification with respect to treatment of:
        - Explicit Inclusion of MAE: Develop clear guidelines on when and how additional margins should be included in projections.
        - Standardization of Waiver of Premium based on original product pricing.
        - Relevant Discount Rates: Permit the use of investment returns assumed in Cash Flow Testing for present value calculations.
        - Aggregate vs. Sample Policy Methods: Clarify when each method should be used.
        - Recognition of a feasible implementation date when finalizing the rate increase proposal.

Potential Refinements to the Current Minnesota Method

One approach, described below, maintains the core principles of the Minnesota Method and refines the method by:

- eliminating the costs associated with terminated policies and
- introducing more precise recognition of block dynamics while providing similar flexibility to address more mature blocks.

This proposed approach is consistent with sound actuarial principles, simpler to apply, and may be more intuitive and accessible to those who are not experts in LTC experience and pricing analysis. It provides a clearer understanding of the actual rate increase needed, removing the embedded cost sharing included in the Minnesota Method (e.g., the blending step). This makes any cost sharing analysis and decisions more explicit and specific to each company/block of business, enhancing transparency and equity across blocks.

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Key Concepts:

1. Assess Total Lifetime Experience: Base the assessment on the most recent assumptions to ensure accuracy.
2. Calculate If-Knew Premium on Only Active Lives: At this premium rate, active insureds would pay only the amount that should have been paid since inception of the policy. This approach represents an element of cost sharing and provides no level of recognition for the deficiency of past premiums associated with terminated policies.
3. Calculate Make-Up Premium on Only Active Lives: Exclude losses associated with terminated lives from the calculation, directly addressing concerns raised by regulators.
    a. The incremental make-up premium reflects the accumulated past premiums the active policyholders would otherwise have paid, spread over the remaining future payment period.
    b. At this rate level, active policyholders are receiving actuarially appropriate benefits for the premiums paid and maintain the opportunity to reduce benefits to adjust the premiums, again maintaining actuarially appropriate benefits relative to premiums.
4. Apply Rate Increase Mitigation or Cost Sharing Adjustments to Incremental Make-Up Premium Only: Make these adjustments explicit and subject to discussion between the regulator and the company, based on the specific aspects of a company's profile and block of business.

We believe that incorporating these modifications will lead to a more predictable, sustainable, and transparent methodology for all stakeholders.

We are currently working on modeling the above refinements to demonstrate their impact on various blocks of business.

Summary

Our primary concerns are:

- the adoption of the current Minnesota Method as the single approach without first addressing the clarifications and refinements needed.
- the need for transparency with respect to the degree of cost sharing that is contained in the Minnesota Method.

We believe that by keeping the door open for further discussion and refinement, we can develop a methodology that provides the necessary clarity and predictability for both insurers, regulators and policyholders.

Thank you for considering these important issues.

Sincerely,

Jan Graeber
Senior Actuary, ACLI

Ray Nelson
Consultant for AHIP

Multi-State Actuarial LTC rate increase review method

Fred Andersen, FSA, MAAA

8/12/2024

Background re: all cost sharing in MN approach

- Implicit and explicit cost sharing
  - Blending away from the makeup premium is one form of cost sharing (implicit)
    - This aspect ensures any rate increase will not lead to improved financial expectations for the company from original pricing
      - This aspect also ensures the policyholder is still getting "bang for the buck" even after a rate increase
      - The rate increase is a reflection of increased costs associated with the policy
        - Otherwise, the rate increase would not be approved
  - The cost-sharing formula is additional (and explicit) cost sharing
    - To address that very high rate increases over time were very likely not presented to the consumer as a possibility at the time of sale

Background re: cost-sharing formula

- Increases the company burden as cumulative rate increases rise
- The cumulative-since-issue, blended if-knew / makeup premium-based increase is reduced by a "haircut" percentage
  - No haircut for the first 15%.
  - 10% for the portion of cumulative rate increase between 15% and 50%
  - 25% for the portion of cumulative rate increase between 50% and 100%
  - 35% for the portion of cumulative rate increase between 100% and 150%
  - 50% for the portion of cumulative rate increase in excess of 150%.
- The formula was developed in 2015

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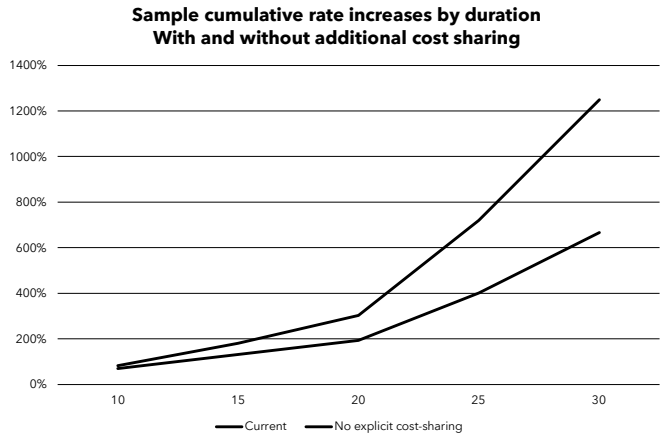
Background re: cost-sharing formula

- For a typical block of business, pattern of rate increases with and without additional cost sharing:



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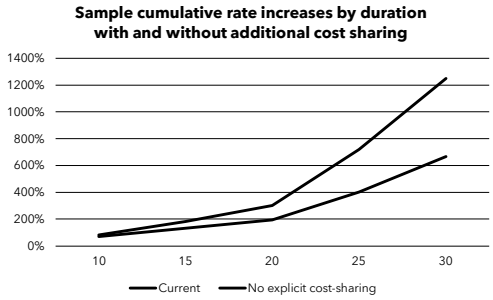
Re-analysis of cost-sharing formula, 9 years later

- Effective at reducing rate increases from those without additional cost sharing
- Increasingly concerning level of cumulative rate increases as blocks approach duration 25
  - The cumulative rate increases are not leveling off
  - Graphical example of the "85/25" issue, a.k.a., the "85/25/400" issue



Re-analysis of cost-sharing formula, 9 years later

- The original formula did not contemplate cumulative rate increases reaching or exceeding 400% over time
- Led to 85/25/400 issue
- Analysis shows that adjusting the parameters of the formula may help address the issue

Proposed revision to cost-sharing formula to address "85/25" issue

- Adjust ranges and percentages in the explicit cost-sharing formula
  - The higher the percentage, the higher the burden for the policyholder
  - The lower the percentage, the higher the burden for the company

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Proposed revision to cost-sharing formula to address "85/25/400" issue

- Current:
  - No haircut for the first 15%.
  - 10% for the portion of cumulative rate increase between 15% and 50%
  - 25% for the portion of cumulative rate increase between 50% and 100%
  - 35% for the portion of cumulative rate increase between 100% and 150%
  - 50% for the portion of cumulative rate increase in excess of 150%.
- Proposal:
  - 5% haircut for the first 100%
  - 20% haircut for the portion of cumulative rate increase between 100% and 400%
  - 80% haircut for the portion of the cumulative rate increase in excess of 400%

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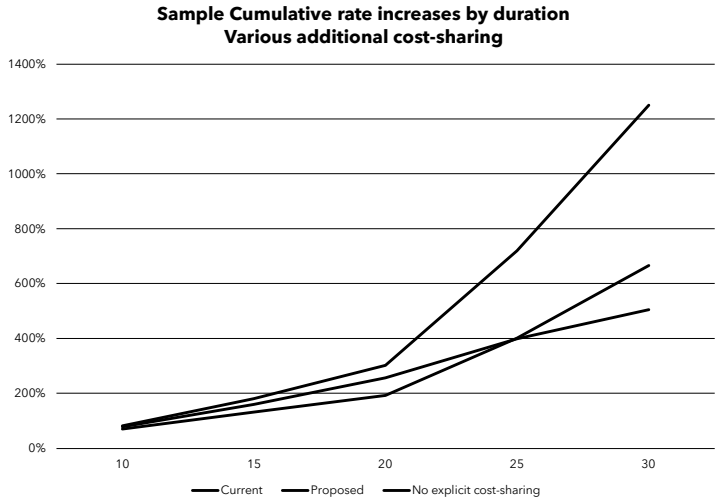
Result of proposed revisions



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Next Steps

- Discuss if the revised additional cost-sharing appropriately addresses the 85/25/400 issue
- Discuss any other potential consequences
- Analyze results for blocks other than the sample block
  - e.g., Older, newer, richer benefits, less rich benefits, different histories of rate increases
- Propose any alternatives

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The Delaware Department of Insurance Office of Long-Term Care Insurance

Trinidad Navarro
Commissioner, Delaware Department of Insurance
August 2024

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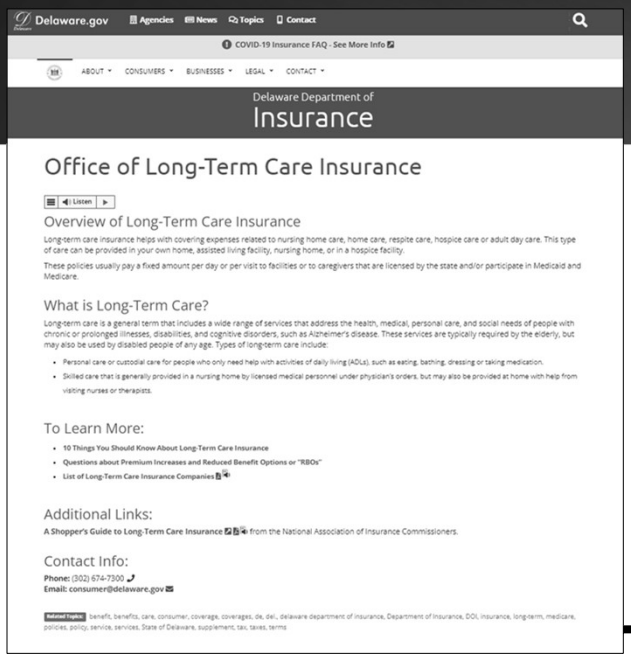


Launched website:

Office of Long-Term Care Insurance - Delaware Department of Insurance - State of Delaware

Trained staff provide consumer assistance with RBOs

2

Delaware Office of Long-Term Care Insurance

New Website Provides Contact Information:

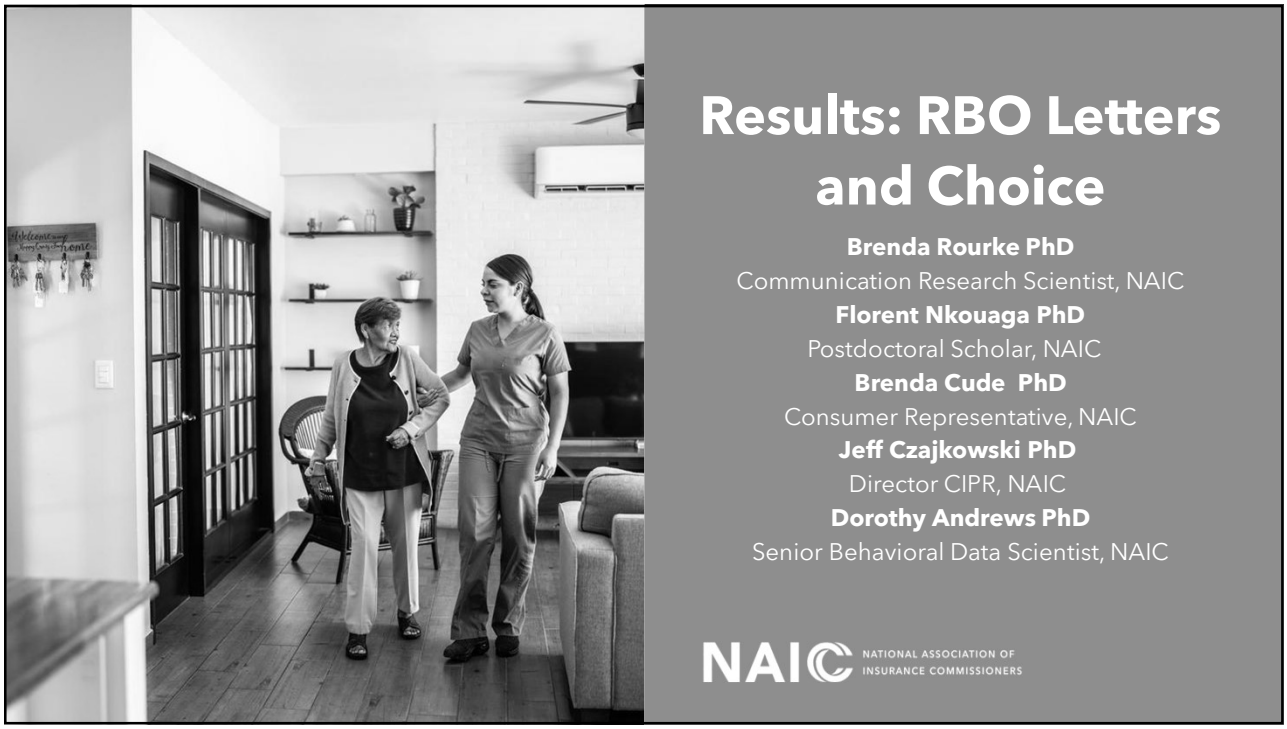
Phone: (302) 674-7300
Email: consumer@delaware.gov

Links To Additional LTC and RBO Information:

- ***10 Things You Should Know About Long-Term Care*** Consumer Alerts - Delaware Department of Insurance - State of Delaware
- ***Questions About Premium Increases and Reduced Benefit Options or "RBOs"*** Questions About Long-Term Care Insurance: - Delaware Department of Insurance - State of Delaware
- ***List of Long-Term Companies*** LTC-Insurance-List.pdf (delaware.gov)
- ***Shopper's Guide To Long-Term Care Insurance from the NAIC*** publication-ltc-lp-shoppers-guide-long-term.pdf (naic.org)

Delaware Office of Long-Term Care Insurance

- Delaware's new Office of Long-Term Care Insurance further supports the many NAIC initiatives involving LTC and RBOs in particular
- The new Office of Long-Term Care Insurance works in direct coordination with Delaware's Medicare Assistance Bureau (DMAB) which provides information, counseling, and assistance to consumers with Medicare
- DOI Staff were recently provided an in-depth training by industry on RBOs, what they are, and how they work.
- DOI Staff and counsel have direct and immediate access to industry executives to provide consumers with specific policy level assistance with RBO's or any other matter related to their particular LTC policy


Results: RBO Letters and Choice
Brenda Rourke PhD
Communication Research Scientist, NAIC
Florent Nkouaga PhD
Postdoctoral Scholar, NAIC
Brenda Cude PhD
Consumer Representative, NAIC
Jeff Czajkowski PhD
Director CIPR, NAIC
Dorothy Andrews PhD
Senior Behavioral Data Scientist, NAIC
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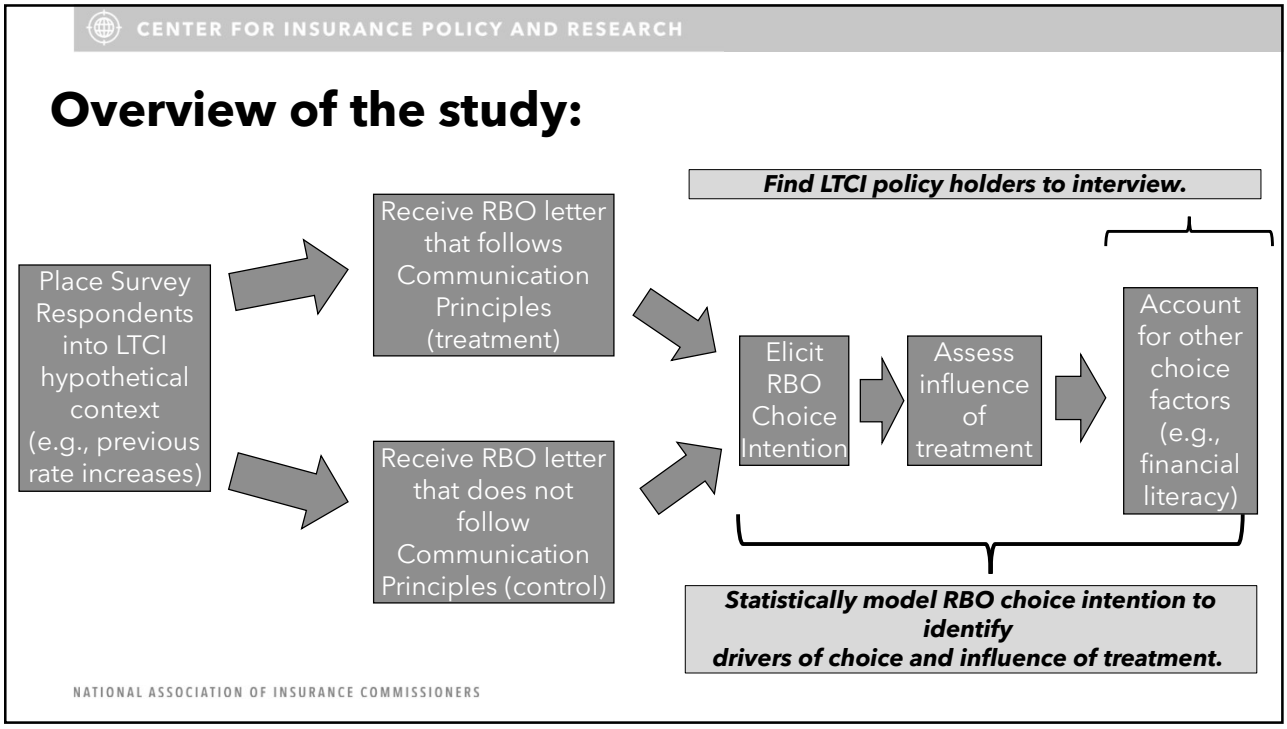
CENTER FOR INSURANCE POLICY AND RESEARCH
Overview of the study:
Find LTCI policy holders to interview.
Place Survey Respondents into LTCI hypothetical context (e.g., previous rate increases)
Receive RBO letter that follows Communication Principles (treatment)
Receive RBO letter that does not follow Communication Principles (control)
Elicit RBO Choice Intention
Assess influence of treatment
Account for other choice factors (e.g., financial literacy)
Statistically model RBO choice intention to identify drivers of choice and influence of treatment.
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CENTER FOR INSURANCE POLICY AND RESEARCH

The participants:

Note: Half of the participants were placed in a context that asked them to imagine they are 80 years old.

N= 1118
Female = 581
Male= 537

Zone	n	Percent
Northeast	380	34%
Southeast	201	18%
Midwest	396	35%
Western	141	13%
Total	**1118**	

Age	n	Percent
55 - 64	385	34%
65 - 74	492	44%
75 - 84	220	20%
85 or older	21	2%
Total	**1118**	

66% of the sample is 65 or older.

(see the reference slides for more demographics)

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The interview participants:

9 Interviews Complete

The interviews were one hour long and focused on:

- Perceptions of LTCI
- Their need for care
- Rate increases
- Perceptions of the RBO choice
- The letters they have received.

Demographics

Gender:
Female = 7
Male = 2

Age:
65- 74 = 3
75 -84 = 6

Income:
$150,000 and over = 3
$100,000 - 124,999 = 1
$75,000 - 99,999 = 3
$25,000 – 49,999 = 1
N/A - 1

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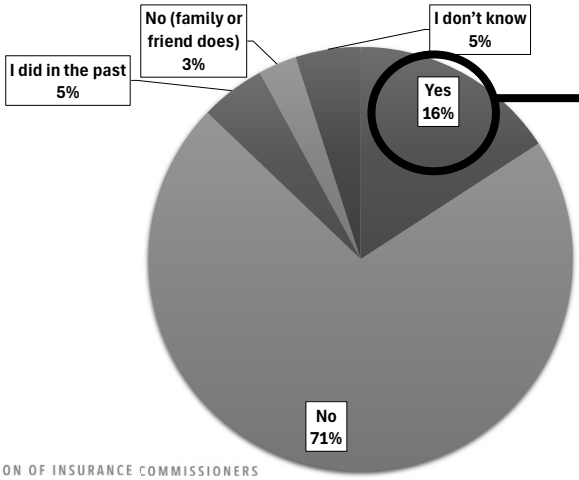
Survey Respondents: Percent of LTCI Policyholders



12% after we defined a traditional long-term care insurance policy.

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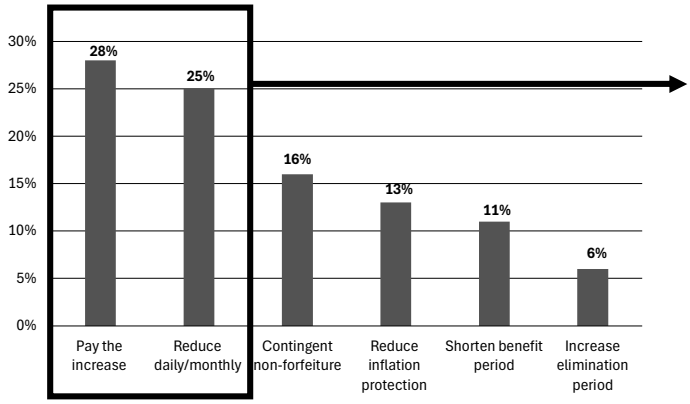
RBO Choice:



- This pattern holds for those that have LTCI and those that no not.
- This is also consistent with previous LTCI reports.

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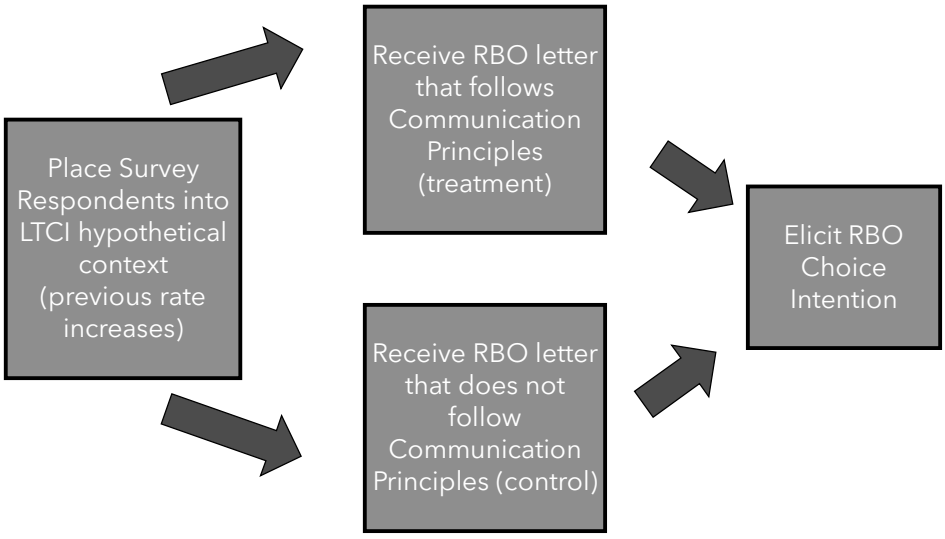

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The Context and Letter:

- ✓ Participants were more likely to accept a rate increase if they were placed in the context that stated they had a prior rate increase.
- ✗ The letter that followed the communication principles and guidelines did not impact choice.

Interview Responses:

- Participants in the higher income ranges had the means to manage the increase (for now).
- They see the value in the policy they have.
- They have spoken to trusted advisors about what they should do.

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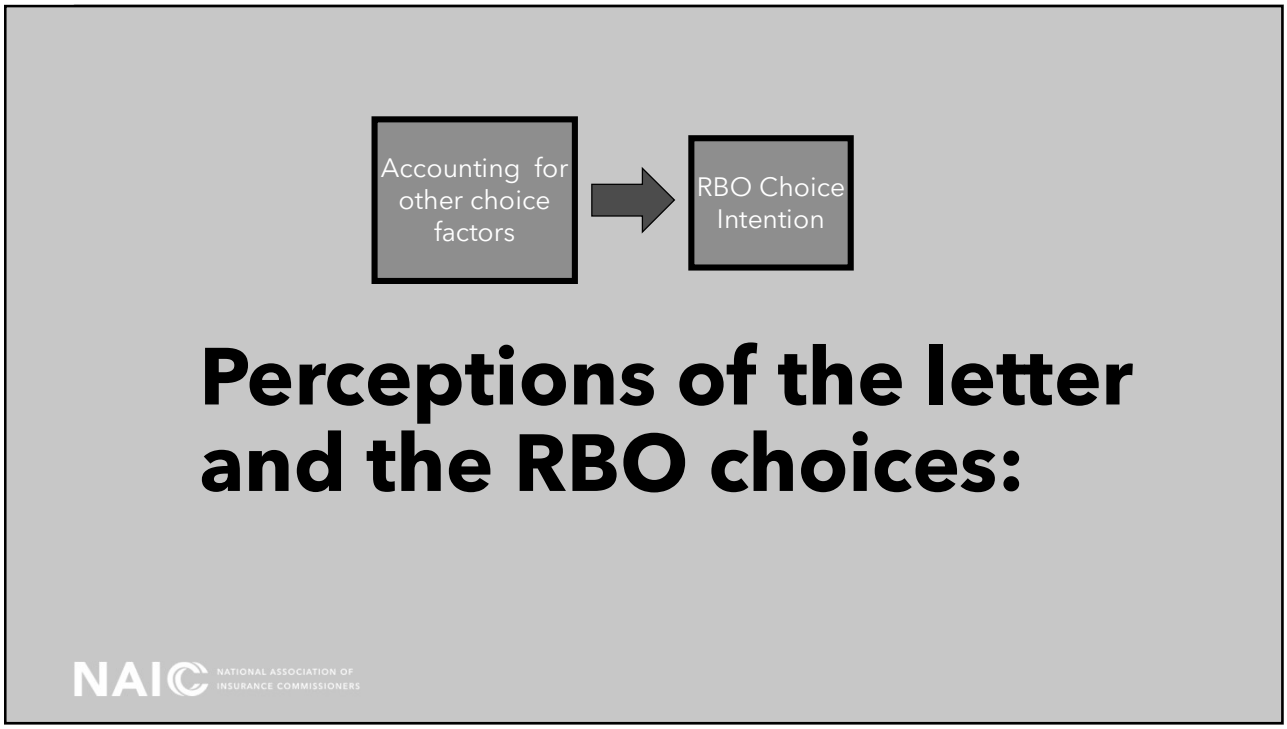
Accounting for other choice factors
RBO Choice Intention
Perceptions of the letter and the RBO choices:
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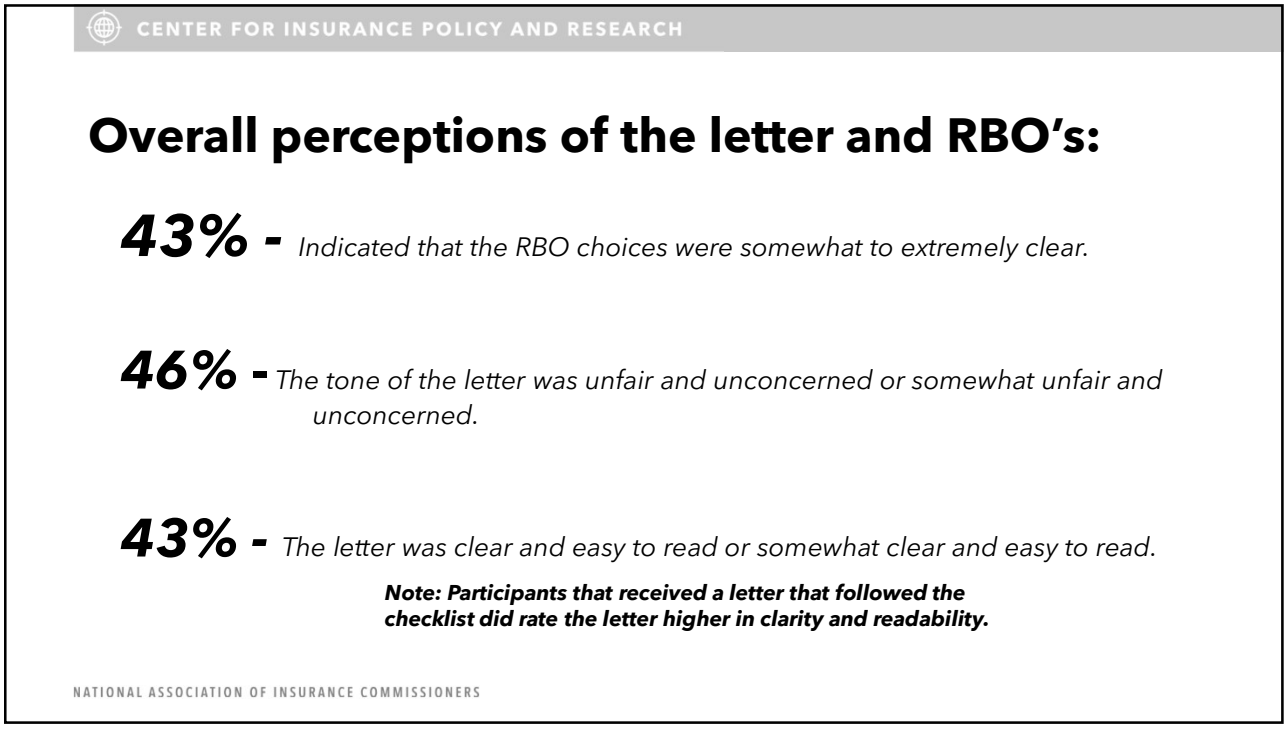
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Overall perceptions of the letter and RBO's:
43% - Indicated that the RBO choices were somewhat to extremely clear.
46% - The tone of the letter was unfair and unconcerned or somewhat unfair and unconcerned.
43% - The letter was clear and easy to read or somewhat clear and easy to read.
Note: Participants that received a letter that followed the checklist did rate the letter higher in clarity and readability.
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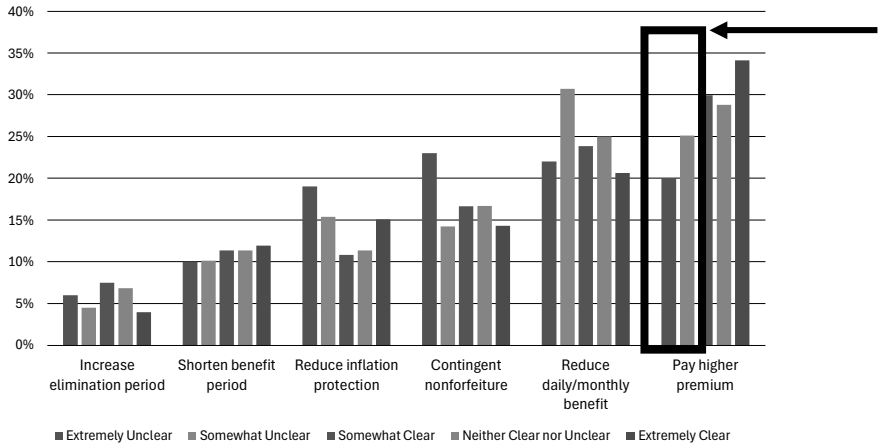
Perceptions of the clarity of RBO options impacted choice:



Those that felt the RBO options were ***extremely unclear were less likely to select - pay the higher premium.***

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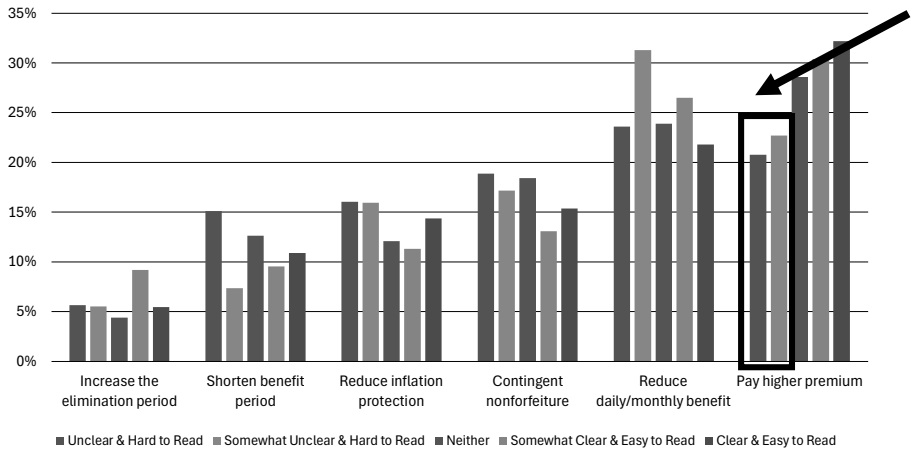
Perceptions of the letter:



Those who felt the letter was ***unclear and hard to read were less likely pay the higher premium.***

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Interview Responses:

- They understand the letters because of their background but they have suggestions for improvement.
  - Tables and how the information is displayed.
  - Use simpler language to benefit the public.

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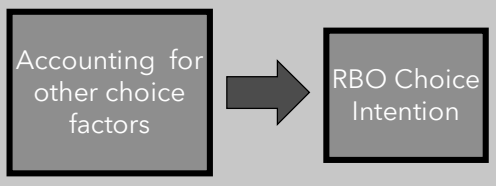

Attitudes and Control:

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Theory of Planned Behavior:

54% **- *Behavioral Control:*** *Felt extremely confident to somewhat confident and agreed that they understood the impact of the options and had the knowledge and skills to make this choice.*

57% **- *Attitudes:*** *Were displeased to somewhat displeased and felt the options were unjust.*

55% **- *Normative Beliefs:*** *Felt that others with long-term care insurance and those important to them would make the same choice.*

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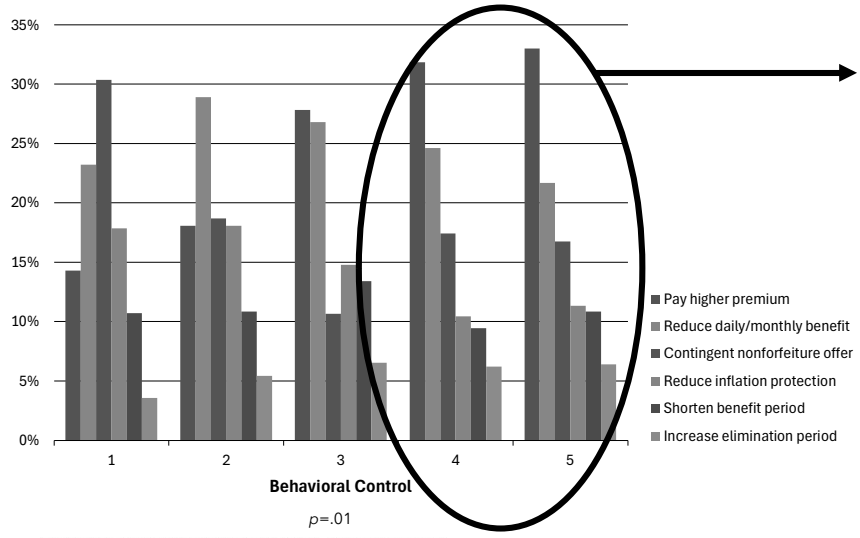
Behavioral Control and Choice:



Those who are confident and believe they have the knowledge and skills were also ***more likely to take the premium increase.***

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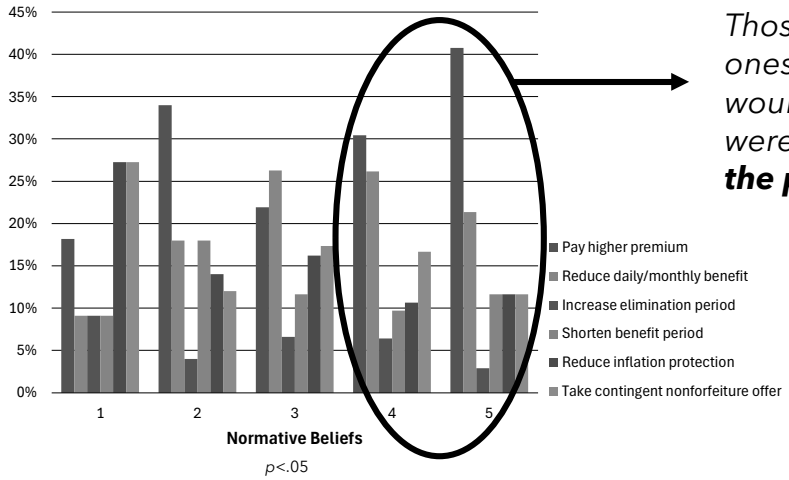
Normative Beliefs and Choice:



p<.05

*Those who believed their loved ones and others with LTCI would make the same choice were **more likely to choose the premium increase.***

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Accounting for other choice factors → RBO Choice Intention

Financial Knowledge and Perceptions of Risk

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Financial knowledge and perceptions of risk:

- Those with more financial knowledge *are more likely to accept the premium increase.*
- Those that are less willing to take risk *are more likely to accept the premium increase.*
  - *62% of the sample are low risk takers.*
- As perceptions of the need for care increase so does the choice *to accept the higher premium.*

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Interview Responses:

- Several of the respondents said that they know they will need long-term care.
  - They have a medical condition.
  - They cared for others that needed this care.
- They want to decide where they go when they need care.
- They don't want to be a burden to their family (financially or physically).

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Summary of the Findings

Participants were more likely to accept the rate increase if they:

- Received a prior rate increase.
- Thought the letter was clear and easy to read.
- Thought the RBO options were clear.
- Said they had enough information and were in control of their choice.
- Had confidence and belief in their knowledge and skills.
- Believed their loved ones and other with LTCI would make the same choice.
- Had more financial knowledge.
- Were less likely to take risks.
- Believed they are likely to need long-term care

The letter alone did not impact choice.

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Next Steps:

- Continue to model the data using multivariate analysis.
- Perception of the clarity of the letters matters.
  - Are there ways to improve the checklist?
- Confidence in knowledge and skills is important.
  - Having enough information and financial knowledge.
  - Discuss ways to better educate policyholder about their choice.

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