Health Actuarial (B) Task Force
Health Actuarial (B) Task Force March 21, 2023, Minutes
   Long-Term Care Actuarial (B) Working Group Working Group Mar. 21, 2023, Minutes Attachment (One)
   Long Term Care Rate Increase Checklist Discussion Document (Attachment One-A)
   Society of Actuaries (SOA) Presentation (Attachment Two)
   American Academy of Actuaries Health Practice Council (HPC) Presentation (Attachment Three)
The Health Actuarial (B) Task Force met in Louisville, KY, March 21, 2023. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Anita G. Fox, Vice Chair, represented by Kevin Dyke (MI); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Eric Unger (CO); Karamia M. Woods represented by Stephen F. Flick (DC); Gordon I. Ito represented by Kathleen Nakasone (HI); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Julia Lyng (MN); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Jennifer Catechis represented by Anna Krylova (NM); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Jodi Frantz (PA); Cassie Brown represented by Aaron Hodges (TX); Jon Pike represented by Ryan Jubber (UT); and Mike Kreidler represented by Lichiou Lee (WA).

1. **Adopted its 2022 Fall National Meeting Minutes**

Muldoon made a motion, seconded by Schallhorn, to adopt the Task Force’s Dec. 5, 2022, minutes (see NAIC Proceedings – Fall 2022, Health Actuarial (B) Task Force). The motion passed unanimously.

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

Andersen said he and Lombardo are now the Working Group’s co-chairs. He said the Working Group met Feb. 17 and took the following action: 1) discussed disbanding the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup; 2) exposed a request for comments on a proposal to revise the nationally coordinated long-term care insurance (LTCI) rate increase review checklist; 3) exposed a request for comments on the Minnesota and Texas LTCI rate increase review methodologies, as used in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework); and 4) heard an update on LTCI valuation issues. He said both requests for comment exposures have a deadline of April 24, and the Working Group plans to meet in May to discuss comments received.

Andersen said any changes that are made to the checklist or either rate increase review methodology could affect the LTCI MSA Framework. He said he believes any changes to the checklist can be completed this year, and any changes to either rate increase review methodology will likely occur next year.

Andersen made a motion, seconded by Muldoon, to adopt the report of the Long-Term Care Actuarial (B) Working Group, including its Feb. 17 minutes (Attachment One). The motion passed unanimously.

3. **Disbanded the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup**

Andersen made a motion, seconded by Muldoon, to disband the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup and transfer the functions of the two subgroups to the Long-Term Care Actuarial (B) Working Group. The motion passed unanimously.
4. **Heard an Update from the CCIIO**

Brent Plemons (federal Center for Consumer Information and Insurance Oversight—CCIIO) said the plan year 2024 Rate Review Timeline Bulletin for federal Affordable Care Act (ACA) rate filing submissions was posted to the federal Centers for Medicare & Medicaid Services (CMS) website on March 15. He said the initial filing submission deadline for states with effective rate review programs, which are all states other than Oklahoma and Wyoming, is the earlier of the date set by the state and July 19. He said the two states without effective rate review programs have a deadline of June 1. He said the CCIIO intends to post initial rate filing information received to its website, ratereview.healthcare.gov, on July 26. He said if rate filings contain a qualified health plan (QHP) serviced by the healthcare.gov exchange, the filings need to be finalized by Aug. 16; and for states with state-based exchanges or non-QHP off-exchange filings, the finalization deadline is Oct. 16. He said the CCIIO plans to post final rate information no later than Nov. 1.

Plemons said the new Uniform Rate Review Template (URRT) Version 6.0 differs from the previous version (5.4) only in the removal of rounding limitations, the removal of the Actuarial Value (AV) de minimis range validation, and the state and market fields on Worksheet 1 having been moved to the left. He said updated URRT instructions for Version 6.0 will be available soon. He said the instructions do not specify where to enter factors for reinsurance waivers, but it is allowable to enter the factor on Worksheet 1, where a federal reinsurance factor would normally be entered. He said if a reinsurance waiver factor is used, insurers should be mindful of the single risk pool requirement and not apply all the reinsurance to any one plan.

Jeff Wu (CCIIO) said federal guidelines for cost-sharing reduction (CSR) loads are not particularly detailed. He said insurers can and should load for CSR amounts that the federal government will not reimburse. They can do this by spreading all of the load across all plans within the single risk pool or applying the load only to the plans that generate CSR deficiencies. Wu said whichever loading methodology is chosen, the total amount of the load should be actuarially justified, reasonable, and recover any deficiencies.

Lombardo said the transfer of filings from the System for Electronic Rates & Forms Filing (SERFF) into the federal Health Insurance and Oversight System (HIOS) in 2022 worked extremely well for Connecticut, and he has not heard of many instances to the contrary from other states. He asked if it is correct that the CCIIO is leaving the determination of actuarial justification and reasonableness of an insurer’s CSR loading methodology to state insurance regulators. Wu said this is correct. Lombardo asked if there is a timeframe for the finalization of the Actuarial Value Calculator. Wu said it will likely be close to the time that the Notice of Benefit and Payment Parameters is finalized, and he believes this will occur soon. He said this will ideally be in early March 2024 for the plan year 2025 guidance. Dyke said it continues to be a challenge for state insurance regulators to determine whether an insurer’s CSR loading methodology is actuarially sound and in keeping with the single-risk pool requirements.

Muldoon said regarding the July 26 posting of final rates, there have been instances in prior years where insurers, for various reasons, have not had their rates posted to ratereview.healthcare.gov by the federally prescribed date. He asked if there is a way to ensure that all insurers have their rates posted by the July 26 deadline. Plemons said the only recourse the CCIIO has is for its rate review team to contact the insurer and attempt to get its final rates submitted and posted. Wu asked Muldoon if he believes insurers who have not had their rates posted by the deadline are failing to do so deliberately as a strategy or if it is due to mistakes or errors on the insurers’ part. He said if it is thought that the former reason is the explanation, the CCIIO needs to be very thoughtful about how to handle such a situation. Muldoon said he assumes the failure to have rates posted by the deadline was due to an error, and he has no indication that it was being used as a competitive strategy. Wu said the CCIIO will monitor the situation for the 2024 plan year and respond accordingly. Plemons said he will consult with CCIIO staff to determine if there is a way to get final rates posted for insurers that do not meet the deadline due to errors or mistakes.
Muldoon said some state insurance regulators have questions concerning the details of what should be considered appropriate for an insurer’s CSR loading methodology. Lombardo said a meeting of interested state insurance regulators will be held soon to discuss these issues.

Lombardo said Connecticut has a state-based exchange, and there have been instances where insurers have missed the deadline for posting final rates. He said he does not believe these insurers were attempting to gain a competitive advantage, but other insurers that have met the deadline have concerns that these insurers are waiting to see rates posted by the deadline to modify their own rates in order to gain a competitive advantage. He said to ensure the integrity of the rate filing system, all rates for a given market should be posted and available at the same time. Wu said if an insurer displays a pattern of missing the posting deadline, the matter should be investigated.

Lombardo said state insurance regulators are available to assist with the CCIIO’s efforts in resolving these issues. Dyke said it is possible that the implementation of the transfer of filings from SERFF into the federal HIOS has created an issue with insurers verifying that their final rates are available for posting, and it may be beneficial for the CCIIO rate review team to encourage insurers to periodically check the HIOS to ensure that their rates are validated.

5. **Heard a Presentation from the SOA Research Institute**

Dale Hall (Society of Actuaries—SOA) gave a presentation (Attachment Two) on the Research Institute’s findings related to social, physical, and cultural determinants of health and their incorporation into actuarial data and workstreams, as well as Research Institute experience studies and other health research activities.

6. **Heard a Presentation from the Academy HPC**

Barb Klever (Blue Cross Blue Shield Association—BCBSA) gave a presentation (Attachment Three) on American Academy of Actuaries (Academy) Health Practice Council (HPC) activities.

7. **Heard an Academy Professionalism Update**

Shawna Ackerman (California Earthquake Authority—CEA) said the Actuarial Board for Counseling and Discipline (ABCD) recently published its 2022 annual report, which is available on the ABCD website, abcdboard.org. She said the ABCD responded to 96 requests for guidance (RFGs) in 2022, and about one-third of the requests were from the health practice area. She said Precept 1, Professional Integrity, and Precept 2, Qualification Standards, of the Academy’s Code of Professional Conduct continue to be popular RFG topics. She said an RFG concerning obtaining organized activity continuing education (CE) credits was received toward the end of 2022. She also encouraged actuaries to accumulate organized activity CE credits earlier rather than later during the year.

Robert Damler (Actuarial Standards Board [ASB]—Retired) said two general Actuarial Standards of Practice (ASOPs) that apply to all practice areas are in the process of being revised. He said ASOP No. 12, Risk Classification (for All Practice Areas), is undergoing revision and review by a task force, and it is anticipated that the revised ASOP No. 12 will be presented to the ASB later this year and then exposed for comment. He said revisions to ASOP No. 41, Actuarial Communications, were exposed for comment in 2022, and these comments are being reviewed by a task force. He said he expects that a second exposure draft of ASOP No. 41 revisions will be published within the next six to 12 months. He said revisions to ASOP No. 10, U.S. GAAP for Long-Duration Life, Annuity, and Health Products, were approved by the ASB in the past few months, and the new version will be effective May 1. He said an old Actuarial Compliance Guideline No. 4, which was the last such guideline in existence, has been converted to ASOP No. 57, Statements of Actuarial Opinion Not Based on an Asset Adequacy Analysis for Life Insurance, Annuity, or Health Insurance Reserves and Related Actuarial Items. He said ASOP No. 57 will become effective June 15.
Damler said there are several ASOPs under development or revision. He said these include ASOP No. 7, Analysis of Life, Health, or Property/Casualty Insurer Cash Flows; ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities; ASOP No. 36, Statements of Actuarial Opinion Regarding Property/Casualty Loss and Loss Adjustment Expense Reserves; ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies; and ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification.

8. **Discussed a Meeting of the Long-Term Care Actuarial (B) Working Group at the Summer National Meeting**

Lombardo said he and Andersen intend for the Working Group to meet in person at the Summer National Meeting in Seattle, WA.

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

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The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met Feb. 17, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sanjeev Chaudhuri (AL); Ahmad Kamil (CA); Lilyan Zhang (FL); Nicole Boyd (KS); Marti Hooper (ME); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Anamaria Burg and R. Michael Markham (TX); and Tomasz Serbinowski (UT).

1. **Discussed Disbanding the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup**

   Andersen said Serbinowski will no longer be chair of the Working Group, and he and Lombardo will be co-chairs of the Working Group. Lombardo said the work of the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup will now be done by the Working Group, and the Health Actuarial (B) Task Force will consider the proposal to disband the two subgroups during its March 21 meeting. Andersen said that any members of the two subgroups and any other state insurance regulators are welcome to become members of the Working Group if they are not already. Lombardo said that Serbinowski will continue as a member of the Working Group.

2. **Exposed a Request for Comments on a Proposal to Revise the Nationally Coordinated LTCI Rate Increase Review Checklist**

   Andersen said the Working Group, and the Long-Term Care Valuation (B) Subgroup began work approximately five years ago on a project to develop a single checklist that reflects significant aspects of long-term care insurance (LTCI) rate review increase checklists used by all individual states. He said these checklists typically contain questions that states ask insurers at the beginning of an LTCI rate increase request. He said the Nationally Coordinated LTCI Rate Increase Review Checklist (Checklist) that was developed contains aspects of the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* and input from many states’ experiences with their individual checklists. He said the intent of creating the Checklist was to move away from having all states using different checklists, and to add efficiency to the overall rate increase review process nationwide. He said it was recognized that some states may still need to request information that is not asked for in the Checklist, but the intent was that approximately 90% of the information that any one state requires would be requested through the Checklist.

   Andersen said the Health Actuarial (B) Task Force adopted the Checklist in 2018. He said many states are relying on the Checklist for their LTCI rate increase reviews, but insurers that have filed rate increase requests report that many states are not relying on it. He said that when the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and Multistate Actuarial Team (MSA Team) began work in 2019, it decided to rely upon the Checklist for its LTCI Multistate Rate Review process. He said after the first few pilot MSA Team rate increase reviews, it was recognized that requests for additional information were similar for each of the pilot reviews, and a supplemental MSA Team checklist was developed. He said the supplemental checklist includes requests for information, including benefit utilization experience, cost of care trends, and waiver of premium treatment. He said the MSA Team has found that when the Checklist was combined with the supplemental checklist (Attachment), the number of reviewer objections and interactions with filers have been greatly reduced, resulting in a more efficient review process. He said the Working Group proposes consideration of revising the Checklist by
Lombardo said it will be helpful if states that do not use the Checklist and the supplemental MSA Team checklist identify specific items that are not included in them that prevent the state from using them for their LTCI rate increase reviews.

3. Exposed a Request for Comments on the Minnesota and Texas LTCI Rate Increase Review Methodologies

Andersen said from 2016 to 2019, the Long-Term Care Pricing (B) Subgroup and the Working Group discussed and vetted the LTCI rate increase review methodologies that Minnesota and Texas use. He said appropriate recognition of the shrinking block issue and treatment of past losses were discussed for each of the methodologies. He said the concept of cost-sharing by the insurer as it relates to reducing the burden to policyholders without causing excess financial distress to the insurer was also discussed. He said the decline in interest rates and the impact on available investment returns to support LTCI blocks was also considered. He said the Minnesota and Texas approaches were deemed to be appropriate by most participants in the discussions.

Andersen said at roughly the time that discussions concerning the Minnesota and Texas approaches concluded, the Long-Term Care Insurance (EX) Task Force was created, with its primary mission being increasing uniformity in rate increase approvals among the states. He said this led to greater scrutiny of the Minnesota and Texas approaches, and it was determined that these two methodologies would be used for the LTCI Multistate Rate Review process pilot program. He said the Minnesota and Texas approaches have been codified into the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) that the Executive (EX) Committee and Plenary adopted in April 2022.

Andersen said the MSA Team has applied the Minnesota and Texas methodologies to several LTCI rate increase filings. He said as these blocks have grown older and passed from premium-paying periods to claims-paying periods, more data has become available for evaluation. He said the MSA Team has faced challenges with applying the two methodologies in certain instances, and it wants to determine if the approaches can be improved for future use. He said the most common feedback to date on the Minnesota approach is a potential lack of transparency and that he hopes details available in the Framework can assist in better understanding it. He said he thinks the Minnesota approach achieves an appropriate balance between fairness to consumers and avoiding further insurer financial distress. He said that it is possible that a lack of transparency can be attributed to necessary actuarial judgment that insurers and state insurance regulators apply for assumptions used in premium and claims projections. He said some of the issues the MSA Team has encountered in using the TX methodology are situations where past rate increases were granted prior to the development of the TX methodology, precisely defining what is meant by a past loss, mature blocks of business having high sensitivity to later duration factors while placing less emphasis on past experience, and potential imbalances between fairness to consumers and avoiding further insurer financial distress.

Markham said although he thinks the Texas methodology is fairly transparent, he has found some insurers have difficulty performing the required calculations for rate increase request submittals. Serbinowski said he has seen that insurers easily project future experience for current in-force business using current assumptions, but some have difficulties developing projections using initial filing assumptions because of a lack of initial filing documentation. He said because the Texas approach compares these two different projections, the results of using it can be questionable due to the possible lack of quality in the projection using initial filing assumptions. Lombardo said that some state insurance regulators and insurers have a desire for a one-size-fits-all methodology.
to be used in the MSA Team reviews, but because different blocks of business have different characteristics, he does not think the MSA Team is close to being able to develop such a uniform approach. He said the MSA Team is open to finding a uniform approach and is working towards finding a methodology that may be a better fit for the majority of rate increase reviews submitted.

Jan Graeber (American Council of Life Insurers—ACLI) said industry is not necessarily requesting there be a single, uniform methodology that is used, but would like to know what characteristics of a block make the MSA Team determine which of the Minnesota or Texas approaches will be used. Muldoon suggested the MSA Team use a process upon receiving a rate increase request to determine whether the Minnesota or Texas approach is best suited to the block being reviewed, and then base the recommended rate increase on only the methodology that was deemed best. Lombardo said the MSA Team does perform this sort of analysis upon its initial review, and thinks it is a good idea to document a flowchart of the analysis process used. He said there are instances where the MSA Team sees there are benefits to using both approaches, and this results in a rate increase recommendation that is a blend of the two approaches.

Andersen said the Working Group will expose a request for public comment on the Minnesota and Texas actuarial approaches as described in the Framework document until April 24. Muldoon suggested that the MSA Team provide the insurer with a copy of the spreadsheet used with the Minnesota methodology to arrive at the recommended rate increase that was calculated. Andersen said the Working Group will include this suggestion in the set of comments on the Minnesota and Texas approaches.

4. **Heard an Update on LTCI Valuation Issues**

Andersen said the Long-Term Care Valuation (B) Subgroup has been inactive since the adoption of Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) in 2017. He said many of the members of the Subgroup have been involved with the review of annual AG 51 filings.

Andersen said one of the key trends seen in AG 51 reviews for the past few years is cost of care inflation, particularly for companies with policies that include a 5% inflation protection feature. He said the inflation in the cost of care is creating issues with reserve adequacy observed in AG 51 filings. He said another issue observed is the impact of COVID-19 on LTCI experience data in 2020. He said the impact of COVID-19 on experience data trended closer to normal in 2021, and the expectation was that there would be a negligible COVID-19 effect on 2022 LTCI experience data. He said one of the reviewers’ findings is that the COVID-19 impact has leveled off between 2021 and 2022. He said an issue is whether the experience data seen in 2022 will be the new norm, or if there will be delayed COVID-19 impacts to experience in future years. He said the 2022 AG 51 filings are due in approximately six weeks, and the reviewers will report any issues that develop from the reviews to the Working Group.

Lombardo said the Working Group will begin work on incorporating new mortality and lapse tables proposed in American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute’s Final Long-Term Care Insurance Mortality and Lapse Study into VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the Valuation Manual.

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

Meetings/Member Meetings/B CMTE/HATF/2023_Spring/02-17-23/Minutes_LTCAWG_02-17-23.docx
Three LTC rate increase review “checklists” for discussion – 2/17/23 LTC Actuarial Working Group

I. Recommended checklist for each state
   - NAIC Health Actuarial Task Force-adopted document, with the goal for states attaining 90% to 100% of the information necessary to make a decision about determining approvable rate increases.

II. MSA Supplemental checklist
   - NAIC Health Actuarial Task Force-adopted document, with the goal for states attaining 90% to 100% of the information necessary to make a decision about determining approvable rate increases.

III. Additional information requested to be included in a 50-state checklist

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I. Recommended checklist for each state

   **Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews**
   Adopted by the NAIC Health Actuarial (B) Task Force on 3/23/18

1. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
   A. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
   B. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

2. Rate increase history that reflects the filed increase.
   A. Provide the month, year, and percentage amount of all previous rate revisions.
   B. Provide the SERFF filing numbers associated with all previous rate revisions.

3. Actuarial Memorandum justifying the new rate schedule, which includes:
   A. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
      i. The projection should be by year.
      ii. Provide the count of covered lives and count of claims incurred by year.
      iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies should be provided.
      iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The company should accompany any state-specific information with commentary on credibility, materiality, and impact on requested rate increase.
   B. Reasons for the rate increase, including which pricing assumptions were not realized & why.
      i. Attribution analysis - present the portion of the rate increase allocated to and impact on the lifetime loss ratio from each change in assumption.
ii. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.

iii. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.

iv. Provide commentary and analysis on how credibility of experience contributed to the development of the rate increase request.

C. Statement that policy design, underwriting, and claims handling practices were considered.

i. Show how benefit features, e.g., inflation and length of benefit period, and premium features, e.g., limited pay and lifetime pay, impact requested increases.

ii. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.

iii. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

D. A demonstration that actual and projected costs exceed anticipated costs and the margin.

E. The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.

i. Provide applicable actual-to-expected ratios regarding key assumptions.

ii. Provide justification for any change in assumptions.

F. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the company, where appropriate to result in more credible historical claims as the basis for future claim costs.

i. Explain the relevance of any data sources and resulting adjustments made relevant to the current filing, particularly regarding the morbidity assumption.

ii. A comparison of the population or industry study to the in-force related to the filing should be performed, if applicable.

iii. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.

iv. Provide the year of the most recent morbidity experience study.


i. Comparison with asset adequacy testing reserve assumptions

a) Explain the consistency regarding actuarial assumptions between the rate increase filing and the most recent asset adequacy (reserve) testing filing.

b) Additional reserves that the company is holding above NAIC Model Reg 10 formula reserves should be provided, (such as premium deficiency reserves and Actuarial Guideline 51 reserves).

ii. Assumptions Template in Appendix 6 of the NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation (Guidance Manual) (for policies issued after 2017, where applicable)

iii. Provide actuarial assumptions from original pricing and most recent rate increase filing, and have the original actuarial memorandum available upon request.
H. Guidance Manual Checklist items: summaries (including past rate adjustments); average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; reserve description

I. Assert that analysis complies with actuarial standards of practice, including 18 & 41.

J. Numerical exhibits should be provided in Excel spreadsheets with active formulas maintained, where possible.

4. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

5. Policyholder notification letter – should be clear and accurate.
   A. Provide a description of options for policyholders in lieu of or to reduce the increase.
   B. If inflation protection is removed or reduced, is accumulated inflation protection vested?
   C. Explain the comparison of value between the rate increase and policyholder options.
   D. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
   E. How are partnership policies addressed?

6. Actuarial certification and rate stabilization information, as described in the Guidance Manual and Contingent benefit upon lapse information, including reserve treatment.
Note regarding this document:

Commissioners on the Long-Term Care Insurance (B/E) Task Force requested that the LTC Pricing Subgroup develop a single checklist that reflects significant aspects of LTC rate increase review inquiries from all of the states. In this context, “checklist” means the list of inquiries (often a template) that states typically send at the beginning of reviews of rate increase filings.

This document contains aspects of the NAIC Guidance Manual and checklists developed by several other states. This single checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists in order to have a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90 to 100 percent of the information necessary to make a decision about determining approvable rate increases. State and block specifics will generate the other zero to 10 percent of requests.

This consolidated checklist can be presented to the LTC B/E Task Force prior to or at the March 2018 NAIC national meeting. As states apply this checklist, this checklist or an improved version may be considered for future addition to the Guidance Manual.

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Attachment One-A
Health Actuarial (C) Task Force
03/21/2023
II. MSA Supplemental checklist

To assist in the multi-state actuarial (MSA) review, the following, additional information, would be helpful, where applicable:

1. Benefit utilization:
   a. Current, prior rate increase, and original assumptions; including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells;
   b. Explain how benefit utilization assumptions vary by maximum daily benefit;
   c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.

2. Attribution of rate increase
   a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, other;
   b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
   c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.

3. Reduced benefit options (RBOs)
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonability analysis of the value of each significant type of offered RBO.

4. Investment returns
   a. Provide original and updated / average investment return assumptions underlying the pricing. Explain how the updated assumption reflects experience.

5. Expected loss ratio
   a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and also for inflation-protected and non-inflation-protected blocks.

6. Shock lapse history
   a. Provide shock lapse data related to prior rate increases on this block.

7. Waiver of premium handling
   a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims, and explain how counting is appropriate (as opposed to double counting or undercounting).

8. Actual-to-expected differences
   a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.

9. Assumption consistency with the most recent asset adequacy testing
   a. Explain the consistency or any significant differences between assumptions underlying the rate increase request and those included in Actuarial Guideline 51 testing.
III. Additional information requested to be included in a 50-state checklist

Additional potential information to discuss

- Actual investment rate earned in historical years
- Nationwide projections of premiums using the rates in effect in the state, as if these rates were in effect in all states
- Premiums by duration in addition to by calendar year
- Loss ratios by duration based on original pricing assumptions
- Add to 3B of the Recommended Checklist For Each State: Clear descriptions of any adversity in experience or expectations for factors since original pricing and since the most recent rate increase filing
Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.
Social Physical and Cultural Determinants of Health: Their Incorporation into Actuarial Data and Workstreams

This provides actuaries with guidance on how to use determinants of health (DOH) for actuarial work streams in the health care space.

- DOH data can be used to enrich health care data analysis beyond traditional data elements, such as age, gender, zip code or health diagnosis.

- Often individuals who share similar traditional data characteristics can have very different DOH’s resulting in very different outcomes

- For example, within a county or a three-digit zip code, you can have completely different living environments and local characteristics, such as provider availability, food availability, income levels, cultural differences resulting in very different outcomes for individuals with similar age, gender, geography and health diagnoses
SDOH Data Resources

- DOH data is evolving but still fragmented and inconsistent. Can be categorized into Primary and Secondary data

  • Primary Source Characteristics
    - Their use was addressed in the SOA's Quantitative SDOH Paper:
    - Inconsistent definition or coding between different entities
    - Frequently self-reported, resulting in subjectivity and personal perspective
    - Difficult to maintain best practices

  • Secondary Source Derivation
    - Compiles Primary data into global measures of relative DOH intensity
    - Don’t tie directly to the claimant, but indirectly to claimant elements (often geographical area)
    - Used as a proxy for member statuses

SDOH Data Resources

- Secondary Source Characteristics
  - Consistency – values of characteristics are relatively stable
  - Persistency – production of these data sources is likely to continue over time
  - Comprehensiveness – Capture most populations and relevant DOHs
  - Robustness – Captures differences and variations (i.e. by geography)
  - Applicability – How well does a measure match with populations being analyzed
  - Neutrality – Minimizing biases in choice of variables or clustering of results
  - Version Control – Being transparent about methodology changes over time
  - Open and Clear Methodology – Good documentation of source materials
DOH Ecosystem As It Relates To Analytics and Actuarial Functions

Data and Analytics sources: vendor(s), government organizations, community entities

Data aggregation

Payer/Health system provider
Payer-sourced data
ID individuals, ID groups/communities
Tie-in to payer data warehouse
Review/Calculate impact
Feedback for improvement
Incorporate into other workstreams (pricing, valuation, etc.)

SHARPS*
ID of appropriate interventions from Network
Outreach and engagement
Closed loop reporting, tracking outcomes

CBOs** and other Intervention Providers

Social services provided; generally over a period of time

Additional Challenges and Considerations with Using DOH Data

- Traditional workstreams such as pricing, reserving, risk adjustment and evaluation may be enhanced by incorporating DOH data
- Traditional models for evaluation, including strict requirements for financial return on investment, may not be appropriate in the context of DOH
- Ethical and Practical Considerations
  - Does the work reflect a fair use of data and modeling
  - Does the work align with existing practice
  - Use of SDOH in models should be easy to integrate, maintain, justify, adapt and simple
  - Avoid being technically correct but ethically problematic

*Social Health and Resource Providers
**Community Benefit Organizations
Additional Health Research

Experience Studies, Practice Research & Data Driven In-house Research

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objectives</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Adjustment White Paper</td>
<td>Identifies Risk Adjustment (RA) and relates to policy issues and address issues encountered through use of Risk Adjustments.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>State-Based Price/Portfolio Candidacy Research</td>
<td>Efficacy of the Health and Life (H/L) preferred loss and portfolio options for state-specific, pool-based products for state-specific, pool-based products.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Social/Political and Cultural Determinants of Health</td>
<td>Qualitative SSDY research projects.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Digital Health</td>
<td>A study focusing on telehealth and other digital communications.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Emerging Impact of Long COVID on Health Care Outcomes and Medical Conditions</td>
<td>A study that will examine the impact of COVID-19 on patient and medical conditions.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Health Care Journal Health Forum Update</td>
<td>It's not surprising no capitated rate for medical care is emerging capitated rate for medical care is emerging.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Group of Tuition for Premium Evaluation Tables</td>
<td>Developing metrics to inform mortality and severity risk for Group/State pricing.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>HRI - Health Information Research/Pharmacy Trends</td>
<td>This research will examine some key specialty drugs tools toformance gap in drug use between IRS and HIPAA.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Health and Health Care Implications Research Challenges and Considerations</td>
<td>A summary of the challenges involved in conducting research that requires health information that requires health information that requires health information.</td>
<td>5/30/2023</td>
</tr>
<tr>
<td>Initiative 10.5: HRI Project - Analyzing Characteristics of the top 5% membership, and who have 50% of Medical Expenditures</td>
<td>The analysis of the characteristics of the group's top 5% members and who have 50% of medical expenditures.</td>
<td>5/30/2023</td>
</tr>
</tbody>
</table>
American Academy of Actuaries
Health Practice Council—Spring 2023 Updates

March 21, 2023—National Association of Insurance Commissioners (NAIC) Health Actuarial (B) Task Force (HATF) Meeting

Barbara Klever, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries

About the American Academy of Actuaries

• The American Academy of Actuaries is a 19,500-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.
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Health Practice Council—Key Policy Priorities for 2023

• Health equity
• COVID-19 and other public health challenges
• Insurance coverage and benefit design
• Health care costs and quality
• Medicare sustainability
• Long-term services and supports (LTSS)
• Financial reporting and solvency
• Professionalism
Health Equity

- Issue Briefs:
  - *Data Collection for Measurement of Health Disparities* (forthcoming)

- Events:
  - Health Equity Symposium (TBA)

COVID-19 and Other Public Health Challenges

  - Topic is included in our *Drivers of 2024 Health Insurance Premium Changes* issue brief (forthcoming)
COVID-19 and Other Public Health Challenges: Climate Change and Health

- Climate Change Joint Task Force:
  - In November 2021, the Academy launched the Climate Change Joint Task Force. Membership is comprised of members from the health, casualty, life, and pension practice areas and reports to the Risk Management and Financial Reporting Council (RMFRC).
  - The task force has submitted numerous comment letters to federal agencies, and other stakeholders, on climate-related disclosures and financial risks. For example, the Task Force has submitted a comment letter to the International Sustainability Standards Board.

Health Insurance Coverage and Benefit Design

- Issue Brief and Webinar:
  - *Drivers of 2024 Health Insurance Premium Changes* (forthcoming)
- Comment Letters:
  - Comments on proposed rule for the *2024 Notice of Benefit and Payment Parameters (NBPP)* (January 2023)
  - Comments on *Draft 2024 Actuarial Value (AV) Calculator Methodology* (January 2023)
Health Care Costs and Quality

- Issue Briefs:
  - *Addressing High Insulin Spending: Moving Beyond Co-pay Caps* (forthcoming)
  - *Gene Therapy Drug Costs* (forthcoming)

Medicare Sustainability

- Issue Brief:
  - *Medicare’s Financial Condition: Beyond Actuarial Balance* (forthcoming)

- Capitol Forum Webinar:
  - *Medicare Trustees Report: A Deep-Dive Discussion With the Program’s Chief Actuary”* (forthcoming)
Long-Term Services and Supports (LTSS)

- Issue Briefs:
  - Refresh of *Essential Criteria for Long-Term Care Financing Reform Proposals* issue brief (originally published November 2016—forthcoming).

Financial Reporting and Solvency

- Comment Letters:
  - Comments to the NAIC Health Risk-Based Capital (E) Working Group on Investment Income (February 2023).
  - Comments to the NAIC Long-Term Care Actuarial (B) Working Group on AG 51, Appendix A-010 (LTC reserve adequacy) (February 2023).
HPC NAIC Workstreams—HRBC

- Health Risk-Based Capital (E) Working Group (HRBC)
  - Request for comprehensive review of the H2—Underwriting Risk component and managed care credit calculation in the health risk-based capital formula.
    - July 2021—Academy comment letter.
    - January 2022—Academy report.
    - July 2022—Timeline letter.
    - November 2022—Academy Health Underwriting Risk Factors Analysis Work Group commences work.
    - December 2022—Update to the NAIC HRBC Working Group at the Fall National Meeting.
    - February 2023—Comments to the NAIC HRBC Working Group on Investment Income

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HPC NAIC Workstreams—HRBC

- Health Care Receivables Factors Work Group
  - The work group is completing a review of the current health care receivables factors for the NAIC.
  - Work task 1: Update the chart of health care (HC) receivables (HC Receivables now being reported on the Blue Blank as well as the Orange Blank).
  - Work task 2: Evaluate 2018-2021 NAIC data.
HPC NAIC Workstreams—LTCAWG

- NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG)
- Long-Term Care Insurance Mortality and Lapse Study
  - Original request from the NAIC LTCAWG
  - Developed by the Long-Term Care Valuation Work Group of the Academy and the Society of Actuaries Research Institute (SOARI).
  - Presentation to NAIC HATF in November 2021.
  - Update presentation to NAIC LTCAWG in June 2022.
  - Exposed by the NAIC LTCAWG until Sept. 5, 2022.
  - Status: LTCAWG is to draft changes to VM-25 and to adopt tables within the report (TBD).

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Under the Public Policy tab, access Academy:
- Comments and letters
- Issue briefs
- Policy papers
- Presentations
- Reports to the NAIC
- Testimony
Thank You

Questions?

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williams@actuary.org