HEALTH ACTUARIAL (B) TASK FORCE

Health Actuarial (B) Task Force August 10, 2025, Minutes
- Health Actuarial (B) Task Force July 14, 2025, Minutes (Attachment One)
  - Long-Term Care Insurance (LTCI) Multistate Approach (MSA) Cost Sharing Presentation (Attachment One-A)
  - MSA Cost Sharing Alternate Proposal (Attachment One-B)
  - American Council of Life Insurers (ACLI)/America's Health Insurance Plans(AHIP) Comment Letter (Attachment One-C)
  - MSA Framework Cost Sharing Formula Proposal (Attachment One-D)
- Long-Term Care Actuarial (B) Working Group July 21, 2025, Minutes (Attachment Two)
  - Long-Term Care Actuarial (B) Working Group June 2, 2025, Minutes (Attachment Two-A)
    - LTCI Multistate Rate Review Approach Exposure (Attachment Two-A1)
    - Colorado Division of Insurance (DOI) Comment Letter (Attachment Two-A2)
    - ACLI/AHIP Comment Letter (Attachment Two-A3)
    - Risk & Regulatory Consulting (RRC) Comment Letter (Attachment Two-A4)
    - MSA Cost-Sharing Alternatives (Attachment Two-A5)
- Society of Actuaries (SOA) Research Institute Activities Update (Attachment Three)
- Academy of Actuaries (Academy) Professionalism Update (Attachment Four)
- Academy Health Practice Council Update (Attachment Five)
- Academy Presentation on 2026 Affordable Care Act (ACA) Premium Rate Drivers (Attachment Six)

Draft Pending Adoption

Draft: 8/14/25

Health Actuarial (B) Task Force
Minneapolis, Minnesota
August 10, 2025

The Health Actuarial (B) Task Force met in Minneapolis, MN, Aug. 10, 2025. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jon Pike, Vice Chair, represented by Ryan Jubber (UT); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Tricia Davé (CT); Karima M. Woods represented by Stephen Flick (DC); Michael Yaworsky represented by Kyle Collins (FL); Scott Saiki represented by Arlene Ige (HI); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Holly W. Lambert represented by Scott Shover (IN): Vicki Schmidt represented by Nicole Boyd (KS); Michael T. Caljouw represented by Mary Hosford (MA); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by David Nelson (MN); Angela L. Nelson represented by William Leung (MO); Jon Godfread represented by Colton Storseth (ND); Eric Dunning represented by Margaret Otto and Michael Muldoon (NE); Justin Zimmerman represented by Seong-min Eom (NJ); Ned Gaines represented by Maile Campbell (NV); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andy Schallhorn (OK); Michael Humphreys represented by Dave Yanick (PA); Alexander S. Adams Vega represented by Carlos Vallés (PR); Cassie Brown represented by R. Michael Markham (TX); Scott A. White represented by Tim Connell (VA); and Patty Kuderer represented by Rocky Patterson (WA).

1. Adopted its July 14 Minutes

Dyke said the Task Force met July 14. During this meeting, the Task Force took the following action: 1) adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2025, Health Actuarial (B) Task Force*); 2) heard a presentation on the: a) history and recent activity associated with multistate actuarial (MSA) reviews and b) proposed changes to the cost-sharing formula used in the single long-term care insurance (LTCI) MSA rate review approach methodology found in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework); and 3) adopted the alternative proposal changes to the cost-sharing formula used in the single LTCI MSA rate review approach methodology found in the LTCI MSA Framework.

Leung made a motion, seconded by Yanick, to adopt the Task Force's July 14 minutes (Attachment One). The motion passed unanimously.

2. Adopted the Long-Term Care Actuarial Working Group's July 21 and June 2 Minutes

Dyke said the Long-Term Care Actuarial (B) Working Group met July 21 and June 2. During its July 21 meeting, the Working Group took the following action: 1) adopted its June 2 minutes, which included the following action: a) discussed comments received on the exposure of alternative and Missouri proposal modifications to the single LTCI MSA rate review approach cost-sharing formula and b) agreed to recommend the alternative proposal to the Health Actuarial (B) Task Force as a modification to the cost-sharing factors to be used in the LTCI MSA Framework.

Leung made a motion, seconded by Yanick, to adopt the Long-Term Care Actuarial (B) Working Group's July 21 (Attachment Two) and June 2 (Attachment Two-A) minutes. The motion passed unanimously.

3. Heard an Update from the Federal CCIIO

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) said the CCIIO wants to improve the health insurance exchanges by rooting out fraud, waste, and abuse, and enhance program integrity by ensuring the right benefits are provided to the right people, delivering a positive consumer experience, and

supporting sustainable exchanges. He said the 2025 Marketplace Integrity and Affordability Rule has been finalized. Nelson said the rule contains key features that are important to the market. He said the CCIIO is taking strong steps to strengthen income verification processes and also modifying some eligibility redetermination procedures to ensure people know that they have coverage if they are covered by zero-premium plans. He said the rule removes deferred action for childhood arrivals recipients from the definition of lawfully present, which is a return to the definitions that were in place when the federal Affordable Care Act (ACA) initially took effect.

Nelson said Aug. 13 is the deadline to submit final 2026 ACA rates to the federally facilitated exchange, and issuers in these states must submit final 2026 qualified health plan (QHP) data to the Centers for Medicare & Medicaid Services (CMS) and the System for Electronic Rates and Forms Filing (SERFF). He said, given uncertainties this year around the extension of the enhanced advanced premium tax credits (EAPTCs) and funding of cost-sharing reductions (CSRs), states can use the Sept. 11–12 limited data correction window to allow issuers to submit revised QHP rate filings and finalize determinations. Nelson said the correction window is usually for just minor corrections, such as errors in inputting numbers and administrative corrections. He said the CCIIO recognizes that, for this year, the uncertainty in the system might require some broader changes during the window and is prepared to help make sure that issuers are able to get the most accurate rates set ahead of the open enrollment period. Nelson said the CCIIO rate review team is in the process of contacting states on the federal platform to determine the potential volume of revised rate filings that it can expect to receive during the data correction window.

Nelson said data presented in a report by Wakely Consulting Group has identified a higher level of risk in the market than was expected by many issuers, and the CCIIO recognized that better risk adjustment data is needed to help calculate more accurate rates. He said the CCIIO posted data on the number of hierarchical condition categories (HCCs) per plan member by state and also posted extra information on plan liability risk scores by state. He said the following have been posted: effectuated enrollment data through May; issuer-specific and state-level counts of consumers identified as duly enrolled in Medicaid and receiving EAPTCs; plan-level data on how many open enrollment plan selections were for consumers new to the exchanges; and data related to the number of plan enrollees with no claims from 2019 to 2024.

Nelson said rate filings containing only non-QHPs and filings containing a QHP in states with a state-based exchange that does not use the federal platform must be finalized by Oct. 15 or an earlier date if set by the state. He said the CMS will post the final rates on Oct. 31.

Dyke asked if regulators are not sure whether a company may subsequently file or ask for a rate adjustment, should they refrain from issuing rate determinations, or can a determination be undone. Rebecca Lund (CCIIO) said once a final determination is entered in SERFF, the submission is locked in the Marketplace Plan Management System (MPMS). She said the regulator will need to notify their CCIIO rate review contact that the submission needs to be deactivated in MPMS and then let the issuer know that it was deactivated. Lund said the issuer can then submit an updated filing in SERFF.

Dyke asked if the CCIIO has any administrative measures in place concerning issuer adjustments to rate filings due to changes in funding of cost-sharing reductions (CSRs) that may be made through legislation. Nelson said the CCIIO does not currently have any administrative measures in place for this.

Chaudhuri asked if the CCIIO has any guidance or instructions for regulators concerning situations where an issuer has submitted two sets of rates to address changes in EAPTCs or CSRs, and the alternate filing needs to replace the primary filing. He asked if one set of rates has been certified as of Aug. 13, and a change occurs that necessitates replacing the primary filing with the alternate filing, can the certification be undone and the system reopened for submission of the alternate filing. Lund said if the final determination has been made, it will need to be deactivated in MPMS, and the issuer will need to submit an updated filing in SERFF during the Sept. 11–12

limited data correction window. Patterson asked if "updated filing" means a new filing or if a prior filing can be revised. Lund said initial filings cannot be revised, so they must be deactivated, and then a new filing must be submitted.

Dyke said that, considering the issues created by uncertainty about EAPTCs and CSRs, the CCIIO should consider extending the deadline for rate review determinations to be entered past the current Aug. 13 deadline.

4. Heard an Update on SOA Research Institute Activities

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Three) on SOA Research Institute activities. He said 19 companies representing approximately 97% of the market participated in the 2015–2022 Group Long-Term Disability Incidence Study that will be published soon. He said the data is structured so claim incidence can be studied by elimination period, group size, and disability diagnosis groups. Hall said the SOA is also in the process of doing a follow-up to this study on claim termination, and the deadline for data submissions is Sept. 30.

Hall said 15 different companies representing over three-fourths of market share have submitted data for the Long-Term Care Experience Study. He said some media reports have incorrectly stated that the study uses data for policies issued between 2000 and 2023, and that the correct statement is that the study uses policy experience from 2000 to 2023 from all associated policy issue years.

5. Heard an Academy Professionalism Update

Darrell Knapp (American Academy of Actuaries—Academy) and Dyke gave an update (Attachment Four) on questions received by the Academy's Committee on Qualifications (COQ), Actuarial Standards Board (ASB) activity related to revisions to current Actuarial Standards of Practice (ASOPs) and the development of new ASOPs, and Actuarial Board for Counseling and Discipline (ABCD) activities and publications.

Knapp said over the last year, the COQ has been gathering feedback on ways to improve the clarity and readability of the U.S. Qualification Standards (USQS), some of which would be incorporated the next time the USQS is opened for updates. He said the COQ is asking various stakeholders, including the Task Force, if the USQS is currently meeting their needs and is attempting to determine what the timing is to consider reopening the USQS.

Knapp said the ABCD has received approximately 10 requests for guidance per month so far this year, which is slightly more than the historical average. He said complaints received so far this year are still few, and the number is lower than the historical average.

6. Heard an Academy Health Practice Council Update

Katie Dzurec (Academy) gave a presentation (Attachment Five) on the Academy Health Practice Council's recent and upcoming activities, publications, and webinars.

7. Heard an Academy Presentation on 2026 ACA Premium Rate Drivers

Annette James (Academy) gave a presentation (Attachment Six) on 2026 federal ACA premium rate drivers. Dyke asked if the Academy identified which of the market stability measures has the greatest impact. James said having a wide spectrum of risk and a large risk pool tends to stabilize the market, and she thinks that the expiration of the EAPTCs will likely have the largest impact on the markets.

8. Discussed the Effect of the Birthday Rule on Medicare Supplement Plan Rates

Muldoon said that he and Otto made a presentation to the Task Force at its Nov. 16, 2024, meeting regarding initially low underpriced rates in the Medicare supplement market and subsequent large rate increases. He said they discussed the birthday rule, a solution some states have already implemented. Muldoon asked if any states would be willing to present the impact of the birthday rule on the cost of plans in their Medicare supplement markets. Dyke said the Task Force will discuss this topic during a future meeting.

Having no further business, the Health Actuarial (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/HATF/2025_Summer/08-10-25 HATF/HATF Minutes 08-10-25.docx

Draft: 7/23/25

Health Actuarial (B) Task Force
Virtual Meting
July 14, 2025

The Health Actuarial (B) Task Force met July 14, 2025. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jon Pike, Vice Chair, represented by Ryan Jubber (UT); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Sydney Sloan (CO); Jerry Bump represented by Arlene Ige (HI); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by David Nelson and Fred Andersen (MN); Angela L. Nelson represented by William Leung (MO); Jon Godfread represented by Colton Storseth (ND); Eric Dunning represented by Margaret Otto (NE); Justin Zimmerman represented by Seong-min Eom (NJ); Ned Gaines represented by Maile Campbell (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andy Schallhorn (OK); Michael Humphreys represented by Shannen Logue (PA); Cassie Brown represented by R. Michael Markham (TX); Scott A. White represented by Tim Connell (VA); and Patty Kuderer represented by Rocky Patterson (WA).

1. Adopted its Spring National Meeting Minutes

Andersen made a motion, seconded by Schallhorn, to adopt the Task Force's March 23 minutes (*see NAIC Proceedings – Spring 2025, Health Actuarial (B) Task Force*). The motion passed unanimously.

2. Heard a Presentation on the LTCI Multistate Rate Review Approach and Proposed Changes to the Cost-Sharing Formula

Andersen gave a presentation (Attachment One-A) on the history and recent activity associated with multistate actuarial (MSA) reviews, and proposed changes to the cost-sharing formula used in the single long-term care insurance (LTCI) MSA rate review approach methodology found in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). Andersen said that during the Long-Term Care Actuarial (B) Working Group's June 2 meeting, the Working Group agreed to recommend the alternative proposal (Attachment One-B) to the Task Force as a modification to the cost-sharing factors to be used in the LTCI MSA Framework.

Jan Graeber (American Council of Life Insurers—ACLI) gave an overview of an AHIP/ACLI comment letter (Attachment One-C) detailing concerns about adopting the alternative proposal.

3. Adopted the Alternative Proposal

Andersen made a motion, seconded by Trexler, to adopt the alternative proposal changes to the cost-sharing formula used in the single LTCI MSA rate review approach methodology found in the LTCI MSA Framework (Attachment One-D). The motion passed, with Nevada opposing.

Dyke said the alternative proposal cost-sharing formula, along with previously adopted changes to the LTCI MSA Framework, will be sent to the Health Insurance and Managed Care (B) Committee for its consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.

LTC rate increases – cost sharing

Fred Andersen, FSA, MAAA

Chief Life Actuary, Minnesota Department of Commerce

Multi-state LTC rate reviews – Background

- Revisions to Multi-state actuarial (MSA) Framework
  - MSA Framework was adopted in 2022
  - Company option to file a rate increase initially with the MSA team
  - MSA team reviews and issues a recommended rate increase amount
    - Webinar, including feedback from states, before recommendation is finalized
  - Company then files with each state
    - Hope is that the state approves increases in line with the MSA recommendation
  - MSA Framework only applies to these company-initiated MSA filings
    - Although a goal is for more consistency between states on rate increase approvals

Multi-state LTC rate reviews – Recent NAIC activity

- In reaction to first 8 MSA reviews, a couple concerns:
  - Confusion resulting from having 2 methodologies
  - Extent of further rate increases for older policyholders with older policies and high past cumulative rate increases
- In 2024, LTC Actuarial Working Group (LTCAWG) and LTC Task Force adopted a single methodology
  - Will be considered at B Committee in August
- March 2025 presentation to B Committee – no disagreement on methodology and cost-sharing direction
- In June 2025, LTCAWG recommended revised cost-sharing factors to reduce rate increases for those who have faced past high cumulative rate increases
  - These past high cumulative rate increases tend to have occurred for older policyholders with older policies

Revised cost-sharing factors

- After deliberation and consideration of legal and discrimination issues…
  - Cost-sharing was decided on as the best way to address the high cumulative rate increase issue
- Cost sharing is embedded in the MSA approach two ways
  - Indirectly: reduction from makeup premium in blended approach
  - Directly: formula which increases company cost-sharing burden as cumulative rate increase gets higher
- Several proposals to revise cost-sharing formula were considered by LTCAWG

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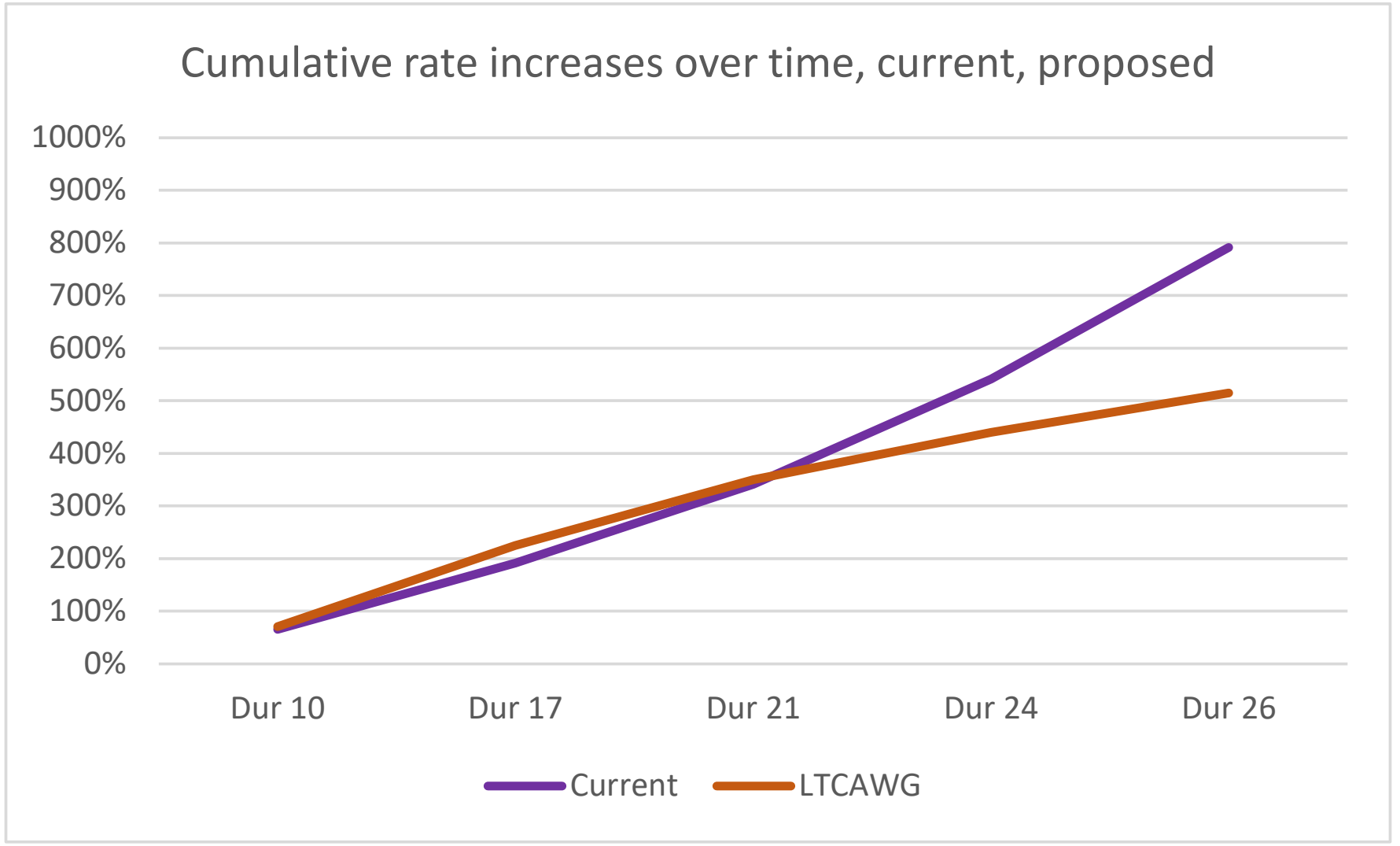
- Cost sharing is embedded in the MSA approach two ways
  - Indirectly: reduction from makeup premium in blended approach
  - Directly: formula which increases company cost-sharing burden as cumulative rate increase gets higher
- Multiple proposals to revise cost-sharing formula were considered by LTCAWG
  - Formula recommended by LTCAWG substantially increases cost-sharing factors when cumulative blended amount exceeds 400%
  - New formula addressed regulator comments during the development process
    - Reduce cumulative rate increases over 300%, greatly reduce cumulative rate increases over 600%

LTCAWG recommendation

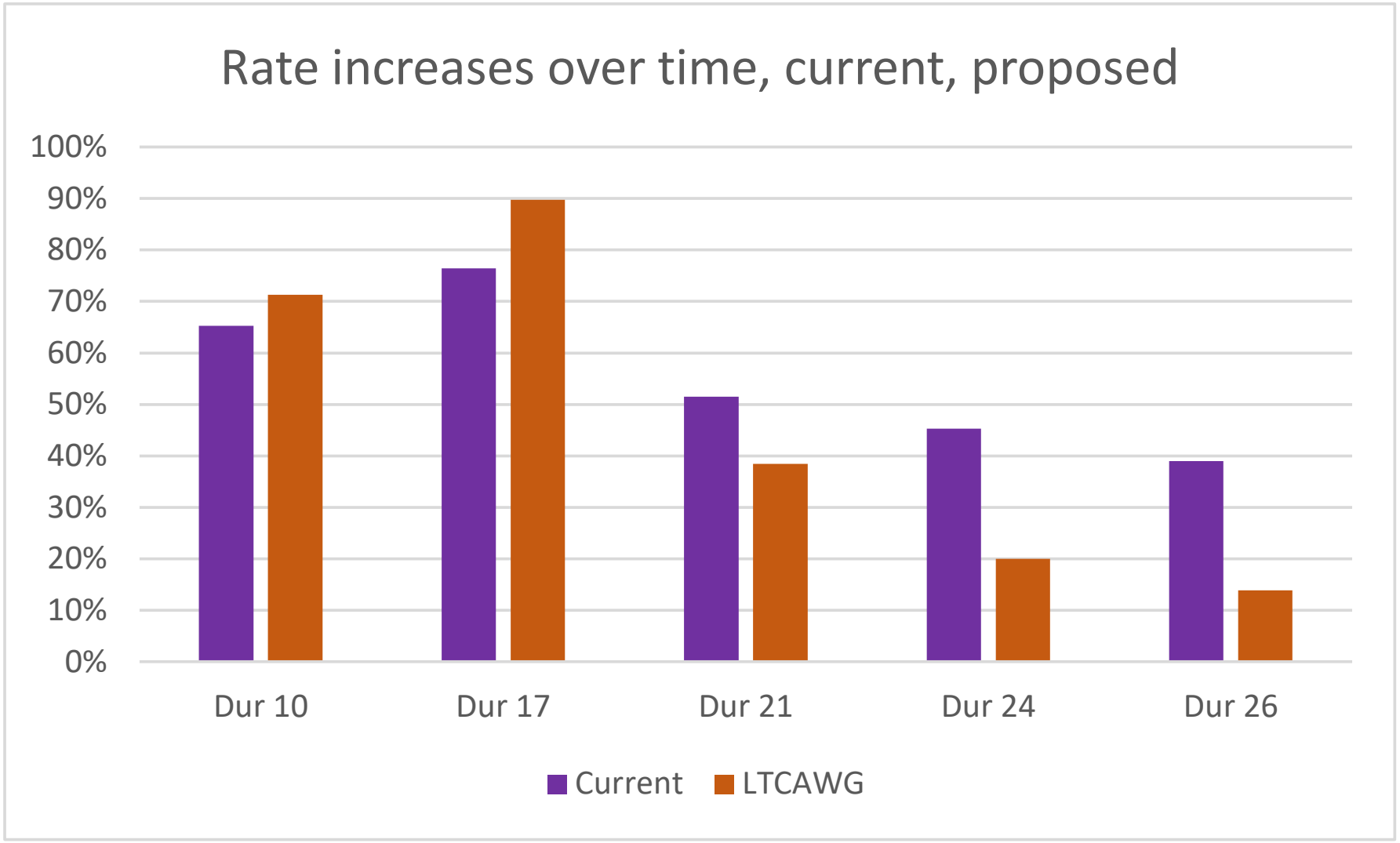
Blended range		Current PH Share	LTCAWG PH Share
0%	100%	**84%**	**95%**
100%	400%	**57%**	**65%**
400%	800%	**50%**	**30%**
800%		**50%**	**15%**
		50%	**5%**

Attachment One-A
Health Actuarial (B) Task Force
8/10/25

Revised cost-sharing factors



Revised cost-sharing factors



HATF consideration of adoption

- LTCAWG cost-sharing formula
- Would go to B committee as part of package with new MSA approach
- If adopted by B committee and exec / plenary, would only apply to MSA recommendations on MSA-filed rate increases
  - States can still decide on their own re: rate increase approvals for their states' policyholders
  - Goal is more consistency between states

Attachment One-B
Health Actuarial (B) Task Force
8/10/25

MSA Cost-sharing Proposals

Fred Andersen, FSA, MAAA

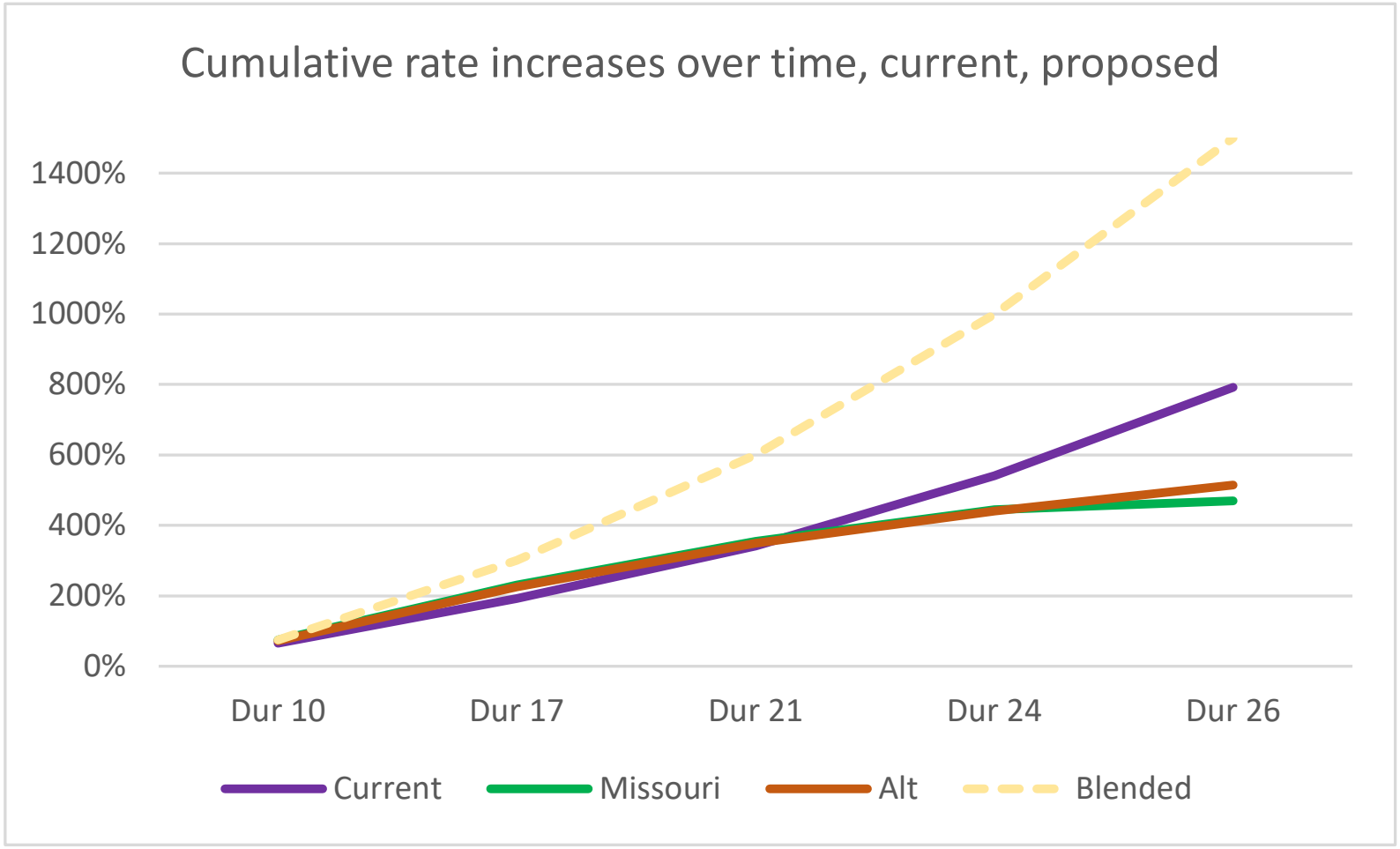
Chief Life Actuary, Minnesota Department of Commerce

Comparison of proposals

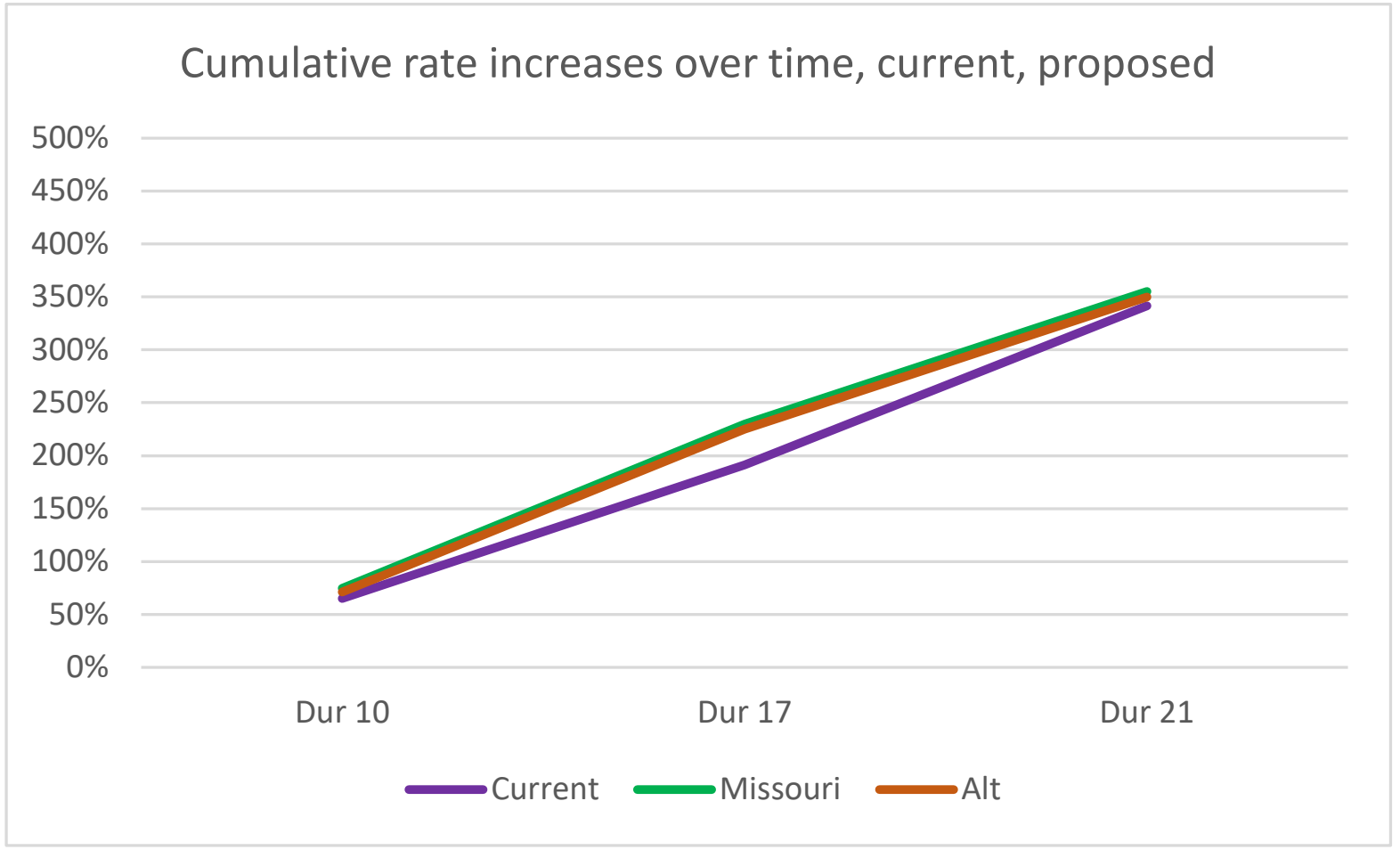
Blended range		Current PH Share	Alt PH Share	Missouri PH Share
0%	100%	**84%**	**95%**	**100%**
100%	400%	**57%**	**65%**	**65%**
400%	800%	**50%**	**30%**	**30%**
800%	1000%	**50%**	**15%**	**15%**
1000%		**50%**	**15%**	**5%**

Note that “Current” reflects a blend of cost sharing factors for the first two ranges

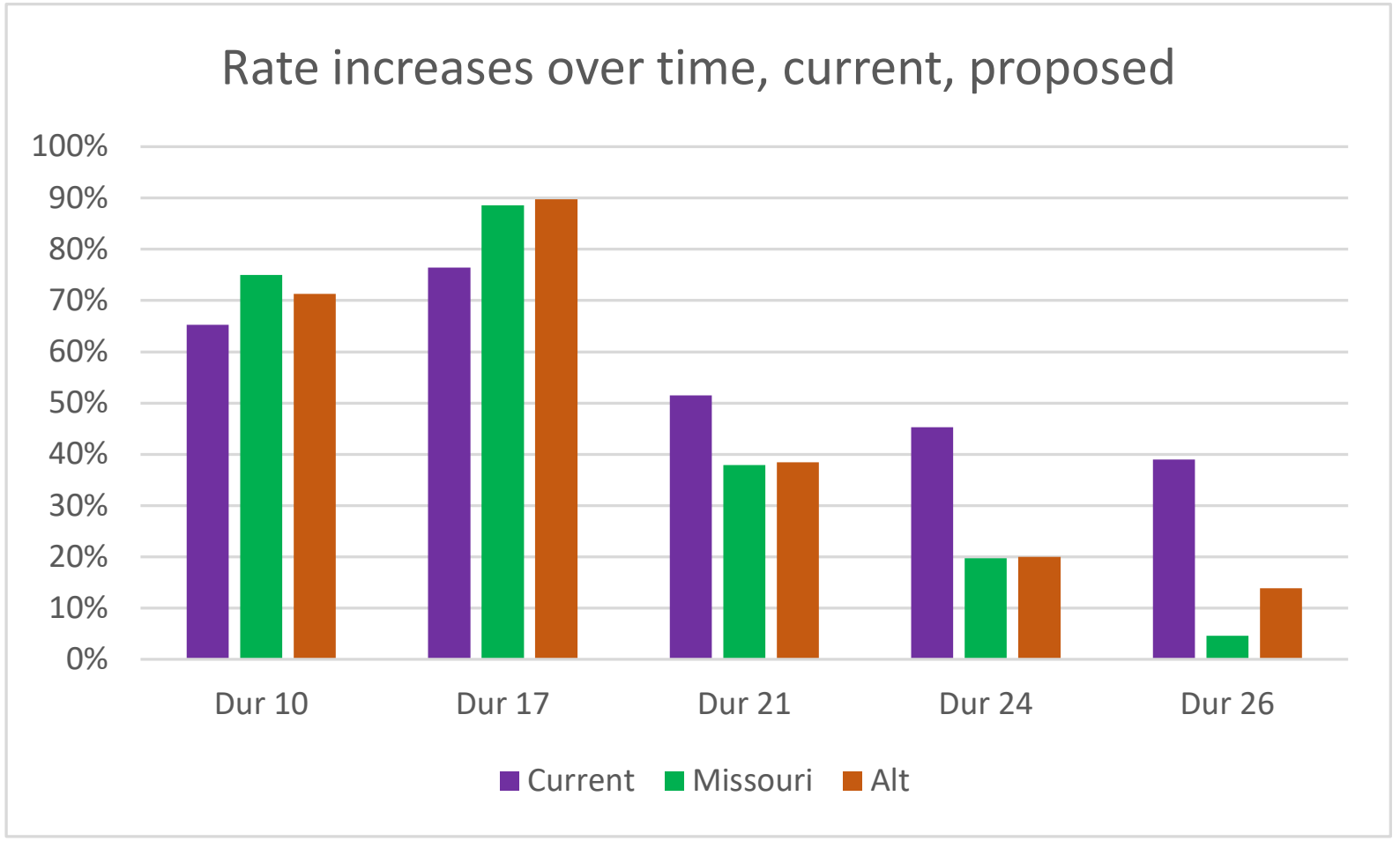
Comparison of Missouri and Alternative cumulative rate increases to current



Middle duration impact



Comparison of rate increases over time



July 14, 2025

Kevin Dyke, Chair of Health Actuarial Task Force
Ryan Jubber, Vice Chair, Health Actuarial Task Force

Dear Chair Dyke and Vice Chair Jubber:

As indicated in the call notice of the NAIC Health Actuarial (B) Task Force (HATF) scheduled for Monday, July 14th, HATF plans to "discuss and consider adoption of the Alternative Proposal for revised cost-sharing factors associated with the MSA Framework's Single LTCI Multistate Rate Review Approach". While the meeting notice did not include a formal request for comments, we are sharing the following input ahead of the upcoming call. Given the significance of the proposal and its potential impact, we believe it is important to provide our perspective for the record.

- The MSRR framework has not met its intended goal. The framework was developed in response to the NAIC Long-Term Care (EX) Task Force's charge to create a consistent and transparent national approach for reviewing LTC rates that results in rates that are grounded in sound actuarial principles. This proposal moves away from those core values and introduces arbitrary adjustments, bringing back the very challenges the MSRR was originally designed to address.

- The process leading to the development of the MSRR framework has generally lacked clarity, transparency, and coordination. The extent to which states will adopt and consistently apply the framework remains uncertain and continues to raise important questions about its effectiveness.

- Over the past 5 years, ACLI and AHIP have offered alternatives, raised concerns, and asked questions, most of which have not been fully addressed. Even among regulators, the votes show a lack of consensus on various aspects of the MSSR framework.

- Adding cost-sharing may sound reasonable on the surface, but it's not backed by actuarial principles. It amounts to a cap on rate increases, which undermines the very purpose of MSRR.

- We've seen similar debates play out more than a decade ago. Efforts to cap rate increases at that time contributed to outcomes resulting from one major insolvency, where thousands of policyholders lost coverage.

- Protecting consumers isn't about keeping premiums low in the short term. It's about making sure the coverage they've paid for is there when they need it. If companies can't collect the rates needed to support claims, policyholders could end up with reduced benefits or none at all.

We appreciate the considerable time and effort that has gone into developing this proposal. We offer our comments in the spirit of continued constructive engagement.

Sincerely,

Jan Graeber
Senior Actuary, ACLI

Amanda Herrington

Amanda Herrington
Executive Director, AHIP

cc: Ray Nelson, AHIP's Consulting Actuary

Appendix C—Actuarial Approach Detail

MSA Approach

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

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
   a. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.

2. If-knew premium and makeup premium aspects – aggregate application.
   a. Makeup percentage:
      i. {[PV (claims) / original LLR] - PV (past premium)} / PV (future premium) – 1.
      ii. To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.
      iii.
   b. If-knew percentage:
      i. [PV (claims) / PV (premiums)] / original LLR – 1.
      ii. Premiums in the formula are at the original rate level.
      iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   c. Definitions and explanations:
      i. PV means present value.
      ii. LLR means lifetime loss ratio.
      iii. Interest rates underlying PVs and LLRs are based on:
         1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
         2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over five years of the current rate to a target rate (currently 4%) is assumed.
      iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
      v. Insurer-provide premium and claim cash flows may be adjusted based on assumption review.
      vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification.
   a. Over a range of issue years, issue ages, benefit periods, and inflation protection:
      i. Calculate an estimate of the original premium.
         1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
         2. Apply first principles.
            a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
            b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
            c. Divide by the sum of the PV of an annuity of 1 per year.
            d. Multiply {b / c] times (1 + originally assumed profit percentage) to attain the original premium.

e. This premium provides the basis for comparison against the makeup and if-knew premium.

3. Replace the original premium with a benchmark premium.
   a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
   b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
   c. The benchmark aspect is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

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

iii. Calculate an estimate of the if-knew premium.
   1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
      b. Verifying the impact on expectation changes on rates
         i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
         ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
            1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
            2. Experience
            3. Impact on LLR of changes in expectations of morbidity.
            4. Industry information and trends (for reasonableness checks).
      c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
         i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer's aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
         ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
            1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
            2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.

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

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

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

6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. 5%~~No~~ haircut for the first 100~~15~~%.
      ii. 35~~10~~% for the portion of cumulative rate increase between 100~~15~~% and 400~~50~~%.
      iii. 70~~25~~% for the portion of cumulative rate increase between 400~~50~~% and 800~~100~~%.
      ~~iv. 35% for the portion of cumulative rate increase between 100% and 150%.~~
      ~~v.~~iv. 50~~85~~% for the portion of cumulative rate increase in excess of 800~~150~~%.

      Reviewers note: The cost-sharing formula (Step 6) was ~~reviewed in 2024 and~~ revised in 2025 to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. ~~The NAIC is working to develop consensus around exact cost-sharing factors. In the meantime, there may be latitude in applying cost-sharing factors to address this issue.~~

7. Reduction for past rate increase:
   a. Take 1 plus the cost-sharing-adjusted blend amount and divide by 1 plus the previous, cumulative rate increases, then subtract 1. This is the approvable rate increase.

8. Summary.
   a. Review current assumptions.
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.

f. Deduct past rate increases.

g. Example – if:

i. The original premium is $1,000

ii. Makeup premium is ~~$3,000~~$30,000.

iii. If-knew premium is $1,500.

iv. 46~~60~~% of policyholders remain.

v. Past rate increases are 405~~50~~%:

vi. Blended amount is:

1. $~~3,000~~ 30,000/ $1,000 * 0.46~~60~~ +
2. $1,500 / $1,000 * 0.54~~40~~
3. – 1 =
4. 1380~~180~~% + 81~~60~~% – 1 = 1461~~240~~% – 1 = 1361~~140~~%

vii. Reduced cumulative approval after ~~C~~cost sharing is:

1. ~~100% * 1.000.15~~95%*1.00 +
2. ~~90~~65% * 3.00~~0.35~~ +
3. ~~75~~30% * 4.00~~0.5~~ +
4. 15~~65~~% * 5.61~~90.4~~ =
5. ~~110~~494%, refelecting cost sharing of (1-4.94/13.61) = 64%

viii. Deduction for past rate increases results in:

1. (1 + ~~1.1~~4.94) / (1 + 4.05~~5~~) – 1 =
2. Approvable rate increase of ~~40~~18%

Draft: 7/23/25

Long-Term Care Actuarial (B) Working Group
E-Vote
July 21, 2025

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force conducted an e-vote that concluded July 21, 2025. The following Working Group members participated: Fred Andersen, Chair (MN); Sarah S. Bailey (AK); Sanjeev Chaudhuri (AL); Ahmad Kamil and Thomas Reedy (CA); Sydney Sloan (CO); Stephen Flick (DC); Lilyan Worlund (FL); Weston Trexler (ID); Scott Shover (IN); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); David Yetter (NC); Margaret Otto (NE); Jennifer Li (NH); William B. Carmello and Neil Gerritt (NY); Craig Kalman (OH); Andy Schallhorn (OK); Andrew Bux and Timothy Hinkel (OR); Jim Laverty (PA); Carlos Vallés (PR); R. Michael Markham (TX); Tomasz Serbinowski (UT); Rebecca Rebholz (WI); and Joylynn Fix (WV).

1. Adopted its June 2 Minutes

The Working Group conducted an e-vote to consider adoption of its June 2 minutes. During this meeting, the Working Group took the following action: 1) discussed comments received from the exposure of the alternative proposal and Missouri proposal for revised cost-sharing factors associated with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula for use in the single long-term care insurance (LTCI) multistate actuarial (MSA) rate review approach methodology found in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework); and 2) agreed to recommend the alternative proposal modifications to the single LTCI multistate rate review approach cost-sharing formula to the Health Actuarial (B) Task Force.

A majority of the members voted in favor of adopting the Working Group's June 2 minutes (Attachment Two-A). The motion passed.

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

Meetings/Member Meetings/B CMTE/HATF/2025_Summer/08-10-25 HATF/LTCAWG Evote 07-21-25.docx

Draft: 6/18/25

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
June 2, 2025

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met June 2, 2025. The following Working Group members participated: Fred Andersen, Chair (MN); Paul Lombardo, Vice Chair (CT); Sarah S. Bailey (AK); Ahmad Kamil and Thomas Reedy (CA); Sean Brady (CO); Stephen Flick (DC); Weston Trexler (ID); Scott Shover (IN); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); David Yetter (NC); Margaret Garrison (NE); Jennifer Li (NH); Neil Gerritt (NY); Craig Kalman (OH); Andy Schallhorn (OK); Jim Laverty (PA); R. Michael Markham (TX); Tomasz Serbinowski (UT); Rebecca Rebholz (WI); and Joylynn Fix (WV).

1. Discussed Comments Received on Alternative and Missouri Proposal Modifications to the Single LTCI Multistate Rate Review Approach Cost-Sharing Formula

Andersen presented comments received from the exposure (Attachment Two-A1) of the alternative proposal and the Missouri proposal for revised cost-sharing factors associated with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula for use in the single long-term care insurance (LTCI) multistate actuarial (MSA) rate review approach methodology found in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework), which is used in MSA filing reviews. He said comments were received from the Colorado Division of Insurance (DOI) (Attachment Two-A2), AHIP and the American Council of Life Insurers (ACLI) (Attachment Two-A3), and Risk & Regulatory Consulting (RRC) (Attachment Two-A4).

Andersen gave a presentation (Attachment Two-A5) comparing policyholder cost-sharing, cumulative rate increases, middle duration impact, and rate increases over time among the current alternative proposal and Missouri proposal cost-sharing formulas. He said the explicit cost-sharing amounts shown are in addition to the implicit cost-sharing amounts that result from the blending of the if-knew and makeup premiums in the single rate review methodology. Andersen said the primary goal of the cost-sharing formulas is to limit rate increases for policyholders above age 85 who have held their policies for over 25 years, and with cumulative rate increases above 400% (the 85/25/400 issue). He said the goal for the meeting is for the Working Group to determine which of the alternative or Missouri proposals it will recommend to the Health Actuarial (B) Task Force for consideration.

Jan Graeber (ACLI) gave an overview of the AHIP/ACLI comment letter. Andrew Larocque (RRC) gave an overview of RRC's comment letter. Andersen said the graphs in RRC's comment letter appear to show pre-cost-sharing rate increase percentages along the x-axis, which is associated with rate increases earlier in the life of a product, rather than after the application of the blended if-knew and makeup premiums. Larocque confirmed this to be accurate. Brady gave an overview of the Colorado DOI comment letter. He said Colorado opposes the Pennsylvania Insurance Department's (PID) proposal that the MSA team would not recommend a rate increase for any state higher than 100% of the current rates in that state.

Lombardo said many of the legacy LTCI blocks are at the point where they are in the 85% to 90% cumulative rate increase area and will not be affected by no explicit policyholder cost-sharing in the first 100% of the cumulative rate increase in the Missouri proposal. He said he is more supportive of the alternative proposal. Serbinowski said he agrees with Lombardo but thinks commissioners are more likely to support the Missouri proposal's greater insurer cost-sharing for cumulative rate increases in excess of 1,000%.

2. Discussed a Recommendation to Consider Alternative Proposal Modifications to the Single LTCI Multistate Rate Review Approach Cost-Sharing Formula

Andersen asked Working Group members which proposal they preferred—the Missouri proposal, the alternative proposal, or neither. The majority of the members preferred the alternative proposal. Andersen said the Working Group will recommend the alternative proposal to the Health Actuarial (B) Task Force as a modification to the cost-sharing factors to be used in the LTCI MSA Framework.

3. Discussed Other Matters

Andersen said that during a future meeting, the Working Group will discuss the PID proposal that the MSA team would not recommend a rate increase for any state higher than 100% of the current rates in that state.

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

SharePoint/NAIC Support Staff Hub/Meetings/Member Meetings/B CMTE/HATF/2025_Summer/6-2-25 LTCAWG/LTCAWG Minutes 06-02-25.docx

From: King, Eric
To: King, Eric
Subject: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due May 12
Date: Friday, March 28, 2025 3:01:15 PM

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

The Long-Term Care Actuarial (B) Working Group is considering revised cost-sharing factors to accompany implicit cost-sharing contained in the blended / if-knew aspect of the MSA approach adopted by the Working Group and the Long-Term Care Insurance (B) Task Force in late 2024.

Please provide comments to eking@naic.org on the following cost-sharing proposals by May 12, 2025:

Missouri Proposal:

- No haircut for the first 100%.
- 35% for the portion of cumulative rate increase between 100% and 400%
- 70% for the portion of cumulative rate increase between 400% and 800%
- 85% for the portion of cumulative rate increase between 800% and 1000%
- 95% haircut for the portion of the cumulative rate increase in excess of 1000%

"Alternative" Proposal, discussed on the February 21, 2025 Working Group call:

- 5% haircut for the first 100%.
- 35% for the portion of cumulative rate increase between 100% and 400%
- 70% for the portion of cumulative rate increase between 400% and 800%
- 85% for the portion of cumulative rate increase in excess of 800%

There will be a Working Group call in mid to late May to choose between the proposals or factors in between those stated in the proposals.

By May 12, 2025, please also provide comments on a proposal previously provided by the Pennsylvania Department. This proposal states that the Multi-State Actuarial Team would not recommend a rate increase for any state higher than 100% of current rates in that state. The idea is to provide a path forward for states with lower past cumulative approvals by avoiding recommendation of extremely high rate increases. In subsequent filings with states (or if arrangements are worked out with a state), companies could file to recoup what was justified.

From: Brady - DORA, Sean
To: King, Eric
Cc: Nugent, Peter; Batista, Deborah; Sloan, Sydney
Subject: Re: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due May 12
Date: Tuesday, May 6, 2025 3:35:37 PM

Colorado response:

"Colorado prefers the "Alternative" Proposal, discussed on the February 21, 2025 Working Group call. Our reasoning is that we are in favor of having some amount of cost sharing for the first 100% of rate increases. While we do want to encourage early rate increases, we think 0% cost sharing does not appropriately penalize underpriced products.

The difference in the higher rate increases we do not think will be relevant as often, and frequently the blocks and companies reaching cumulative rate increases above 800% require special consideration that will likely change the cost sharing anyway.

Colorado does not agree with Pennsylvania's proposal to limit what the MSA could recommend to 100% of current rates. Our opinion is that states are not bound to the MSA's recommendation, and if the state feels the recommendation is inappropriate, they can choose not to follow it."

On Fri, Mar 28, 2025 at 2:01 PM King, Eric <EKing@naic.org> wrote:

> ***To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties:***
>
> The Long-Term Care Actuarial (B) Working Group is considering revised cost-sharing factors to accompany implicit cost-sharing contained in the blended / if-knew aspect of the MSA approach adopted by the Working Group and the Long-Term Care Insurance (B) Task Force in late 2024.
>
> Please provide comments to eking@naic.org on the following cost-sharing proposals by May 12, 2025:
>
> Missouri Proposal:

- No haircut for the first 100%.
- 35% for the portion of cumulative rate increase between 100% and 400%
- 70% for the portion of cumulative rate increase between 400% and 800%
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"Alternative" Proposal, discussed on the February 21, 2025 Working Group call:

- 5% haircut for the first 100%.
- 35% for the portion of cumulative rate increase between 100% and 400%
- 70% for the portion of cumulative rate increase between 400% and 800%
- 85% for the portion of cumulative rate increase in excess of 800%

There will be a Working Group call in mid to late May to choose between the proposals or factors in between those stated in the proposals.

By May 12, 2025, please also provide comments on a proposal previously provided by the Pennsylvania Department. This proposal states that the Multi-State Actuarial Team would not recommend a rate increase for any state higher than 100% of current rates in that state. The idea is to provide a path forward for states with lower past cumulative approvals by avoiding recommendation of extremely high rate increases. In subsequent filings with states (or if arrangements are worked out with a state), companies could file to recoup what was justified.

--

Sean Brady FSA FLMI
Actuary

P 303.894.7485
1560 Broadway, Suite 850, Denver, CO 80202
sean.brady@state.co.us | www.colorado.gov/dora

May 12, 2025

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

Dear Chairs Lombardo and Andersen,

The American Council of Life Insurers (ACLI)[1] and the America's Health Insurance Plans (AHIP)[2] appreciate the opportunity to comment on the NAIC Long-Term Care Actuarial (B) Working Group's (LTCAWG) revised cost-sharing factors released for public exposure on March 28, 2025.

We commend the LTCAWG for its continued efforts to navigate the complexities of long-term care insurance rate reviews through the Multi-State Rate Review (MSRR) framework. While we understand and respect the goal of achieving an appropriate balance between the interests of policyholders and insurers, we are concerned that the recent revisions move beyond that balance by further expanding cost-sharing obligations on insurers. We recognize that transitional approaches may help bring additional states into the process, but care must be taken to avoid reinforcing disparities or delaying meaningful progress toward consistent implementation.

As outlined in our previous comment letters, we believe that successful implementation of the MSRR framework requires the LTCAWG to keep the following principles at the forefront:

- Avoiding Arbitrary Caps: Maintaining actuarial soundness and timely implementation must remain central to the framework, particularly for policies well into their claim years and blocks that have experienced approval delays.

- Offering policyholders appropriate, actuarially sound options can help manage rate impacts without undermining consistency across states.

- Promoting predictable and transparent processes benefits all stakeholders and is key to achieving broad, uniform adoption.

- Recognizing the impact of prior regulatory actions is essential to a balanced approach. Cost-sharing should not apply to portions of a rate increase that stem from previously delayed, limited, or denied actuarially justified filings. Insurers should not be penalized for outcomes shaped by regulatory decisions outside their control. The framework should

[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.

reflect both actuarial soundness and the historical context contributing to current cumulative rate needs.

ACLI and AHIP respectfully reiterate our strong support for the MSRR's original objectives: to advance a consistent, actuarially grounded approach to long-term care rate review that promotes transparency, timeliness, and equitable outcomes across states. We encourage the LTCAWG to bring this process to a timely and workable resolution that can be implemented consistently.

Sincerely,

Jan Graeber
Senior Actuary, ACLI

Ray Nelson
Consultant for AHIP

Memo

From: Lynn Manchester, FSA, MAAA, Director, RRC

Background

The Long Term Care Insurance Multistate Rate Review Subgroup ("the Subgroup") is considering revised cost-sharing factors to accompany implicit cost-sharing contained in the blended / if-knew aspect of the proposed MSA approach, considered by the Working Group and the Long-Term Care Insurance (B) Task Force in late 2024. Three approaches are being considered:

- Missouri (MO) Proposal
  - No haircut for the first 100%.
  - 35% for the portion of cumulative rate increase between 100% and 400%
  - 70% for the portion of cumulative rate increase between 400% and 800%
  - 85% for the portion of cumulative rate increase between 800% and 1000%
  - 95% haircut for the portion of the cumulative rate increase in excess of 1000%
- "Alternative" Proposal
  - 5% haircut for the first 100%.
  - 35% for the portion of cumulative rate increase between 100% and 400%
  - 70% for the portion of cumulative rate increase between 400% and 800%
  - 85% for the portion of cumulative rate increase in excess of 800%
- Pennsylvania (PA) Proposal
  - The Multi-State Actuarial Team would not recommend a rate increase for any state higher than 100% of current rates in that state. The idea is to provide a path forward for states with lower past cumulative approvals by avoiding recommendation of extremely high rate increases. In subsequent filings with states (or if arrangements are worked out with a state), companies could file to recoup what was justified.

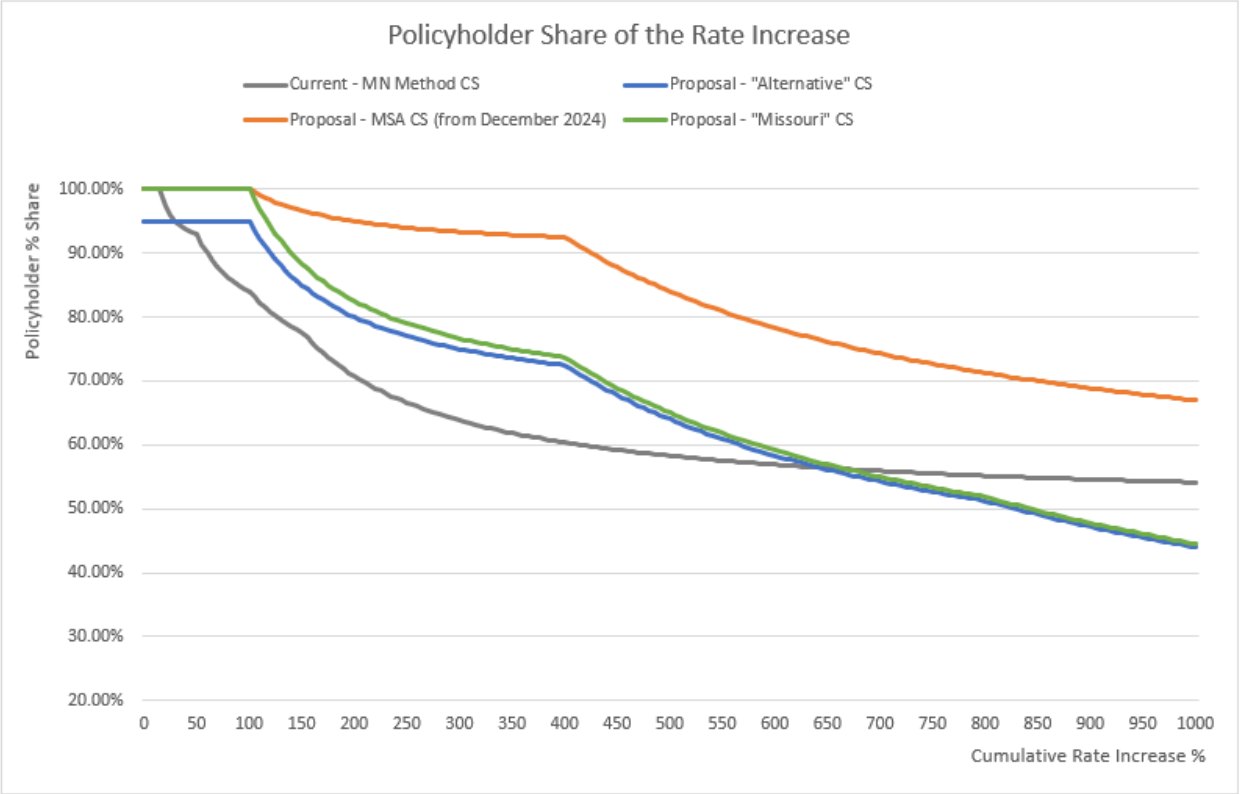
RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the Subgroup members.

RRC Comments

1. Overall, we applaud these continued efforts. We understand that there are current industry challenges associated with differences in rate approval practices among states and agree with efforts to increase uniformity of those practices while continuing to maintain the individual state decision making authority.

2. Based on the nature of the proposals, which are not focused on the actuarial soundness of the rate increases or the underlying assumptions but are focused on goals of consistency and efficiency, our comments below are focused on outcomes and not actuarial soundness.

3. We present the following graph for illustration purposes of how each proposed cost sharing (CS) method (other than PA, because it differs in nature) compares with the Current Minnesota Method Cost Sharing (gray line in the graph below) and the Proposed Cost Sharing method reviewed by the Subgroup in December 2024 (orange line in the graph below).



4. We have the following observations regarding the two newly proposed methods:

    a. The alternative method is more beneficial to policyholders than the Missouri proposal across all levels of the rate increase. When compared to the current MN method, there is a benefit to the policyholders in the first 30% of the rate increase and starting around 642% of the rate increase. In between 30% and 642%, the current MN method is more beneficial.

    b. There is a low frequency of cumulative rate increases exceeding 500%, so the benefits observed to the policyholder in the tail end of the Alternative or Missouri methods may be infrequently realized.

With the low frequency of cumulative rate increases exceeding 500%, the net impact of these changes appears to significantly benefit the companies and not the policyholders, relative to the Minnesota Method.

5. Regarding the Pennsylvania proposal, it appears this proposal would be beneficial to policyholders who in some cases have received rate increases exceeding 100%. By imposing a cap, this would provide policyholders with more certainty on the maximum amount of potential future rate increases and may limit policy lapsation.

Thank you for the opportunity to provide comments on this important initiative. We can be reached at 813-506-7238/Lynn.Manchester@riskreg.com or 617-429-0069/Andrew.Larocque@riskreg.com if you have any questions.

Attachment Two-A5
Health Actuarial (B) Task Force
8/10/25

MSA Cost-sharing Proposals

Fred Andersen, FSA, MAAA

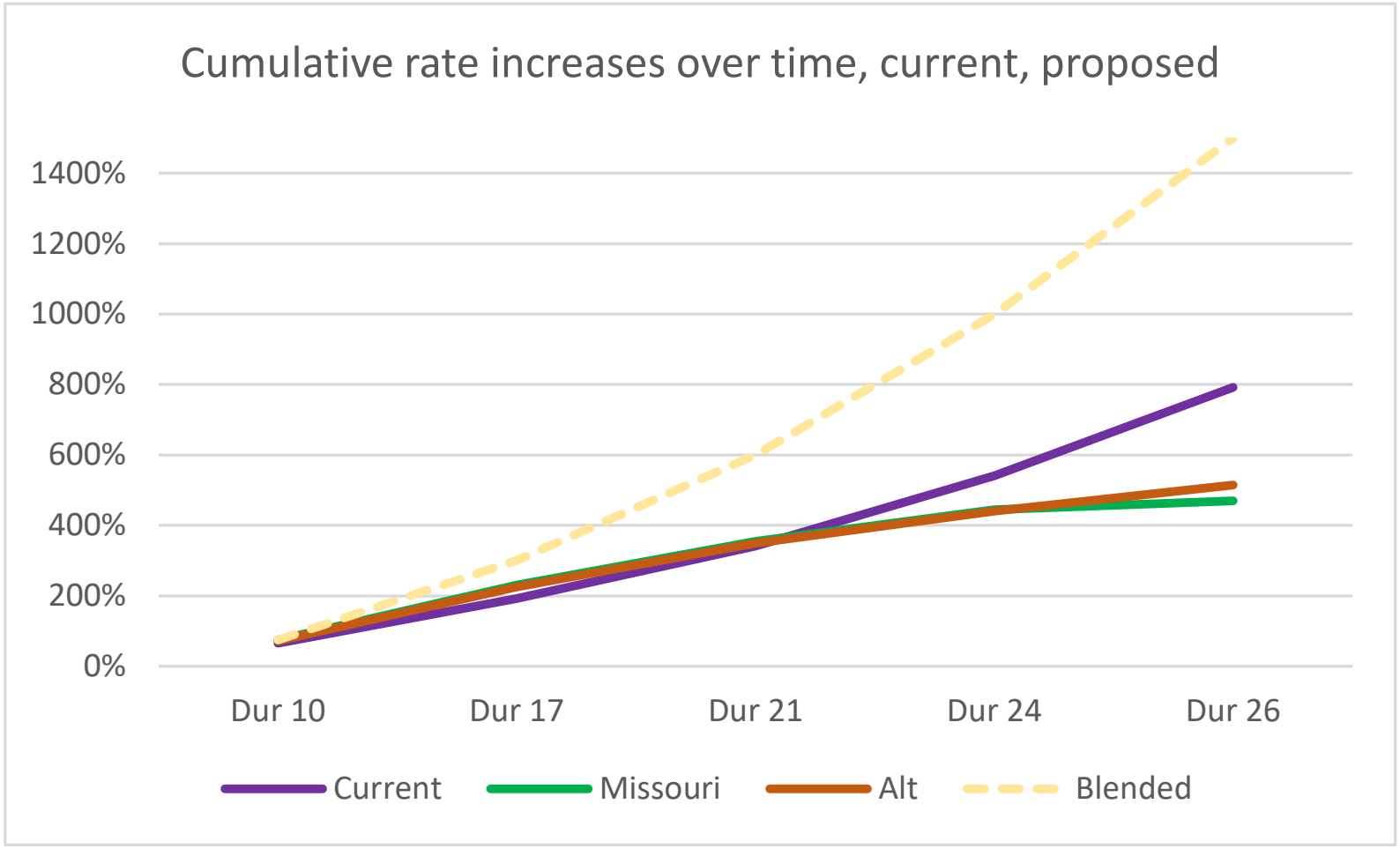
Chief Life Actuary, Minnesota Department of Commerce

Comparison of proposals

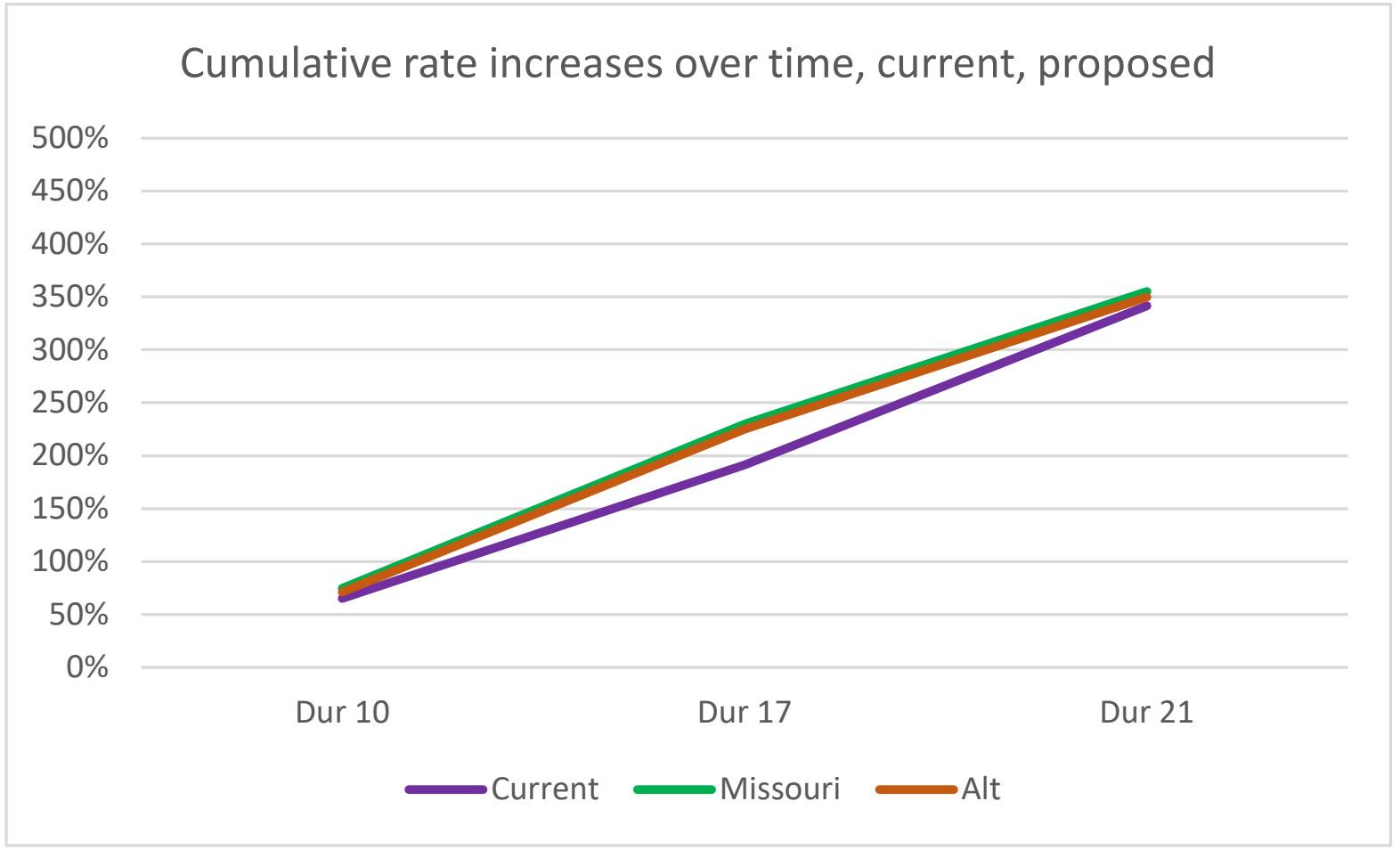
Blended range		Current PH Share	Alt PH Share	Missouri PH Share
0%	100%	**84%**	**95%**	**100%**
100%	400%	**57%**	**65%**	**65%**
400%	800%	**50%**	**30%**	**30%**
800%	1000%	**50%**	**15%**	**15%**
1000%		**50%**	**15%**	**5%**

Note that “Current” reflects a blend of cost sharing factors for the first two ranges

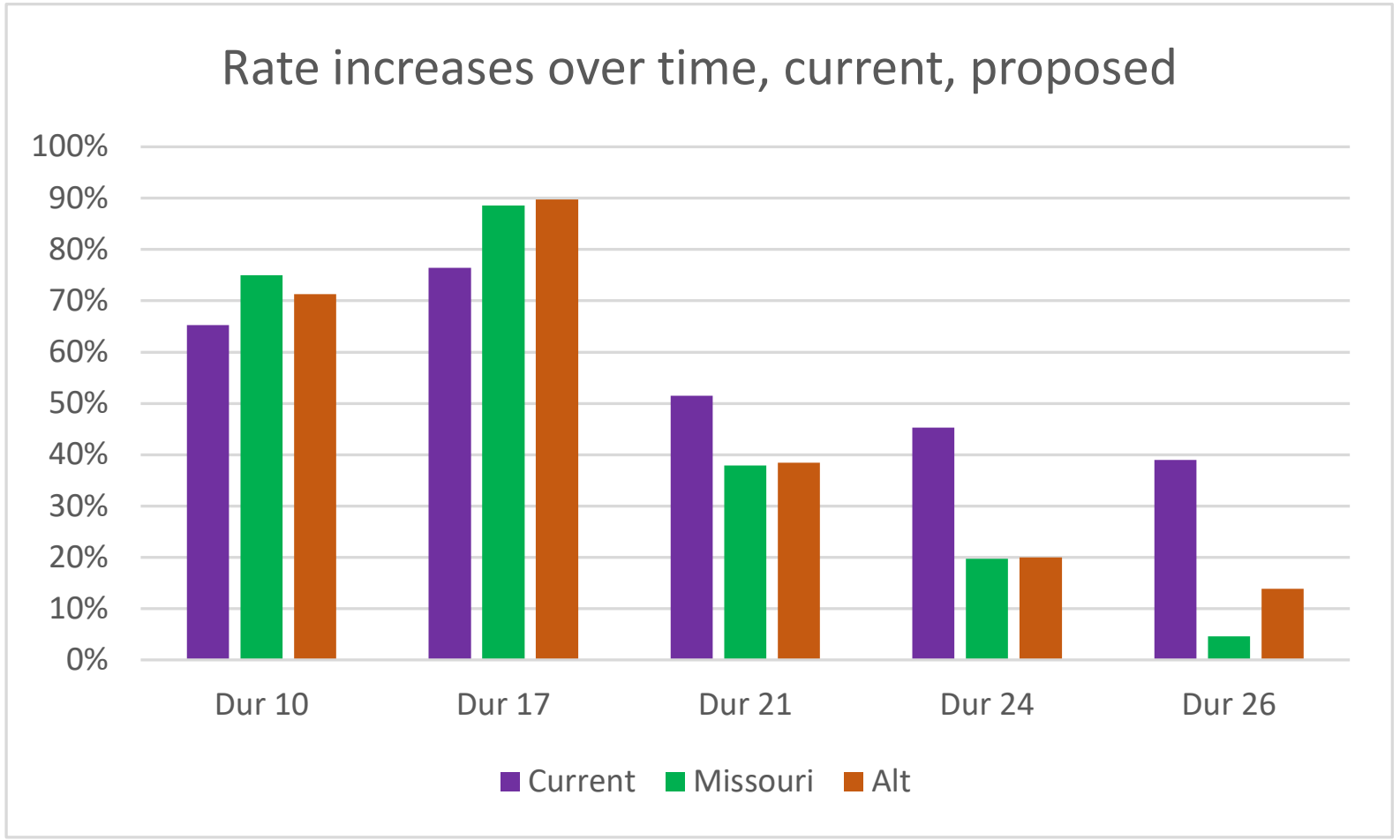
Comparison of Missouri and Alternative cumulative rate increases to current



Middle duration impact



Comparison of rate increases over time



SOCIETY OF ACTUARIES RESEARCH UPDATE TO HATF

August 10, 2025

Dale Hall, FSA, MAAA, CERA
Managing Director of Research

Attachment Three
Health Actuarial (B) Task Force
8/10/25

Experience Studies Pro Update

Experience Study	Timing	Participating Company Count	Estimated Market Share
2015-2022 Group Long-Term Disability Incidence	3Q 2025	19	97%
2023-2024 Fixed Indexed Annuity Contract Owner Behavior	3Q 2025	17	57%
2009-2023 Individual Life Term Conversions	4Q 2025	15	38%
2023-2024 Fixed-Rate Deferred Surrender	4Q 2025	24	68%
2022-2024 Variable Annuity Contract Holder Behavior	4Q 2025	17	51%

SOA Research INSTITUTE

Experience Studies Pro Update

- Long Term Care Study with NAIC
  - Analyze policy persistency and claim incidence, termination, and utilization trends
  - Updated data request released in April
  - Experience data collection target of September 15, 2025
  - Current industry representation at 75% of market share

- https://www.soa.org/research/opportunities/2025/2000-23-ltc-datarequest/

SOA Research INSTITUTE

Additional Health Research

Experience Studies & Practice Research

Attachment Three
Health Actuarial (B) Task Force
8/10/25

Project Name	Objective	Expected Completion Date
ACA@15	This report will examine the success of the ACA to different stakeholders in the Individual, Small Group and Medicaid Marketplaces	https://www.soa.org/resources/research-reports/2025/aca-at-15/
HIV + Medicare	This research involves evaluating the impact of HIV positive individuals on Medicare Advantage.	https://www.soa.org/resources/research-reports/2025/hiv-medicare-survey-population/
Assessing and Valuing the Impact of Technology in HealthCare	Examines the way actuaries value Technology within the Healthcare System	https://www.soa.org/resources/research-reports/2024/impact-technology-healthcare/
The Impact of Social Determinants of Health on Risk Adjustment	Analyzes the potential impact of SDOH factors on Risk Adjustment	https://www.soa.org/resources/research-reports/2025/sdoh-medicaid-risk-adjustment/
Provider Use of AI in Healthcare	Explore uses of AI to improve healthcare clinical and financial outcomes	8/14/2025
Healthcare Insurance Reinsurance Captive Landscape Insurance/Reinsurance Captive Landscape	Focus on Health Reinsurance Captive Landscapes by Jurisdiction	8/14/2025
Impact of Wildfires on US Health and Life Insurers-Morbidity Report	Examines impact of Wildfire smoke on air quality and the impact on morbidity	8/29/2025
2015-2022 Group Long-Term Disability Incidence Study - Report	Perform a study of group long-term disability incidence.	9/30/2025
HCCI Quick Hit - Specialty Pharmacy Trends	This research will examine some key specialty drugs to look at how increases in uptake in drugs worth between 10K and 200K are driving current pharmacy trend.	10/31/2025
2000-2023 Long Term Care Experience Study - Report	Complete an experience study of Long-Term Care claim incidence, termination, and utilization.	3/31/2027

SOA Research INSTITUTE

Attachment Three
Health Actuarial (B) Task Force
8/10/25

Attachment Four
Health Actuarial (B) Task Force
8/10/25

Academy Professionalism Update

NAIC Summer National Meeting

August 2025

American Academy of Actuaries

About the Academy

Mission:
To serve the public and the U.S. actuarial profession

Community:
Serving over 20K MAAAs & public stakeholders for 60 years

Standards:
Setting qualification, practice, and professionalism standards

Impact:
Delivering over 300 insight-driven publications & resources annually

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American Academy of Actuaries

Committee on Qualifications

The Committee on Qualifications (COQ)

- recommends to the Academy's Board of Directors the minimum qualification standards, including continuing education requirements, necessary to qualify credentialed actuaries to issue statements of actuarial opinion in the United States.
- answers questions relating to qualifications.
  - As of mid-July, the COQ has received 15 questions in 2025, covering primarily continuing education requirements.

The most recent U.S. Qualification Standards took effect Jan. 1, 2022.

Actuarial Standards Board (ASB)

The ASB sets standards for appropriate actuarial practice in the United States through the development and promulgation of Actuarial Standards of Practice (ASOPs). These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.

2024 ASB Annual Report

www.actuarialstandardsboard.org

Actuarial Standards Board (ASB)

ASB met in June and reviewed proposed revisions of

- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*
- ASOP No. 49, *Medicaid Managed Care Capitation Rate Development and Certification*

In September, the ASB plans to continue review of ASOP No. 49 and review a pension ASOP.

General ASOPs under revision or development

- ASOP No. 1, *Introductory Standard of Practice*
- ASOP No. 12, *Risk Classification (for All Practice Areas)*
- ASOP No. 41, *Actuarial Communications*

Health ASOPs under revision or development

- ASOP No. 7, *Life or Health Cash Flow Analysis*
- ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits* (approved for revision)
- *Pricing Reinsurance or Similar Risk Transfer Transactions Involving Life Insurance, Annuities, or Long-Duration Health Benefit Plans* (new)

Actuarial Board for Counseling and Discipline

Mission

The Actuarial Board for Counseling and Discipline (ABCD) was established in the bylaws of the American Academy of Actuaries to strengthen the adherence by members of the five U.S.-based actuarial organizations to the recognized standards of ethical and professional conduct.

The Board has two primary functions:

- It responds to actuaries' **request for guidance** on professional issues.
- It considers **complaints** about possible violations of the Code of Professional Conduct.

- 2024 Annual Report available at ABCD-Annual-2024.pdf
- May/June 2025 Up to Code article, Mission Professionalism

www.abcdboard.org

American Academy of Actuaries

Upcoming Professionalism Events

COQ, ASB, ABCD: The Professionalism Trifecta

- September 5 webinar

Life and Health Qualifications Seminar

- New Format: Attendees to select either a life track or a health track
- November 17-20
- Arlington, Va

American Academy of Actuaries

Questions?

For professionalism questions, comments, or suggestions, please contact

Virginia Hulme, Assistant Director, Professionalism

professionalism@actuary.org

American Academy of Actuaries

Attachment Five
Health Actuarial (B) Task Force
8/10/25

Health Practice Council Update

Health Actuarial (B) Task Force (HATF) Meeting

August 10, 2025

American Academy of Actuaries

About the Academy

Mission:
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Community:
Serving over 20K MAAAs & public stakeholders for 60 years

Standards:
Setting qualification, practice, and professionalism standards

Impact:
Delivering over 300 insight-driven publications & resources annually

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American Academy of Actuaries

Recent NAIC Engagement

Submitted:

Final report to the Health RBC (E) Working Group on the H2 Underwriting Risk Component and Managed Care Credit Calculation in the Health RBC Formula

Joint comments to the Big Data and Artificial Intelligence (H) Working Group on the AI in Insurance Model Law proposal

Joint comments to the Risk-Based Capital Model Governance (EX) Task Force on the RBC Model Governance Chair Exposure

Recent & Upcoming HPC Activity

Publications

- Health Insurance Market Dynamics Resource Guide
- The Impact of COVID-19 on Long-Term Care Insurance Experience—2025

Webinars/Events:

- August 5: 2026 Health Insurance Premiums in Focus: Policy Changes and Impacts on Market Stability

Recent Academy Activity

Webinars/Events:

- Analysis of NAIC AI/Machine Learning Surveys Webinar
- Social Security Trustees Report: A Deep-Dive Discussion With the Program's Actuaries
- ASOP No. 2 Practice Note Webinar
- Insuring the Future: Insurance Investment Summit

Other Resources:

- Cyber Risk Toolkit Updates

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Health Practice Council Update

Health Actuarial (B) Task Force (HATF) Meeting

August 10, 2025

American Academy of Actuaries

About the Academy

Mission:
To serve the public and the U.S. actuarial profession

Community:
Serving over 20K MAAAs & public stakeholders for 60 years

Standards:
Setting qualification, practice, and professionalism standards

Impact:
Delivering over 300 insight-driven publications & resources annually

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Recent NAIC Engagement

Submitted:

Final report to the Health RBC (E) Working Group on the H2 Underwriting Risk Component and Managed Care Credit Calculation in the Health RBC Formula

Joint comments to the Big Data and Artificial Intelligence (H) Working Group on the AI in Insurance Model Law proposal

Joint comments to the Risk-Based Capital Model Governance (EX) Task Force on the RBC Model Governance Chair Exposure

Recent & Upcoming HPC Activity

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2026 Health Insurance Premiums in Focus: Policy Changes and Impacts on Market Stability

Health Actuarial (B) Task Force (HATF) Meeting

August 10, 2025

Annette James, MAAA, FSA, FCA

Vice President, Health

American Academy of Actuaries

Agenda

- Market stability considerations
- The interconnectedness of health coverage sources
- Premium rate development timeline
- Key drivers of 2026 premium changes
- Q&A

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Market Stability Considerations

Market stability—Core Concepts

Key Components of a stable market

- Adequate enrollment to produce stable, predictable claims
- A balanced risk pool that includes enrollees with a broad range of risks, not only those with high expected claims
- A reliable and predictable regulatory framework to support fair competition among financially viable insurers

Market stability can help support access to affordable insurance, consumer choice, and insurer competition

Market Stability in the Individual Market
Current provisions promoting stability

- Premium tax credits and cost-sharing reductions
  - Improve affordability and broaden the risk pool to attract healthy lives
- Single risk pool requirement
  - Require premiums reflect the market's overall risk profile, supporting competition on price
- Risk adjustment
  - Intention to compensate plans based on the relative health status of enrollees
  - Supports uniform market rules and the single risk pool requirement
  - Reduces incentives to avoid less healthy enrollees
- Uniform market rules
  - Examples: guaranteed issue and renewal, prohibition on health status rating
  - Facilitate access to coverage, including for people with pre-existing conditions

Market Stability in the Individual Market
Current provisions promoting stability

- Essential health benefit requirements ensures comprehensive coverage across all plans
- State laws and regulatory oversight
  - Examples: rate review, financial solvency requirements, consumer protections
  - Facilitate fair and competitive health insurance markets
- Transparency requirements facilitate price competition
  - Can encourage consumers to compare costs before receiving care

Market Stability in the Individual Market

Policy changes that could improve stability

Expanded use of Individual Coverage Health Reimbursement Arrangements (ICHRAs)

- Could improve overall risk pool and reduce premiums if used by a broad cross-section of employees to purchase coverage in the individual market
- Employers are more likely to offer ICHRAs when the individual market is affordable and stable

Reinsurance or invisible high-risk pools

- Offsetting high-cost claims could lower premiums and increase enrollment, especially those ineligible for premium tax credits, depending on how programs are structured and funded

Market Stability in the Individual Market
Policy changes that could threaten stability

Expiration of enhanced premium tax credits
- Will likely raise net premiums, lower enrollment, and increase adverse selection

Stricter eligibility requirements
- Will likely lower enrollment and increase adverse selection

Increased availability of non-compliant plans
- Could expand consumer choice in the short term, but would likely draw healthy people out of the regulated market and increase adverse selection

Incentivizing cross-state insurance sales
- Weakening state oversight could undermine stability in states with stronger rules

Potential impacts: Higher premiums, reduced insurer competition, and less consumer choice

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Interconnectedness of Health Coverage Sources

Primary coverage sources for the Under-65 Population

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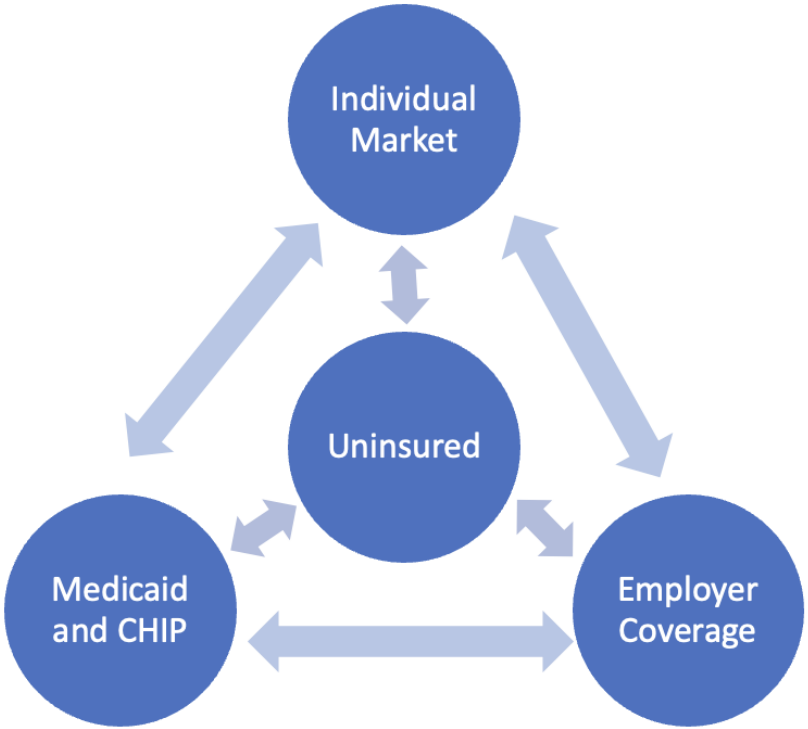

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Premium Rate Development Timeline

2026 Illustrative Premium Rate Development Timeline

Approximate Internal Insurer Deadlines (assumes early June submission deadline)	
Product development and experience analysis	Sept. 2024–Feb./March 2025
Plan design development and actuarial value testing	Nov. 2024–April 2025
Examine prior experience and make necessary adjustments	March 2025
Set target provider reimbursement levels	Early-mid April 2025
Project data based on expected medical and Rx trend	Mid-late April 2025
Obtain internal approvals, finalize rates, prepare filing materials	May 2025
External Deadlines	
Initial rate filing deadlines*	May 2025–June 2025 (varies by state)
Final application deadline*	Aug. 13, 2025
Final limited data correction window*	Sept. 12-13, 2025
Rate filing data published	Oct. 15, 2025
Open enrollment begins	Nov. 1, 2025
Plan year begins	Jan. 1, 2026

* State-based exchanges have some flexibility to set their own deadlines, and some follow the federal deadlines

Rate Development Begins More Than a Year in Advance

- Premium rate development process must account for any updates to federal or state rules
- Timely finalization of these rules helps insurers meet internal and external filing deadlines
- Updating rates to fully reflect new policies can take six weeks or more
- The earlier any changes are made, the more readily they can be reflected in premium rates

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Key Drivers of 2026 Premium Changes

Potential Drivers of 2026 Premium Changes

The *Drivers of 2026 Premium Changes* issue brief is intended to describe how premiums may change in the upcoming plan year. It is not intended to be used or relied on by actuaries, insurers, or regulators for rate filings.

Potential Drivers of 2026 Premium Changes

Premium development components

- Who is covered—the composition of the risk pool
- Projected medical costs
- Other premium components—administrative costs, taxes, profit/risk charge
- Laws and regulations

Insurers develop premium *rates*, not premium *increases*. The rate review process assesses whether premium *rates* are reasonable.

Potential drivers of 2026 Premium Changes
Medical trend factors

Inflation
- Input costs for health care services continue to increase

Continued growth in drug spending
- Higher unit price growth
- New and expensive gene, cell, and biologic therapies
- Increased demand for weight-loss drugs, if covered

Increased use of behavioral health services
- Enforcement of state parity laws
- Provider network expansions
- Provider reimbursement increases

Potential Drivers of 2026 Premium Changes
Risk composition factors—individual market

Market integrity rule

- Tightened enrollment and verification procedures raise adverse selection concerns → higher premiums

Expiration of enhanced premium tax credits

- Expected to reduce enrollment significantly → increased adverse selection → higher premiums

Medicaid redeterminations

- Experience of former Medicaid enrollees currently in ACA marketplace now included in claims experience used to develop 2026 rates
- In some states, this cohort has been younger and healthier, improving the risk profile and placing modest downward pressure on rates
- In other states, this cohort appears to have higher health needs, resulting in upward pressure on rates.

Other factors impacting morbidity of the risk pool

Potential Drivers of 2026 Premium Changes

Risk composition factors—Small Group Market

The Small Group Market in most states has experienced a slow but steady decline

Continued shift to alternative coverage sources could continue the decline

Self-funding and level-funding among small employers

- Shifts among small employers from ACA-compliant coverage to other funding arrangements could worsen the small group risk pool

Account-based plans (e.g., ICHRAs)

- Shift workers/dependents from group coverage to the individual market
- If small employers with high-cost members choose this, there could be improvements in the small group risk pool and declines in the individual market risk pool

Potential Drivers of 2026 Premium Changes
Other factors

State and local factors

- Local market conditions
- State-specific legislative and regulatory requirements

Additional uncertainty

- Uncertainty regarding the impacts of recent policy changes on enrollment, morbidity, utilization, and prices could lead to increased risk margins

Key Takeaways

- Market stability is foundational to affordability, competition, and consumer access in the individual market.
- Premium increases in 2026 are likely due to rising medical costs, increased drug spending, and worsening risk pools.
- Policy decisions matter - expiration of enhanced tax credits and stricter eligibility verification rules could significantly reduce enrollment and increase premiums.
- Cross-market interconnectedness is critical - policy decisions regarding Medicaid and employer coverage can ripple through the individual and small group markets.
- Early policy clarity helps insurers price more accurately and avoid unnecessary volatility.

Appendix: Resource Guide on Health Insurance Market Dynamics

PRIVACY.FLOWCODE.COM

[Health Insurance Market Dynamics: A Resource Guide] **(July 2025)**

Questions?

Upcoming Events

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Actuarial Perspectives and Solutions for Strengthening the U.S. Retirement System
September 18 | Washington, D.C.

Life and Health Qualifications Seminar
Nov. 17-20 | Arlington, Va.

Seminar on Effective P/C Loss Reserve Opinions
Dec. 8-9 | Salt Lake City, Utah

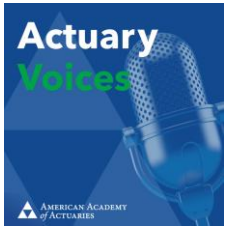
Other Academy Resources

Access these Resources:

[*Contingencies* Magazine]

[Policy Forum]

[Actuarially Sound Blog]



[Actuary Voices Podcast]

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Thank You!

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