HEALTH ACTUARIAL (B) TASK FORCE

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Draft Pending Adoption

Draft: 8/10/20

Health Actuarial (B) Task Force
Conference Call
August 4, 2020

The Health Actuarial (B) Task Force met virtually Aug. 4, 2020. The following Task Force members participated: Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Jim L. Ridling represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Elizabeth Perri (AS); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Chlora Lindley-Meyers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Mike Causey represented by Kevin Conley (NC); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its May 27, April 23 and Feb. 14 Minutes**

The Working Group met May 27, April 23 and Feb. 14. During its May 27 meeting, the Task Force adopted a 2021 federal Affordable Care Act (ACA) rates COVID-19 guideline. During its April 23 meeting, the Task Force discussed issues related to the impact of COVID-19 on the pricing and regulatory review of 2021 (ACA-compliant health insurance policies. During its Feb. 14 meeting, the Task Force took the following action: 1) adopted its 2019 Fall National Meeting minutes; and 2) adopted changes to the annual financial statement Long-Term Care Insurance Experience Reporting Forms as forwarded by the Long-Term Care Actuarial (B) Working Group.

Mr. Lombardo made a motion, seconded by Ms. Miller, to adopt the Task Force’s May 27 (Attachment One), April 23 (Attachment Two), and Feb. 4 (Attachment Three) minutes. The motion passed unanimously.

2. **Heard an Update from the SOA on Health Insurance Research**

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Four) on recent SOA health insurance research.

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

Mr. Kupferman said the Long-Term Care Actuarial (B) Working Group met Aug. 4 and took the following action: 1) adopted the reports of the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup; 2) heard an update from the American Academy of Actuaries (Academy) regarding its Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables for long-term care insurance (LTCI); and 3) heard an update from the SOA on recent work on the SOA’s Long-Term Care Experience Study. He said revisions to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions for the revised Forms have been adopted by the Blanks (E) Working Group, and will be effective for the 2020 reporting year annual financial statement. He said he is confident the revised Forms will help state insurance regulators better answer LTCI questions from policyholders and media.

Mr. Kupferman made a motion, seconded by Mr. Ostlund, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Five). The motion passed unanimously.

4. **Heard the Report of the Health Care Reform Actuarial (B) Working Group**

Mr. Shea said the Health Care Reform Actuarial (B) Working Group has not met since the 2019 Fall National Meeting.

Brent Plemons (federal Center for Consumer Information and Insurance Oversight—CCIIO) gave an update on ACA rate filings for the 2021 plan year. He asked state insurance regulators to make sure their insurers are not filing rates using retired Health Insurance Oversight System (HIOS) plan IDs for rate submissions. He said an issuer should not retire a plan and then present a new plan, even if it is the same metal level as the retired plan, using the HIOS ID associated with the retired plan. He said a new HIOS ID should always be used.
Mr. Plemons said the CCIIO has observed occurrences of unintentional market withdrawals. He said each issuer should have renewing plans in the system, and an issuer that does not will be classified as withdrawing from the market. He said guidance on this topic can be found on page 11 of the Uniform Rate Review Template (URRT) instructions.

Ms. Hooper said the CCIIO recently issued guidance on premium holidays and that the Working Group may discuss this guidance during a future conference call.

5. **Heard an Update from the Academy Council on Professionalism**

Shawna Ackerman (California Earthquake Authority—CEA), Kathleen Riley (Actuarial Standards Board—ASB), and Godfrey Perrott (Actuarial Board for Counseling and Discipline—ABCD) gave a presentation (Attachment Six) on recent ASB and ABCD activities.

6. **Heard an Update from the Academy Health Practice Council**

Barb Klever (Blue Cross Blue Shield Association—BCBSA) gave an update (Attachment Seven) on recent Academy Health Practice Council activities and publications.

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

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Health Actuarial (B) Task Force
Conference Call
May 27, 2020

The Health Actuarial (B) Task Force met via conference call May 27, 2020. The following Task Force members participated:
Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Stephen W. Robertson represented by Karl Knable (IN); Chlora Lindley-Myers (MO): Mike Causey represented by Ted Hamby (NC); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Jillian Froment represented by Laura Miller (OH); Jessica K. Altman represented by Tracie Gray (PA); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. Adopted a 2021 ACA Rates COVID-19 Guideline

Mr. Sundberg presented comment letters from America’s Health Insurance Plans (AHIP) (Attachment One-A), the Blue Cross Blue Shield Association (BCBSA) (Attachment One-B), and Risk & Regulatory Consulting LLC (RRC) (Attachment One-C) that were submitted in response to the Task Force’s public exposure of a draft guideline that state insurance regulators may use to assist the states in assessing the impact of COVID-19 on 2021 federal Affordable Care Act (ACA) health insurance rates. He said the guideline is not intended to be prescriptive and is not proposed as a requirement, but is offered by the Task Force only as a guidance document.

Ray Nelson (AHIP) gave an overview of AHIP’s comment letter. He said AHIP member companies agree that the guideline may be helpful, but its use should not be mandatory. He suggested that wording be added to the guideline to stress that it may be used as a guide, but it is not required as a checklist for required information. Mr. Trexler said individual states should be given the discretion and flexibility to use the guideline as they see fit, including making it a requirement. The Task Force decided that the language included on the Overview & Contents tab, which indicates that the guideline is not prescriptive, but a state may require its use, is sufficient. The Task Force agreed to make changes related to mislabeled items and add Milliman’s 2021 COVID Impact document to the Table of Actuarial Resources tab as noted in the comment letter.

Barb Klever (BCSA) gave an overview of the BCBSA’s comment letter.

Becky Sheppard (RRC) gave an overview of RRC’s comment letter. The Task Force agreed to make changes related to making the Table of Actuarial Resources tab a standalone document, additions to the Impact to Risk Adjustment 2021 tab, and fixing various typographical errors as noted in the comment letter.

Mr. Kupferman made a motion, seconded by Mr. Ostlund, to adopt the guideline with the changes described above. Mr. Sundberg said the guideline will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.
May 22, 2020

Mr. Jaakob Sundberg, Chair
Health Actuarial (B) Task Force
National Association of Insurance Commissioners
100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Submitted via email: eking@naic.org

Re: AHIP’s Comments on the May 2020 Exposure of ACA 2021 COVID-19 Rate Review Guideline

Dear Mr. Sundberg:

On behalf of America’s Health Insurance Plans (AHIP),¹ we appreciate the opportunity to provide comments on behalf of our member companies regarding the draft ACA 2021 Coronavirus (“COVID-19”) Rate Review Guideline excel template.

There is significant uncertainty around the potential impacts COVID-19 may have on 2021 health care costs, creating a unique challenge for health insurance providers and regulators as they work to finalize 2021 premiums. We appreciate NAIC’s efforts to provide state regulators with an optional resource to assist in assessing the impact of COVID-19 on 2021 ACA premiums. This tool provides a listing of actuarial resources that can be helpful to carriers and regulators when considering the impact of COVID-19 on 2021 ACA rates, and provides a common format for measuring the impact of numerous factors on proposed rates.

We appreciate the importance of providing optional tools to help regulators and health insurance providers account for the various impacts COVID may have for 2021 rates. However, we recommend the template be used as an optional resource only and not be adopted as a required tool for finalizing rates. We are concerned a standard template is overly prescriptive and the fields are too granular. As a result, requiring such a template could limit the ability of actuaries to adopt an actuarially sound method of estimating COVID cost impacts based on their analyses. At this point in the rate filing and approval timeline, requiring use of the template could create additional challenges for issuers. We are specifically concerned about the following:

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¹ AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Visit www.ahip.org for more information.
May 22, 2020
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- A “one-size-fits-all” template limits the ability of carriers to appropriately assess and price for the potential impacts of COVID. Carriers must develop actuarially-sound rates but do so through different assessments of underlying assumptions and actuarial pricing methods, which in many cases do not fit into the structure of the Excel template.
- The level of granularity suggested by the model does not reflect the various methods used by carriers when developing rates. Actual carrier projections are based on higher level aggregate claims analysis than what is contained in the template. Furthermore, plan actuaries and epidemiologists are unlikely to have the information at the level included in the template.
- The template does not allow issuers to add, modify, or omit COVID-related cost factors to reflect their analyses of projected impacts.
- The level of detail would be onerous for carriers if a state required completion of the template, especially at this point in the rate filing timeline with many initial filing deadlines past or quickly approaching.

Thus, we recommend the Task Force emphasize the template is intended as an optional resource for both carriers and regulatory actuaries and not a prescriptive data collection tool to be mandated by states. We suggest that the spreadsheet be marked as “For Voluntary Use By Carriers” and that the following language be added to the purpose of the template:

_This template is not intended to be, and should not be used as, a checklist for rate filings. States should have the option to use this document as a guide only, and should rely in the first instance on the assumptions and underlying requests from issuers. Issuers should describe the basis for the COVID impact in their rate development in whatever level of detail is reasonable for the rate action being requested and should not be required to provide data for elements not material to that issuer._

We recognize that some states are already pursuing state-specific guidance on COVID cost assumptions. We recommend states considering such an approach seek input from their carriers before finalizing guidance.

In addition to the primary concerns discussed above, we have the following detailed comments and questions regarding the spreadsheet:

- The data provided in the spreadsheet—particularly in the “COVID-19 Rate & Factor Impacts” and “COVID Issuer Impact estimates” tabs—is proprietary carrier information that should remain confidential. The “Overview and Contents” tab of the spreadsheet should include a statement that this data is proprietary and will remain confidential and protected from open record disclosures.
- The Premium PMPM calculations in cells R25:R27 on tab “COVID-19 Rate & Factor Impact” appear to hard code an 80% loss ratio. If 80% is not the target loss ratio, are carriers to revise the formula to be consistent with their actual premium development or use the default 80%?
• Cell B15 on the same tab notes additional scenarios than ‘Most-Likely’ can be added to the spreadsheet. We recommend the template allow for more updated scenarios to be added at a later date as the final pricing scenario will include more updated information and modeling that what was included in the initial filing.

• The factor support tabs for impacts (12), (13) and (14) appear to be mis-numbered in cell B2 on each tab’s sheet.

• The Milliman 2021 COVID Impact should be added to the Table of Actuarial resources since many issuers in the market engage Milliman for pricing work. Thus, the inclusion of this resource will assist in the credibility of the estimates for issuers who utilize Milliman: https://www.milliman.com/en/insight/COVID19-Considerations-for-commercial-health-insurance-rates-in-2021-and-beyond

We appreciate the opportunity to respond to your request for comments. If you have any questions, or would like to discuss any of these comments, please contact me at (501) 333-2621 or contact AHIP consultant Ray Nelson at rnelson@triplusservices.com.

Sincerely,

Bob Ridgeway
Senior Government Relations Counsel
America’s Health Insurance Plans
May 22, 2020

The Honorable Todd Kiser  
Health Actuarial (B) Task Force  
National Association of Insurance Commissioners  
444 North Capitol St., NW Ste 700  
Washington, D.C. 20001-1512

Submitted via email, Eric King, EKing@naic.org

RE: Health Actuarial Task Force COVID-19 Rate Review Guideline Exposure

Dear Commissioner Kiser:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Health Actuarial Task Force COVID-19 Rate Review Guideline Exposure posted on May 14, 2020.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide healthcare coverage for one in three Americans. For 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

The Rate Review Guideline Exposure is an excel template that state DOIs may use to assist in assessing the impact of COVID-19 on 2021 ACA rates. The template includes a resource list and a list of assumptions to be considered in developing the impact of COVID-19 on rates.

BCBSA believes the template could be useful to promote a common understanding between issuers and regulators on the assumptions to be considered in rate development for the COVID-19 impact. However, BCBSA recommends that the template be used only as a guide for issuer and regulatory actuaries on the assumptions related to COVID-19 and not as a prescriptive data collection tool.

We are concerned that the tabs with the rate and factor impacts and projected 2021 claims experience are too detailed and prescriptive for the kinds of projections actuaries could reliably make right now. The template assumes a level of detail in projections that can’t be supported by claims data or scientific studies by the time issuers need to submit their 2021 ACA rate filings. For example, the tab on projected 2021 claims experience includes providing overall claims impact for sixteen assumptions related to COVID-19. This display makes it appear that these factors do not interact with one another and that issuers know the COVID-19 impact to that level of precision. We note that requiring issuers to provide assumptions at this granular level may result in inconsistent responses across carriers because of differing actuarial methods to pricing.
and not due to true actuarial impacts. This, in turn, would devalue one of the stated goals of assessing the impact of COVID-19.

We recommend that regulators provide flexibility in how issuers document and submit the factors related to COVID-19. Issuers have been working on rate filings and may have laid out their assumptions in a different manner than presented in the template. Requiring issuers to fill out the template in a prescriptive manner will add to the administrative burden and may not add value to the process. A more practical solution for the NAIC would be to require commentary in the actuarial memorandum regarding how COVID-19 was recognized in the rating. It would be reasonable to require issuers to provide an explanation within the rate filing of impact of COVID-19 on the overall rate change and the documentation of assumptions related to COVID-19.

In addition, BCBSA recommends that issuers only be required to file one set of rates and not be required to file dual sets of rates – with and without COVID-19. As mentioned above, we think it is reasonable for the rate filing to contain information on the overall impact of COVID-19 on the rates. However, we do not believe that requiring issuers to submit a full rate filing without COVID-19 is useful. We note that a separate rate filing creates administrative burden for rates that do not reflect the reality of the COVID-19 pandemic.

We commend the Task Force for compiling the resources list and the list of assumptions. We note that the resources available will likely continue to evolve over the summer, and both issuer and regulatory actuaries will need to keep up-to-date on the changing situation.

We appreciate your consideration of our comments. If you have any questions or want additional information, please contact Barb Klever at barbara.klever@bcbsa.com.

Sincerely,

Barbara Klever, FSA, MAAA
Senior Actuary, Policy
Memo

To: Eric King, NAIC and Todd E. Kiser, HATF Chair, Commissioner Utah Insurance Department
From: Tricia Matson, Partner and Becky Sheppard, Senior Associate & Actuary
Date: May 22, 2020
Subject: RRC comments regarding the draft template that state DOIs may use to assist in assessing the impact of COVID-19 on 2021 ACA rates

Background

The April 23rd, 2020 Health Actuarial (B) Task Force (HATF) meeting included multiple presentations regarding the potential impact of the ongoing COVID-19 pandemic on the health insurance marketplace. The meeting provided an opportunity for members of HATF, interested regulators, and Interested Parties to gain perspective on considerations that may impact the 2021 Patient Protection and Affordable Care Act (ACA) rate review, and ask questions. Following that meeting, HATF sent out an Excel template titled “ACA 2021 Coronavirus Rate Review Guideline – May 15th.xlsx” (the Guideline) which contained an overview of considerations regarding COVID-19 that may impact the review of 2021 rates. The Guideline is not prescriptive but rather provides potential considerations and possible resources. The Guideline does NOT include estimate values or impacts.

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 HATF members.

RRC Comments

• Overall comments:
  o We appreciate that HATF quickly compiled these comprehensive guidelines and feel that they will be a useful tool in preparation for ACA 2021 rate review. The pace and magnitude with which the COVID-19 pandemic is evolving can make it difficult to have timely resources and we appreciate that HATF made the necessary resources available.
  o We agree with the approach of not including actual values or ranges in the guidelines since there is a great deal of uncertainty and the results may have wide variation across issuers.

• Regarding the “Table of Actuarial Resources” tab
  o Given that these resources will likely be evolving during the rate review cycle, we believe it may be beneficial to use this tab as a standalone document that could be updated more frequently.
  o It is unclear whether the intent is for the “Information Contained in Resource” column to be fully populated. It may be helpful and time-saving to know what type of information is in the resource, so we would recommend that if possible.
• Regarding the “COVID-19 Rate & Factor Impact” tab
  o It may be helpful to add a cell for the Issuer to describe the “Most-Likely” scenario assumption. For example, they may say “Assumes second wave occurs in 2Q2021 and no vaccine in 2021.”
  o It may be helpful to add formulas to calculate the “COVID-19 impact” in the detailed rate components sections so that reviewers can quickly identify which components had the biggest change.

• Regarding the “COVID Issuer Impact Estimates” tab
  o We believe that it may be beneficial to state on this spreadsheet the inherent assumption that the impact for each potential COVID-19 item would be the same at the market level (or that variations by metal level/plan design will be consolidated on this tab).
  o This tab could be quite time consuming for an issuer and reviewer since the results may not align with the Unified Rate Review Template (URRT) or pricing process so we strongly agree with not making these Guidelines prescriptive.
  o We believe that it may be helpful to ask each Issuer to explain how they are defining COVID-19 claims and claimants. For example, is the Issuer using the CPT code 87635 (which was available beginning March 13, 2020) or some other methodology to identify COVID-19 claims? Testing claims should not be used to identify a COVID-19 claimant unless the corresponding lab data confirms the diagnosis. This could be collected in a cell on this tab.

• Regarding the detailed COVID-19 Factors Support tabs:
  o On the “(1) COVID Treatment Assumptions” tab, it may be helpful to add a calculation of the percentage in each category based on the counts entered in column C so that reviewers can easily compare the percentages across issuers who may have different counts.
  o On the “(4) Conditions Caused by COVID” tab, an additional item that may be helpful to include is the impact from COVID-19 on existing underlying conditions (for example diabetes, obesity, and heart disease). These co-morbidities can have a long term health impact.
  o We observed minor typographical errors on tab “(6) Pop Movements & Morbidity” (the cell B4 title is incorrect and cell B7 should say “who” rather than “eho”).
  o We observed minor typographical errors on tabs (7) through (11) (cell B4 title is missing).
  o Regarding the “(16) Risk Adjustment” tab, some additional items that may be helpful to include are:
    ▪ How COVID-19 claims will be valued in the ACA risk adjustment model (if assumed 2021 cases actually occur). Will there be a separate COVID-19 HCC or will existing HCCs be utilized.
    ▪ Whether business/provider interruptions impact the 2019 risk adjustment data collections (CMS has allowed an additional 2 weeks), and therefore require different projection assumptions than prior years.
    ▪ Whether changes in the risk pool in 2020 remain in 2021 and, if so, whether that impacts the 2021 Risk Adjustment.

• Other comments:
  o The Task Force may want to consider structuring requests for very granular claim impact analyses such that each item provided by the issuer is mutually exclusive. For example, an
issuer may have permanent network changes because a provider goes out of business which would be a “Provider Network Disruption” and that could also cause an impact to the “Area Factor Mix” if the removal of that provider impacts the relative cost. We recommend adding a note in the Guidelines that states some of the COVID-19 considerations may overlap.

- The Task Force may want to consider including in the guidance that some assumptions will be more or less difficult to be measured in the future. For example, an assumption about when a vaccine is available, when a second wave occurs, or the distribution of COVID-19 cases by highest level of treatment can be validated, at least in part, by the future data. However, other items like how much pent-up demand returns, the long term impacts of COVID-19/complications, and general morbidity assumptions will be harder to attribute to COVID-19 and measure.

- Provider risk sharing arrangements have led to some anomalies in 2020 (payers making early payments to providers, etc.). We recommend adding a note on the “(9) Provider NW Disruption” tab to state that risk sharing arrangements impacted by COVID-19 should be considered to the extent they are expected or not expected to occur in 2021 and may have an impact on total claim payment (i.e. if it’s not just timing).
The Health Actuarial (B) Task Force met via conference call April 23, 2020. The following Task Force members participated:
Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway (CO); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Vicki Schmidt represented by Nicole Boyd (KS); Chlora Lindley-Myers (MO); Mike Causey represented by David Yetter (NC); Bruce R. Range represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Kent Sullivan represented by Raja Malkani (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. Discussed the Impact of COVID-19 on 2021 ACA Rates

Mr. Sundberg said the Task Force will hear presentations on factors arising from COVID-19 testing and treatment that may affect the pricing of 2021 federal Affordable Care Act (ACA) health insurance policies.

Cori Uccello (American Academy of Actuaries—Academy) gave a presentation (Attachment Two-A) on the effects that COVID-19 may have on 2020 claims experience, changes in enrollment in various health insurance markets, 2021 premium development, and 2021 rate filing deadlines. Mr. Sundberg asked if the economic downturn and its impact on small businesses may create anti-selection in the small group market or have effects on the individual market if small employers direct employees to obtain individual or Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) coverage. Ms. Uccello said she is not sure, but Small Business Administration loans that are part of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provide funds for small businesses to continue payment of small group insurance premiums. Mr. Shea said employees who lose small group coverage may experience financial hardship when presented with the cost of individual market or COBRA coverage.

Kurt Giesa (Oliver Wyman) gave a presentation (Attachment Two-B) on behalf of the Blue Cross Blue Shield Association (BCBSA) related to health plans’ pricing for COVID-19. Commissioner Conway said he assumes that the Medicare and Medicaid markets will experience greater COVID-19 impacts than commercial markets, and he asked Mr. Giesa if the modelling of this using state-level data has begun. Mr. Giesa confirmed that work has begun on this, and he agreed with Commissioner Conway’s assumption. Mr. Sundberg asked if insurers with knowledge of each other’s COVID-19-related pricing assumptions before filing rates will enhance pricing accuracy. Mr. Giesa said there are advantages and disadvantages to this approach, but he is unable to answer the question.

Justin Giovannelli (Georgetown University) gave a presentation (Attachment Two-C) on behalf of the NAIC Consumer Representatives regarding their concerns related to the impact of COVID-19 on state insurance markets. Mr. Sundberg said if a multiple-scenario, multiple-filing system is used, there will still be uncertainties associated with whichever scenario is chosen. Mr. Giovannelli said the later that the decision is made, the less that uncertainty will be present. Mr. Muldoon said the Nebraska Department of Insurance (DOI) supports insurers making a single rate filing that reflects scenarios with no, low, medium and high COVID-19 incidence. He said he does not understand why separate rate filings with each scenario being approved and implemented at an insurer’s discretion will be necessary, and he thinks this may be burdensome. He stated that the date for final rate approval would need to be later than the Aug. 19 date currently prescribed by the federal Centers for Medicare & Medicaid Services (CMS) in order for this plan to be feasible. Director Lindley-Meyers and Mr. Shea agreed that the date of Aug. 19 will need to be extended for a multiple-scenario system to work.

Jeanette Thornton (America’s Health Insurance Plans—AHIP) gave a presentation (Attachment Two-D) on cost estimates of COVID-19 treatment for U.S. private insurers in 2020 and 2021. Commissioner Conway asked if it will enhance pricing accuracy if insurers can know each other’s COVID-19-related pricing assumptions before filing rates. Ms. Thornton said she will present this question to AHIP member companies, and she has concerns about competitive issues that may arise if this is allowed.
R. Dale Hall (Society of Actuaries—SOA), Dave Dillon (Lewis & Ellis Inc.) and Greg Fann (Axene Health Partners) gave a presentation (Attachment Two-E) on the SOA’s COVID-19 research and its impact on 2021 pricing.

Having no further business, the Health Actuarial (B) Task Force adjourned.
NAIC Health Actuarial Task Force
April 23, 2020

Comments by Cori Uccello, Senior Health Fellow, American Academy of Actuaries

**2020 Claims Experience**

- COVID-19 is resulting in high-cost hospital utilization. These costs can be significant.
- Because of social distancing (and to a lesser extent freeing up space for COVID-19 patients), utilization of lower cost services such as office visits has declined dramatically. In addition, non-emergency hospital services, including high revenue producing elective surgeries, have also declined.
- There is uncertainty as to the net effect on 2020 claims (could be higher or lower total costs than expected).
- The net effect depends in part on whether deferred services are provided later in 2020, are delayed to 2021, or avoided altogether. Which in turn depends on if there is another wave of the outbreak this year, or perhaps rather how severe the next outbreak is.
- Cost sharing for COVID-19 testing and related services is being waived. And some carriers are waiving cost sharing for COVID-19 treatments as well. But it’s not necessarily clear what services qualify for cost-sharing waivers; depends on how terms are defined. Cost-sharing waivers are probably a less important driver of claims compared to the degree of deferred services, but they will still have an effect.
- Expanded availability of telehealth services is filling in some of the gaps in office visits. But many services can’t be provided through telemedicine, especially those elective surgeries.
- Some carriers are advancing payments to providers, typically on a month-to-month basis, with reconciliation. This will likely have only a minor effect on 2020 plan costs and shouldn’t affect 2021 premium development. In other words these advanced payments address providers’ short-term cash flow concerns but are not meant to act as larger or longer-term loans.
- Prescription drug spending is probably the least affected health spending component, at least for now. Drug spending could decrease if people can’t afford their prescriptions due to loss of income. On the other hand, prescription drug spending could increase if and when there are new COVID-19 drug therapies and/or a vaccine become available.

**The economic effects of the outbreak are resulting in changes in insurance enrollment.**

**Enrollment changes in the individual market**

- Some individuals could drop coverage, even if coverage is subsidized, if they can no longer pay premiums. Insurers already provide long grace periods for subsidized enrollees and many are also extending grace periods for unsubsidized enrollees, either voluntarily or due to state requirements. Although important to help enrollees stay covered, long grace periods could expose insurers to more adverse selection risk. On the other hand, previously uninsured individuals have enrolled during special enrollment periods, where available. New enrollees could include healthy individuals who now see more value in being covered.
- New enrollees could also enter the individual market upon loss of employer coverage. Again, there is potential adverse selection risk, offset in part if individuals are subsidy eligible. But subsidy eligibility depends on annual income, as opposed to Medicaid, which determines eligibility on a monthly basis. COBRA experience during the great recession could provide
some insights on the potential for adverse selection. But again, it’s possible that even those not eligible for subsidies see value in obtaining coverage, which could mitigate adverse selection.

- One aspect of enrollment uncertainty is the extent to which there will be efforts to facilitate workers and their families keeping employer coverage, such as through COBRA premium subsidies.
- The number and risk profile of new enrollees could also depend on whether the state has expanded Medicaid. It may be more difficult for individuals losing jobs to be eligible for Medicaid in non-expansion states, leaving the individual market as the only available option.

**Enrollment changes in the small group market**

- Enrollment in the small group market could decline due to employers going out of business, small employers dropping coverage, and partial layoffs.
- Small employers considering whether to keep or drop coverage could tend to keep coverage if they thought they or a family member (or perhaps other workers) have health care needs. This would tend to increase morbidity. In past recessions, some insurers saw morbidity increases in the small group market along with enrollment declines. But again, this could be a different situation as there may be a greater recognition of the value of coverage, regardless of health status.

**2021 premium development**

- Current uncertainty regarding COVID-19 per case treatment costs.
- Providers, especially hospitals, may have success negotiating (and renegotiating) higher payments from payers (depending in part on what federal relief they receive). Some increases in payment may be temporary in nature, thereby affecting 2021 costs only minimally.
- Services deferred during 2020 could be performed in 2021. Also, because some essential services are also being deferred, individuals with chronic conditions could worsen, resulting in higher future costs.
- Costs of new treatment therapies, antibody tests, and/or vaccines need to be considered for 2021.
- With the increase of telehealth being used to fill some gaps in 2020, there is a question of whether that increase will continue to replace certain office visits or whether treatment patterns will return to pre-COVID trends. [Telemedicine could have lower unit costs than office visits, but a sustained shift to telemedicine could result in telemedicine providers pushing for higher prices. Could also increase utilization.]
- When developing 2021 rates, carriers will run multiple scenarios involving different assumptions on whether new COVID waves will emerge in 2021, the degree of deferred services, the amount of testing (including antibody testing), the availability of vaccines, seasonality, etc. to inform their premium development.
- Greater degrees of uncertainty could lead to more conservative assumptions and risk margins.

**2021 Rate Filing Deadlines**

- More information regarding COVID-19 claims, service deferrals, new enrollment, and risk pool profiles is becoming available every day.
- Allowing carriers to revise initial filings and delaying final filings as much as possible would allow carriers to incorporate the latest information available.
Other Issues

• If claims in 2020 are much below expectations, premium rebates may be required under the MLR. As a reminder, the MLR calculation is done as a 3-year average. Also, the MLR is one-sided; carriers do not receive payments if claims are much higher than 2020 expectations.
• COVID-19 is not a factor in the risk adjustment formula.
• Changes to federal and state rules implemented in reaction to COVID-19 have increased administrative burden, especially for carriers that need to adhere to different rules among states.
• It’s appropriate for regulators to consider the relationship between changes in risk-based capital and profit margins in rate filings.
• 1332 waivers could be affected. For instance, some states fund their reinsurance program through insurer assessments, and these assessments fall primarily on group insurance. The economic downturn could result in declines in group market enrollment and an increase in individual market enrollment. This could lead to a decrease in reinsurance funding with a likely increase in reinsurance claims. For states that are allowed to retrospectively adjust the coinsurance or other reinsurance program parameters to either achieve a specified cost to the state (e.g., $50M) or so that the state’s cost matches the assessments collected, reinsurance payments would go down and carriers would therefore bear more of the risk.
HEALTH PLANS PRICING FOR COVID-19

An unprecedented challenge

April 23, 2020
Kurt Giese, FSA, MAAA
Marc Lambright, FSA, MAAA

THE CHALLENGE FOR PRICING ACTUARIES

Pricing for 2021 will be more difficult than pricing the early years of the ACA

- How many will be infected
- What services will be required for those infected, at what cost
- How much and what type of care will be delayed and how much forgiven – over what period of time and with what consequences
- Impact on risk-adjusted markets
- Timing and cost of a vaccine
- Impact of economic consequences

Answers depend upon

- Public policy – reopening the economy
- Individual behaviors
- Governmental actions
- Provider policies and capacity
- Local conditions

ECONOMIC CONSEQUENCES OF THE PANDEMIC

In the last four weeks, 22 million people filed for unemployment.

CONSIDERATIONS

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| 1 | Filing deadlines  
Allowing health plans to file premiums with the most up-to-date information available would be helpful to them in navigating through this time of unprecedented uncertainty and in maintaining stable markets |
| 2 | MLR  
The MLR requirements provide a limiter on health plans’ profits, but make it difficult for health plans to rebuild surplus once it is depleted |
| 3 | Capital health plans’ capital is essential to protect the plans, their customers, and providers from the risk of unpaid claims and potentially, insolvency |
| 4 | 2021 premiums  
Health plans are in the process of developing premiums for 2021. They and their regulators will have to work in partnership to serve their customers and the public |

QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

This report was prepared on behalf of the Blue Cross and Blue Shield Association. There are no third-party beneficiaries with respect to this report, and Oliver Wyman does not accept any liability to any third party.

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The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. The obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date stated.

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The authors of this report are members of the American Academy of Actuaries and meet that body’s qualifications standards for performing this work.

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FROM THE NAIC CONSUMER REPRESENTATIVES

To: Health Actuarial (B) Task Force
   Eric King

Date: April 23, 2020

Re: Impact of COVID-19 on State Insurance Markets

As NAIC consumer representatives, we share your concerns about the impact of the COVID-19 pandemic on patients, insurers, the health care system, and the economy. The crisis has compromised the health, safety, and well-being of millions of Americans, and we are particularly concerned about those who have lost their jobs and may be uninsured at a moment when their health could be at grave risk.

This period of great uncertainty is affecting all NAIC stakeholders, and we are grateful to the members of the Health Actuarial (B) Task Force (HATF) for addressing the impact of COVID-19. To that end, we write to provide resources on projected costs of COVID-19 and two recommendations for the 2021 rate filing process.

Projected Costs of COVID-19

The costs of COVID-19 testing and treatment are expected to be billions of dollars, but there is extreme variation in estimates due to uncertainty about the extent of the crisis. Key factors include the severity of the outbreak, reduced costs as a result of many procedures and services being cancelled, pent-up demand for procedures in 2021, a transition to telehealth services, the cost of a future vaccine once developed, and longer-term effects on network dynamics. Although projections necessarily will be refined as more information becomes available, we hope this compilation of resources is helpful.

- How Health Costs Might Change with COVID-19. The Kaiser Family Foundation estimates that about 15 percent of people infected by coronavirus could require hospitalization, with a smaller share needing invasive mechanical ventilation. Costs will vary by severity and payer, but hospitalization will cost about $20,000, with treatment of the most severe cases costing up to $88,000. The brief includes an extended discussion on how delayed or foregone care could offset some costs, with data on how elective procedures represent a substantial share of hospital spending.

- Health Insurers Do Not Yet Feel the Impact of COVID-19. Comprehensive data on insurer experience is not available. However, insurer perspectives are becoming clearer in media reports and earnings calls. In mid-March, several health insurance executives reported that insurers were not yet concerned that COVID-19 was going to dramatically increase medical claims and spending. Executives viewed the outbreak as an “extension of the flu season” and noted that leaders were “not expecting a material financial impact.” In a recent earnings call, UnitedHealth Group Inc. played down the effects of COVID-19 on its first quarter performance and announced that it will not adjust its guidance for the remainder of 2020.
A separate analysis from S&P Global found that health insurers are performing better than expected during the first quarter, due primarily to the deferral of elective or discretionary medical services. Although COVID-19 claims are expected to rise in the second quarter, especially in hard-hit regions of the country, the authors expect earnings to revert to normal for full-year 2020 and note that “the attack/infection rate through the majority of the first quarter doesn’t indicate a meaningful strain on medical claims.”

- **Potential Costs of COVID-19 Treatment for People With Employer Coverage.** Comparing the costs of COVID-19 treatment to pneumonia, the Kaiser Family Foundation estimates costs for people insured through a large employer’s private health plan. Hospitalization costs would range from $20,000 to $88,000, depending on severity and comorbidities. Treatment costs for Medicare and Medicaid will be lower due to lower provider reimbursement rates: average hospitalization costs would range from $10,000 to $40,000 under Medicare, depending on severity. The brief includes a discussion of the typical length of hospital stays associated with pneumonia and out-of-pocket costs for pneumonia admissions.

- **COVID-19 Cost Scenario Modeling: Estimating the Cost of COVID-19 Treatment for U.S. Private Insurers.** Wakely, on behalf of America’s Health Insurance Plans, estimates direct costs for COVID-19 testing and treatment may range from $84 to $139 billion in 2020 and $28 to $46 billion in 2021. The analysis assumes an infection rate of 20 percent and reflects costs for private insurers (commercial insurers, Medicaid managed care organizations, and Medicare Advantage plans). Different infection rates would yield dramatically different costs, ranging from a total of $56 to $556 billion. For the commercial group and non-group markets, costs could range from $44.6 billion to $438.5 billion over the next two years.

- **Covered California Releases the First National Projection of the Coronavirus Pandemic’s Cost to Millions of Americans with Employer or Individual Insurance Coverage.** Covered California expects the cost of COVID-19 treatment and testing costs to range from $34 to $251 billion for commercial insurers. These are one-year projected costs in the commercial market, with a premium impact that ranges from 2 percent to 21 percent if built into 2020 premiums. Covered California estimates that individual and employer premiums for 2021 could be 40 percent higher due to COVID-19 costs.

- **Morbidity Stress Test: How A Hypothetical Pandemic Could Affect U.S. Health Insurers.** S&P Global Ratings conducted a stress test for a hypothetical pandemic. Assuming a moderate morbidity, insurers would face a 3 to 4 percent increase in medical claims costs and medical loss ratios would be boosted to 88 to 89 percent. This, S&P concludes, would be manageable for most insurers. More severe morbidity, however, means insurers would face a 10 to 12 percent increase in medical claims costs, increasing medical loss ratios to 95 to 97 percent.

- **COVID-19: The Projected Economic Impact of the COVID-19 Pandemic on the U.S. Healthcare System.** Leveraging its database of private health care claim records, FAIR Health estimates that the total average charge per COVID-19 patient that requires a hospital stay will be more than $73,000, with an average estimated allowed amount per commercially insured patient of $38,000. Total charges for all hospitalized COVID-19 patients range from $362 billion to $1.45 trillion, with $139 to
$558 billion in estimated allowed amounts. This range varies based on the expected infection rate and the expectation that 4.9 million to 19.8 million people with COVID-19 may require hospitalization.

**Recommendations for the 2021 Rate Filing Process**

Our top priority is to ensure that as many consumers as possible continue to have access to affordable, comprehensive coverage and that insurance markets are stable. This is particularly true for the individual market, which may need to accommodate millions of new enrollees this year and next. We also acknowledge very real concerns about solvency in some states and that regulators must balance premium affordability with solvency. To best protect consumers as insurers develop 2021 rates, we urge HATF and state regulators to consider the two recommendations below and provide guidance to insurers in their states.

**Recommendation #1: Instruct insurers to prepare multiple rate filings to reflect COVID-19 assumptions based on different degrees of severity**

There is a high degree of uncertainty about what the future holds. As reflected in the data above, the impact of the COVID-19 pandemic on commercial insurers could vary significantly based on the ultimate infection rate, morbidity and mortality, geographic variation, the age of those most affected, long-term effects of the virus, and more. We recognize this uncertainty and the challenge that insurers and state regulators face in preparing and reviewing rates for 2021.

We are, however, concerned that consumers could face rate increases for 2021 that are out of sync with actual costs if a worst-case scenario does not materialize. Insurers may be especially prone to overprice their products in the individual market, where many enrollees receive subsidies and are relatively insulated from premium increases.

To address this uncertainty, we encourage HATF and state regulators to instruct insurers to file multiple rates with varying assumptions about the impact of COVID-19 in 2021. While rates are due this spring (when much information remains unknown), multiple filings—that reflect low, medium, and high levels of severity—would provide state regulators with the information to adjust rates as needed in the fall of 2020. These filings would also help regulators compare rate assumptions across insurers to ensure relatively consistent assumptions about COVID-19 costs and pent-up demand.

Multiple rate filings have been used before in response to uncertainty, including in 2017 to anticipate the potential elimination of cost-sharing reduction payments. HATF was instrumental as a forum during this time. During 2017, many state regulators instructed insurers to file dual rates: one rate reflected the assumption that cost-sharing reduction payments would be made and the other assumed that the payments would not be made. Having dual rate filings on hand allowed state insurance regulators and insurers to be nimble when the payments were eliminated in October 2017. Insurers were able to quickly and easily adjust their rates mere weeks before 2018 rates went live.

We believe the uncertainty here calls for similar advance planning and flexibility. Insurers should know more about their actual costs for 2020 later this year, and we should have better predictions about how widespread the pandemic will be by that time. Multi-rate filing will help ensure that all rates for 2021
are based on the strongest evidence available and informed assumptions that match real-time, real-world experience as much as possible.

We do not believe this approach will overly burden insurers because insurers are or should be running various rate scenarios already. In fact, we believe this more uniform approach will help insurers avoid mispricing relative to their competitors and ending up with large losses as a result.

**Recommendation #2: Direct insurers to submit 2021 individual market rate filings that specify the projected amount of rate increase due to COVID-19**

Uncertainty related to COVID-19 will likely contribute to higher premiums. However, we believe that consumers would be best served by greater transparency about how much rate impact insurers expect COVID-19 to have in 2021.

To address this concern, we urge HATF and state regulators to require insurers to clearly specify the projected amount of rate increase due to COVID-19. General statements or premium surcharges based on uncertainty provide insufficient information for regulators and the public to evaluate. The inclusion of specific information—ideally alongside assumptions about the COVID-19 infection rate, assumed morbidity rate, and other data—will also help insurers demonstrate to regulators that they are adequately preparing in response to the COVID-19 crisis.

Thank you for everything you are doing to protect consumers during this unprecedented crisis and in the midst of significant uncertainty and economic stress. If you have any further questions, please contact Justin Giovannelli (Justin.Giovannelli@georgetown.edu) or Sarah Lueck (lueck@cbpp.org).

Sincerely,
Justin Giovannelli
Sarah Lueck
Ashley Blackburn
Courtney Bullard
Bonnie Burns
Benjamin Chandhok
Laura Colbert
Lucy Culp
Deborah Darcy
Anna Schwamlein Howard
Katie Keith
Amy Killelea, JD
Matthew J. Smith, Esq.
Andrew Sperling
Harold Ting
Wayne Turner
Caitlin Westerson
Silvia Yee
Estimates on Treatment & Testing Costs

New Study: COVID-19 Health Care Costs Could Reach $556 Billion Over Two Years

Links:
- Press Release
- Blog Post
- Full Report

Estimates on Population Impacted

<table>
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<tr>
<th>Assumption</th>
<th>Medicare Advantage</th>
<th>Commercial (Group + Non-Group)</th>
<th>Medicaid MCO</th>
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<td>176,700,000</td>
<td>84,180,000</td>
<td>255,360,000</td>
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<td>Total Number Infected (includes non-tested)</td>
<td>4,896,000</td>
<td>35,340,000</td>
<td>10,836,000</td>
<td>51,072,000</td>
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<td>Number Confirmed Cases</td>
<td>3,380,000</td>
<td>24,690,000</td>
<td>7,540,000</td>
<td>35,610,000</td>
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Estimates on Costs

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<td>Low Infection Rate (10%)</td>
<td>$42.2 – 69.5</td>
<td>$14.1 – 23.2</td>
<td>$56.2 – 92.7</td>
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<td>Baseline Infection Rate (20%)</td>
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<td>High Infection Rate (60%)</td>
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<td>$84.4 – 139.0</td>
<td>$337.5 – 556.1</td>
<td>$59.9 – 78.0</td>
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- Estimated costs range from $56 to $556 billion over 2 yrs
- All costs above are in billions

The Wakely Report did NOT Include:

- Variations by localities and states
- Real-time information on actual length of stays and costs for COVID patients
- The Impact of delayed and deferred care
- Mandate to cover Anti-body testing without cost sharing

Gathering Data On:

- AHIP updating due mid-May
  - Claims experience
  - Population impacted
  - Testing costs
  - Treatment costs – short & long term
  - Drug studies
  - Epidemiological studies
  - Stimulus additions/changes

> AHIP requests States to extend rate filing deadlines to July 22
AHIP/BCBSA Legislative Recommendations

1. Premium Affordability
   - Tailored Approach
   - Risk mitigation (commercial, MA/Part D and MCO)
   - MA RA changes
   - Ensures actuarially sound rates (MCO)

2. Stability for Consumers
   - Employer Support - Premiums
   - Employee Support – COBRA
   - Enhanced APTC

3. Access to Coverage
   - Special Enrollment Period

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COVID-19 Research and Impact on 2021 Pricing

HEALTH ACTUARIAL (B) TASK FORCE
THURSDAY, APRIL 23, 2020

R. Dale Hull, FSA, MAAA, CERA - Society of Actuaries
Dave Dillon, FSA, MAAA - Lewis & Ellis, Inc.
Gregory G. Fann, FSA, FCA, MAAA - Axene Health Partners

SOA Research Projects

• COVID-19 Costs to Commercial Health Insurers
  ▪ Summary of levels of COVID-19 conditions and range of types of care needed
  ▪ Cost estimates of services associated with COVID-19
  ▪ Some cost levels dependent on provider reimbursement arrangements

• COVID-19 Cases and Deaths Database

• Deferred Services: Research Examples

  • 2021 Rating: Model of 2020 – 2021 costs depending on transition to “return to new normal”

EARLY INDICATORS

Based on discussions with national and large regional carriers
• Overall claims down ~30% over the last month
• No significant geographical differences
• ER claims also down ~30%
• Will lower claims cause MLR impact?
• 2021 uncertainties include
  • ER visit stickiness
  • Deferred services costs
  • Vaccination costs
  • Wellness check costs

COVID-19 2021 PRICING: MARKET DIFFERENCES

1. General uncertainty --> Rate Pressure, Volatility
2. Population Shifts
   • Group --> Individual --> Medicaid
   • Individual --> Uninsured
   • Uninsured --> Individual (12 states)
3. Adverse Selection Potential
   • COBRA, Small Group Market Furloughs/Layoffs
4. Benefit/Population Differences
   • Comorbidities, Urban/Rural, Network Breadth, AV & Waived Cost-Sharing, Federal Funding Mitigation, Grace Period, Ind Market Metal Level Dynamics
5. Pent-up Demand
   • Delayed or Cancelled?
   • Timing (e.g. 2020 or 2021)
The Health Actuarial (B) Task Force met via conference call Feb. 14, 2020. The following Task Force members participated: Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Vicki Schmidt represented by Nicole Boyd (KS); Chlora Lindley-Myers represented by William Leung (MO); Mike Causey represented by David Yetter (NC); Bruce R. Ramge represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner (TX); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Mr. Lauten made a motion, seconded by Ms. Eom, to adopt the Task Force’s Dec. 6, 2019, minutes (see NAIC Proceedings—Fall 2019, Health Actuarial (B) Task Force). The motion passed unanimously.

2. **Adopted a Draft of Revisions to the Forms**

   Mr. Kupferman presented a draft of revisions (Attachment Three-A) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions (Attachment Three-B) for the revised forms as forwarded to the Task Force by the Long-Term Care Actuarial (B) Working Group. He also presented comments (Attachment Three-C) on the revisions submitted by Utah.

   Mr. Kupferman gave an overview of the revisions and said the changes suggested in the Utah comment letter will be incorporated into the draft.

   Bob Yee (PricewaterhouseCoopers LLP—PwC) suggested that the reserves reported on Form 3 should be recast using current assumptions. Ray Nelson (America’s Health Insurance Plans—AHIP) said AHIP member companies think Form 3 should reflect the actual history of reserves held. He said requiring reserves to be recast would make completion of the forms more difficult and may create systems programming issues. Mr. Sundberg said he agrees with Mr. Nelson. Mr. Yee suggested companies be given the option of recasting reserves, with a checkbox to indicate this has been done on Form 3. The Task Force agreed to this change.

   Mr. Nelson suggested that policies that have received contingent nonforfeiture benefits be considered as in-force policies for Forms reporting purposes, as they are still eligible to receive benefits and require a reserve to be held. The Task Force agreed to this classification.

   Mr. Nelson suggested that the Form 2 instructions not prescribe the classification of comprehensive policies that later drop rider coverage. The Task Force agreed to this change.

   Mr. Sundberg suggested the Forms include a way for companies to indicate whether waiver of premium amounts are included in claims and premium reporting. The Task Force agreed to this change.

   Mr. Kupferman made a motion, seconded by Mr. Muldoon, to adopt the revised draft Forms and instructions with the changes discussed. The motion passed unanimously.

   Mr. Sundberg said the revised draft forms (Attachment Three-D) and instructions (Attachment Three-E) will be forwarded to the Senior Issues (B) Task Force and the Health Insurance and Managed Care (B) Committee for their consideration.

   Having no further business, the Health Actuarial (B) Task Force adjourned.
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## LTC Experience Reporting Form 2 ($000 Omitted)

**Direct Individual Experience - Stand-Alone Only**

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### Primarily 2002 and Prior Issue Years
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

### Primarily 2003 to 2010 Issue Years
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

### Primarily 2011 and Later Issue Years
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

*Indicate whether policies are assigned to a Primary Issue Period on a per-policy or per-policy form basis:*

- [ ] Policy
- [ ] Policy Form
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<th>Total (Direct and Transferred) Amount Paid Policyholders</th>
<th>Part 2</th>
<th>Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year</th>
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**PART 1 - Total (Direct and Transferred) Amount Paid Policyholders**

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**PART 2 - Sum of Total Amount Paid Policyholders and Reserve Outstanding at End of Year**

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LONG-TERM CARE EXPERIENCE REPORTING FORM 3 (continued) LTC EXPERIENCE DEVELOPMENT ($000 OMITTED)

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Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods.
(1) If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

(2) If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve would be the paid-up value and future incurred claims will be only for LTC benefits.

Report using (1) above unless there are system limitations which require data to be entered under assumption (2).

When reporting dollar amounts, report the amount in thousands ($000 omitted). For non-dollar values, do not truncate the amounts.

Definition of Incurred Claims:

The amount of developed claims incurred during the calendar year is equal to the present value of all claim payments during the year and any changes in claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 of Form 3 are discounted from the valuation date to the midpoint of the incurred year.

If

\[ \text{iy} = \text{Incurred year} \]
\[ \text{T} = \text{Report year} – \text{incurred year} \]
\[ v = \text{Discount rate} \]
\[ t_{\text{Paid Claims}_{iy}} = \text{Paid claims during current or prior calendar year t from claims incurred in year iy} \]
\[ t_{\text{Case Reserve}_{iy}} = \text{Case reserve at end of calendar year t from claims incurred in iy} \]
\[ t_{\text{Transferred Reserve}_{iy}} = \text{Transferred reserve at end of calendar year t from claims incurred in iy and} \]
\[ t = \text{iy, iy+1, iy+2, \ldots, iy + T} \]

then the Present Value of Incurred Claims for incurred year iy:

For T=0

\[ t_{\text{iyPaid Claims}_{iy}} \times v^t + t_{\text{iyCase Reserve}_{iy}} \times v^t + t_{\text{iyIBNR}_{iy}} \times v^t + t_{\text{iyTransferred Reserve}_{iy}} \times v^t \]
For $T > 0$

$$\gamma_{iy} \text{Paid Claims}_{iy} \times v^0 + \gamma_{iy+1} \text{Paid Claims}_{iy} \times v^1 + \gamma_{iy+2} \text{Paid Claims}_{iy} \times v^2 + \cdots + \gamma_{iy+T} \text{Paid Claims}_{iy} \times v^T +$$

$$\gamma_{iy+T} \text{Case Reserve}_{iy} \times v^{T+\frac{1}{2}} + (\gamma_{iy+T} \text{IBNR}_{iy} \times v^{T+\frac{1}{2}}) + \gamma_{iy+T} \text{Transferred Reserve}_{iy} \times v^{T+\frac{1}{2}}$$

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only.

This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.
**Instructions for Form 1**

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual premium, claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons for direct, assumed, and ceded business are exhibited.

**Form 1: Stand-Alone LTC Only**

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Assumed/Ceded Rows**
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

*Health Companies*

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 3 – Claims Opened

The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed

Number of claims that had been opened, which became closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, benefit exhaustion, or conversion to non-forfeiture status.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year, not including any in non-forfeiture status.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders, including those in non-forfeiture status. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid, including claims on policies in non-forfeiture status.

Column 11 – Other Reserves

Total amount of any other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
**Instructions for Form 2**

**Form 2: Direct Individual Experience – Stand-Alone Only**

**Primary Issue Period Splits**

Experience data for each policy should be aggregated in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

**Definitions and Formulas**

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Comprehensive**
Policies that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders. Policies remain classified as comprehensive after optional riders have been dropped.

**Institutional Only**
Policies that provide institutional coverage only.

**Non-Institutional Only**
Policies that provide only non-institutional coverage.

**Column 1 – Calendar Year of Peak Issues**

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

**Column 2 – % Male Lives Insured**

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.

**Column 3 – Average Attained Age**

Arithmetic mean of the attained ages of all in force policyholders in the block at year end.
Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

*Health Companies*

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, benefit exhaustion, or conversion to non-forfeiture status.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of claim reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses by incurred calendar year. This form is aggregated on a nationwide basis.

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X. All reserves are based on the underlying assumptions for the current reserves.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year). The discount rate is the statutory valuation interest rate for case reserves.
Instructions for Form 4

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

Column 3 – Average Attained Age
Unweighted average of the attained ages of all in force certificate holders in the block.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Column 5 – Incurred Claims
Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

Column 6 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.
Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 provides LTC sales and claims experience on a state-by-state basis. These are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on life policies or annuity contracts.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state in which the policy was issued. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 7 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Commented [JS1]: It looks like there were no changes to form 3 instructions or template. Was any decision made about how to handle changes in the calculation of DLR (whether to implement them only in that year, or to recalculate the DLR on past years under the current newest methodology)?

I recommend adding a paragraph to the form 3 instructions that says if you change DLR reserve bases, don’t go back and recast the prior years using the new basis. Just use the new basis for the current and future years (until the reserve basis changes again).
Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

Commented [JS2]: I don’t understand this paragraph. I think it is saying the company needs to be aware of how they are planning to handle waiver of premium. I also don’t know what the “experience fund” is. The paragraph suggests two methods of handling waiver of premium (if I’m reading it right) but none of the spreadsheet forms allow the company to express which method was used.

If you want waiver of premium handled consistently between companies you are better off to explain specifically how you want it handled (including the discounting associated).

There are different reasons for waived premium: on claim in a facility, death of spouse triggers paid up survivor benefit, policy is h-pay and is already paid up. Addressing how you want each situation handled in the reporting would provide greater consistency in company reporting. I’m not certain if there is a reason to handle them differently.

I recommend that the reports exclude the waiver of premium from both claims and premiums. I recommend a separate column in Form 1 for waiver of premium reserve. Whether you ask the companies to discount the waivers as a present value of paid waived premiums, or discount them based on the incurral date of the claim with which they are associated – I don’t have a preference. But I think the instructions should say one way or the other so that it’s calculated consistently.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 3 – Claims Opened
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed
Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.

Commented [353]: Claim reserves are usually made up of a few parts: PVFB on open claims, IBNR, and CBER (closed but expected to reopen). For the CBER, the company is likely holding an ALR (because the person moves from claim status back to active). Do you want the CBER included in the incurred claims if there is a separate ALR held?

Commented [354]: Forms 1, 2, 4, and 5 all reference back to Form 3 for determining how incurred claims should be considered. We might explain the treatment of incurred claims in the general instructions rather than in the middle form with all others referencing the middle form.

Commented [355]: Is it intended here to say that if a claim never enters the elimination period it should never be counted as a claim (open or closed)? It is stated fairly explicitly here in the opened claims, but it isn’t stated that way in the closed claims. The instructions are ambiguous as to whether or not you want them counted at least as closed claims.

Commented [356]: What about claims that never get out of the elimination period? Do these count as closed claims?
Column 5 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.

Commented [357]: Does this only include the claims that were incurred in the current year, or any claim that is still open including those incurred in prior years? (It only exists on the “Current” line so I’m wondering if you mean for it to be column 3 minus column 4)

If you mean you want all claims that the company has remaining open, maybe something like “Open claims are all claims from any incurred year that have been closed as of the end of the year.”

Commented [358]: When the instructions first were in place in 2009, most companies hadn’t had an increase large enough to trigger a lot of CNF business. Now most have, and many offer CNF even if the trigger % is not hit.

How do you want CNF policies to be handled? Their coverage technically doesn’t end, but they are also technically lapsed. (In order to trigger the CNF benefit the model language says you have to lapse your policy).

Some companies offer an Enhanced CNF benefit that is something like 150% of regular CNF, but it may have to be elected rather than triggered at lapse. Since these are somewhat small benefits it feels like they should be considered similarly to regular CNF.

Commented [359]: Are CNF policies in force?

Commented [3510]: The ALR might include a reserve for the CNF benefits, but you may not want the CNF policyholders counted in the lives at end of year. The # of CNF policyholders grows with each rate increase, as does the CNF reserve.

Commented [3511]: Claim reserves are usually made up of a few parts: PVFB on open claims, IBNR, and CBER (closed but expected to reopen). For the CBER, the company is likely holding an ALR (because the person moves from claim status back to active). Do you want the CBER included here?

Commented [3512]: “...return of premium reserves,”
Instructions for Form 2

Form 2 provides data on direct individual LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – % Male Lives Insured
Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.
<table>
<thead>
<tr>
<th>Column 3 – Average Attained Age</th>
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</thead>
<tbody>
<tr>
<td>Unweighted average of the attained ages of all inforce policyholders in the block.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 4 – Earned Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.</td>
</tr>
</tbody>
</table>

**Life, Accident & Health, Fraternal and Property/Casualty Only**

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

**Health Companies**

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

<table>
<thead>
<tr>
<th>Column 5 – Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.</td>
</tr>
</tbody>
</table>

Refer to the instructions for incurred claims included in Form 3, Part 4.

<table>
<thead>
<tr>
<th>Column 6 – Lives In-force Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 7 – Terminations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 8 – New Lives Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.</td>
</tr>
</tbody>
</table>

**Commented [JS18]:** Is “arithmetic mean” more descriptive than “unweighted average”? Also, should this specify that it is for the current inforce only (implied because it is in the “current” rows, but may not hurt to specify)? Also, clarify that this is also as of 12/31

**Commented [JS19]:** Here “current” means the earned premium for the current year. Not necessarily the total past earned premium for those policies currently inforce at 12/31. In other places, current means for the currently inforce at 12/31.

**Commented [JS20]:** Here, “current” means inforce as of 12/31

**Commented [JS21]:** Again – what to do with CNF?

**Commented [JS22]:** Here, “current” means current calendar year.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses incurred by a specific year group of claimants. This form is to be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Commented [JS23]: Should this specify “Disabled life reserves” or Claim reserves? Form 3 does not check the adequacy of CNF reserves, return of premium, waiver of premium, ALR, or reserve deficiencies that are mentioned in the general part of the instructions.

Commented [JS24]: Is form 3 by policy form? Or is it combined for all policy forms? If the instructions say it’s to be aggregated at the nationwide level should it say that it should be aggregated across all policy forms also?

Commented [JS25]: Every Form in the excel spreadsheet says, (“$000 Omitted”), but only form 3 addresses that in the instructions. I recommend that in the general instructions, prior to the individual form instructions, you state something like, “When reporting dollar amounts an any of the forms 1-5, report the amounts in thousands ($000 omitted). For non-dollar fields do not truncate the amounts.” And either repeat that on all the form instructions, or omit it. But don’t just have it on form 3.

Commented [JS26]: There should be commentary to indicate how to handle a change in reserving basis. (only on a go forward basis, or recast all prior years)
Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year).

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.
Instructions for Form 4

Form 4 provides data on direct group LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter "25" in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce certificate holders in the block.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.
Column 5 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve. Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.

Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 is intended to provide data on a state-by-state basis in relation to LTC sales and claims experience. These lines are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on what is primarily a life policy or annuity contract.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Stand-alone LTC**
An LTC product that is sold by itself, not as a rider on another type of insurance.

**Life/LTC Accelerated Benefits Riders**
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

**LTC Extension of Benefit Riders**
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

**Column 1 – State Code**
The state for which data is being reported. Example: CA for California

**Column 2 – New Lives Insured**
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

**Column 3 – Lives In-force Year End**
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Commented [JS32]: Current is used with two meanings on this Form also.

Commented [JS33]: There’s some inconsistency between the nomenclature here. The word doc says Rider, the Excel doc says Policy. It probably doesn’t matter much, but it would be nice if they were consistent. Same goes for the Accelerated Benefits.

Commented [JS34]: Issue state or residence state of the policy? It better be issue state, and it ought to be stated explicitly in the instructions.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 7 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
<table>
<thead>
<tr>
<th>Line</th>
<th>Earned Premiums</th>
<th>Incurred Claims</th>
<th>Claims Opened</th>
<th>Claims Closed</th>
<th>Remaining Open</th>
<th>Terminations</th>
<th>Policies In-force</th>
<th>Lives In-force</th>
<th>Active Life Reserves</th>
<th>Claim Reserves</th>
<th>Other Reserves</th>
<th>Current</th>
<th>Total Inception-to-date</th>
<th>Assumed</th>
<th>Ceded</th>
<th>Net (Direct + Assumed - Ceded)</th>
<th>Assumed</th>
<th>Ceded</th>
<th>Net (Direct + Assumed - Ceded)</th>
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Indicate whether policies on claim that have triggered waiver of premium are considered paid up or paid by waiver.

- □ Paid up
- □ Paid by Waiver

© 2020 National Association of Insurance Commissioners
# LTC Experience Reporting Form 2 ($000 Omitted)
## Direct Individual Experience - Stand-Alone Only

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Indicate whether policies are assigned to a Primary Issue Period on a per-policy or per-policy form basis:

- [ ] Policy
- [ ] Policy Form
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### PART 2 -  Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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### PART 3 - Transferred Reserves

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### PART 4 - Present Value of Incurred Claims

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## PART 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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## PART 4 - Present Value of Incurred Claims

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## PART 5 - Total ( Lump Sum and Annuity) Amount Paid Yearly

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### Part 4: Present Value of Incurred Claims

Indicate whether claim reserves and liabilities for prior years are based on historical or current reserving assumptions:

- [ ] Historical
- [ ] Current
LTC Experience Reporting Form 4 ($000 Omitted)
Direct Group Experience - Stand-Alone Only

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Stand-alone LTC

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<tr>
<th>Current</th>
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<td>Total Inception-to-Date</td>
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</tbody>
</table>

Life/LTC Hybrid Policies and Riders

<table>
<thead>
<tr>
<th>Current (Acceleration only)</th>
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<tr>
<td>Total Inception-to-Date (Acceleration only)</td>
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<tr>
<td>Current (Extended Benefits Policies)</td>
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<tr>
<td>Total Inception-to-Date (Extended Benefits)</td>
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</tbody>
</table>
These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods:
(1) If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

(2) If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve would be the paid-up value and future incurred claims will be only for LTC benefits.

Report using (1) above unless there are system limitations which require data to be entered under assumption (2).

When reporting dollar amounts, report the amount in thousands ($000 omitted). For non-dollar values, do not truncate the amounts.

**Definition of Incurred Claims:**

The amount of developed claims incurred during the calendar year is equal to the present value of all claim payments during the year and any changes in claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 of Form 3 are discounted from the valuation date to the midpoint of the incurred year.

If

\[ iy = \text{Incurred year} \]
\[ T = \text{Report year} – \text{incurred year} \]
\[ v = \text{Discount rate} \]
\[ t_{\text{Paid Claims}_{iy}} = \text{Paid claims during current or prior calendar year} t \text{ from claims incurred in year} iy \]
\[ t_{\text{Case Reserve}_{iy}} = \text{Case reserve at end of calendar year} t \text{ from claims incurred in} iy \]
\[ t_{\text{Transferred Reserve}_{iy}} = \text{Transferred reserve at end of calendar year} t \text{ from claims incurred in} iy \]
\[ t = iy, iy+1, iy+2, \ldots, iy + T \]

then the Present Value of Incurred Claims for incurred year \( iy \):

\[
\text{Present Value of Incurred Claims}_{iy} = t_{\text{Paid Claims}_{iy}} \times v^{	ext{iy}} + t_{\text{Case Reserve}_{iy}} \times v^{	ext{iy}} + t_{\text{IBNR}_{iy}} \times v^{	ext{iy}} + t_{\text{Transferred Reserve}_{iy}} \times v^{	ext{iy}}
\]
For $T > 0$

\[
\gamma^1 \text{Paid Claims}_{\gamma} \times v^{\gamma} + \gamma^1 \text{Paid Claims}_{\gamma} \times v^{1} + \gamma^2 \text{Paid Claims}_{\gamma} \times v^{2} + \ldots + \gamma^T \text{Paid Claims}_{\gamma} \times v^{T} +
\]

\[
\gamma^T \text{Case Reserve}_{\gamma} \times v^{T+\frac{1}{2}} + (\gamma^T \text{IBNR}_{\gamma} \times v^{T+\frac{1}{2}}) + \gamma^T \text{Transferred Reserve}_{\gamma} \times v^{T+\frac{1}{2}}
\]

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only.

This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual premium, claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons for direct, assumed, and ceded business are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 3 – Claims Opened

The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed

Number of claims that had been opened, which became closed during the year due to recovery, exhaustion of benefits, or death.
<table>
<thead>
<tr>
<th>Column 5 – Claims Remaining Open</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open claims</strong> are all claims that have been opened at any date, but have not been closed as of the end of the year.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 6 – Terminations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 7 – Policies/Certificates In-force at Year End</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of policies or certificates in force at the end of the year.</strong></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 8 – Lives In-force at Year End</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Column 9 – Active Life Reserves</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total amount of active life reserves held for policyholders, including those in non-forfeiture status. The amount reported in annual statement Exhibit 6, Line 2 for life, accident &amp; health, and fraternal only.</strong></td>
<td></td>
</tr>
</tbody>
</table>

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

<table>
<thead>
<tr>
<th>Column 10 – Claim Reserves</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Total amount of reserves held for payment of claims that have been incurred but not yet paid, including claims on policies in non-forfeiture status.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 11 – Other Reserves</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Total amount of any other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.</strong></td>
<td></td>
</tr>
</tbody>
</table>

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy should be aggregated in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policies that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policies that provide institutional coverage only.

Non-Institutional Only
Policies that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.

Column 3 – Average Attained Age

Arithmetic mean of the attained ages of all inforce policyholders in the block at year end.
Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

**Life, Accident & Health, Fraternal and Property/Casualty Only**

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

**Health Companies**

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of claim reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses by incurred calendar year. This form is aggregated on a nationwide basis.

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year). The discount rate is the statutory valuation interest rate for case reserves.
Instructions for Form 4

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain inforce as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

Column 3 – Average Attained Age
Arithmetic mean of the attained ages of all inforce certificate holders in the block at year end.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Column 5 – Incurred Claims
Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

Column 6 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.
Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 provides LTC sales and claims experience on a state-by-state basis. These are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on life policies or annuity contracts.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Stand-alone LTC**
An LTC product that is sold by itself, not as a rider on another type of insurance.

**Life/LTC Accelerated Benefits Riders**
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

**LTC Extension of Benefit Riders**
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

**Column 1 – State Code**
The state in which the policy was issued. Example: CA for California

**Column 2 – New Lives Insured**
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

**Column 3 – Lives In-force Year End**
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 7 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 – New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
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.

2021 Health Care Cost Model
Goal: To Assist Regulators, Insurance Company Actuaries and Consulting Actuaries in estimating the impact of COVID-19 on claim costs.
- VBA Excel Model projecting future monthly costs with user inputs
- Commercial Group and Individual, Medicare and Medicaid LOBs
- Model includes different types of trended costs; Updated in July
  - Base Costs
    - Includes Foregone, Deferred, and Recouped Expenses subject to Return Stages
  - Direct COVID-19 Costs
    - SIR Model can generate infection rate scenarios
    - User selected hospitalization rates
  - Behavioral Health Costs Due to Social Distancing
  - COVID-19 Testing and Vaccine Costs

SOA Experience Studies

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBK-2021 IDI Persistency</td>
<td>Complete a study of policy terminations for individual disability and release a report with the findings.</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>SBK-2021 Individual Disability Incidence Report</td>
<td>Complete a study of incidence for individual disability and release a report with the findings and an aggregated database of the experience data.</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>SBK-2021 Long Term Care - Report</td>
<td>Develop a database for long term care claim terminations and incidence experience</td>
<td>7/31/2020</td>
</tr>
<tr>
<td>SBK-2021 Lapse and Mortality Valuation Assumptions</td>
<td>Develop a replacement mortality LTC valuation table rate proposal to replace the current LTC mortality type assumptions. Work done in conjunction with the AAA.</td>
<td>10/30/2020</td>
</tr>
</tbody>
</table>

1 https://www.soa.org/resources/research-reports/2020/us-individual-disability/  
2 https://www.soa.org/resources/experience-studies/2019/claim-incidence-report/
## SOA Practice Research & DDIR

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021 Health Care Cost Model v1.0</td>
<td>Release a model that will enable users to estimate health care cost levels in insured plans across a wide variety of scenarios</td>
<td>7/13/2020</td>
</tr>
<tr>
<td>Direct Primary Care – Evaluating a New Model</td>
<td>Evaluating a model that will enable users to estimate health care cost levels in insured plans across a wide variety of scenarios</td>
<td>8/15/2020</td>
</tr>
<tr>
<td>Direct Primary Care – Evaluating a New Model</td>
<td>Conduct a market survey and literature review to define DPC and examine interview physicians who operate under a DPC model. Create a case study to quantify the impact of DPCs.</td>
<td>11/30/2020</td>
</tr>
<tr>
<td>Health Care Cost Model v2.0</td>
<td>Release a model that will enable users to estimate health care cost levels in insured plans across a wide variety of scenarios</td>
<td>11/30/2020</td>
</tr>
<tr>
<td>Comparing Measures of Social Determinants of Health to Assess Population Risk</td>
<td>Assess how well different measures of SDOH quantify and characterize patient risk status in order to optimize a variety of population health and payment purposes.</td>
<td>8/15/2020</td>
</tr>
<tr>
<td>PrEP Toolkit</td>
<td>Create a toolkit to help actuaries estimate the costs of covering HIV related Pre-Exposure and Post-Exposure Prophylaxis drugs.</td>
<td>10/15/2020</td>
</tr>
<tr>
<td>Initiative 18/11 - 5/50 Project – Analyzing Characteristics of the Top 5% members by cost who drive 50% of Medical Expenses</td>
<td>Validate the 5/50 Premise through % of total costs and average allowed annual costs by percentile grouping. Calculate ability to control the 5% based on prior claims cost risk factors. Develop a methodology for identifying and stratifying future year risks.</td>
<td>11/15/2020</td>
</tr>
</tbody>
</table>

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Aug. 6, 2020. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Bill Carmello (NY); Laura Miller (OH); Tracie Gray (PA); Andrew Dvorine (SC); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. **Adopted its Jan. 23, 2020, and 2019 Fall National Meeting Minutes**

The Working Group met Jan. 23 to adopt a draft of changes to the Long-Term Care Insurance Experience Reporting Forms of the annual financial statement.

Mr. Ostlund made a motion, seconded by Mr. Lombardo, to adopt the Working Group’s Jan. 23, 2020 (Attachment Five-A), and Dec. 6, 2019 (see NAIC Proceedings –Fall 2019, Health Actuarial (B) Task Force, Attachment One) minutes. The motion passed unanimously.

2. **Heard an Update from the Academy on LTC Work Group Activities**

Warren Jones (PricewaterhouseCoopers LLP) gave an update (Attachment Five-B) on the American Academy of Actuaries (Academy) Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables.

Mr. Kupferman asked why, for issue ages 80 and greater, the same mortality table marital status adjustment factors are used for married and single policyholders. Mr. Jones said this is because a difference between married and single policyholder experience was not observed for issue ages 80 and greater. He said there are other apparently anomalous relationships in the proposed tables and adjustment factors that can be explained by the actual observed experience, and that these will be detailed in the final report to the Working Group.

3. **Heard an Update on SOA LTCI Research**

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Five-C) on recent work on the SOA’s Long-Term Care Experience Study.

4. **Adopted the Report of the Long-Term Care Pricing (B) Subgroup**

Mr. Lombardo said the Long-Term Care Pricing (B) Subgroup met Feb. 6 and Jan. 6. He said the Subgroup discussed long-term care insurance (LTCI) cash value buyouts (CVBs) to policyholders in lieu of rate increases, and recent discussions in the Connecticut legislature concerning the ability of stand-alone LTCI policyholders to convert their policies to some form of hybrid LTCI policy, using some of the accumulated value of the stand-alone policy to offset the cost of the hybrid policy. He said state insurance regulators’ main concern expressed is the possibility of antiselection by policyholders that elect CVBs affecting remaining policyholders. He said the Subgroup will continue CVB discussions during an upcoming conference call.

Mr. Lombardo made a motion, seconded by Mr. Schallhorn, to adopt the report of the Long-Term Care Pricing (B) Subgroup, including its Feb. 6 (Attachment Five-D) and Jan. 6 (Attachment Five-E) minutes. The motion passed unanimously.

5. **Adopted the Report of the Long-Term Care Valuation (B) Subgroup**

Mr. Andersen said the Subgroup has not met since the 2019 Fall National Meeting. He said a review group composed of Subgroup members continues to review Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) year-end 2019 filings. He said this is the third year for such reviews. He said the first year
of reviews focused on ultimate lapse rates, mortality tables, reliance on future rate increases, morbidity improvement and future investment performance assumptions used for reserve calculations. He said the second year of reviews took a closer look at morbidity assumptions by developing an inquiry letter that resulted in more useful morbidity information being collected related to claim cost, incidence, termination and benefit utilization.

Mr. Andersen said Subgroup members have engaged with insurers, the SOA and actuarial consulting firms to assess the impact of COVID-19 on LTCI valuation. He said initial findings indicate the presence of COVID-19 impacts on claims costs, situs of long-term care (LTC) services and consumer attitudes towards receiving LTC services during the pandemic. He said there will likely be a hesitation among the elderly to enter an LTC facility and that it is unknown if this will be a short-term or long-term change in LTC service utilization. He said COVID-19 mortality is affecting LTCI reserves, and the extent of the impact needs to be analyzed. He said if there is a continued shift in use of facility-based LTC services, the financial impact on LTCI may be greater than that from increased mortality. He said the most certain impact to LTCI reserves over the past five months has been the further decline in interest rates. He said that any past financial concerns for insurers will likely be worse than they were prior to COVID-19. He said the Subgroup will coordinate with the Long-Term Care Pricing (B) Subgroup, as many of the COVID-19 related issues that affect valuation will also affect pricing. He said the Subgroup will be in contact with the Academy and SOA to determine how their recent work relates to LTCI valuation. He said the Subgroup will present any findings related to COVID-19 during future conference calls over the next few months.

Mr. Andersen made a motion, seconded by Mr. Boerner, to adopt the report of the Long-Term Care Valuation (B) Subgroup. The motion passed unanimously.

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

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Long-Term Care Actuarial (B) Working Group
Conference Call
January 23, 2020

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Jan. 23, 2020. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Laura Miller (OH); Andrew Schallhorn (OK); Andrew Dvorine (SC); Raja Malkani (TX); and Jaakob Sundberg (UT).

1. Adopted a Draft of Revisions to the Forms

Mr. Kupferman presented draft of revisions (Attachment Five-A1) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions (Attachment Five-A2) for the revised Forms. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement. He said the draft revisions were exposed for public comment, and he presented a comment letter (Attachment Five-A3) from the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP).

Ms. Ahrens suggested that the Total Inception-to-Date rows be deleted for the Assumed and Ceded sections of Form 1. The Working Group agreed to these changes.

Jan Graeber (ACLI) asked if the current Form 3 will be retained in the set of Forms. Mr. Kupferman said Form 3 will be retained, and no changes to it have been proposed.

Mr. Ostlund made a motion, seconded by Ms. Ahrens, to adopt the draft Forms (Attachment Five-A4) and instructions (Attachment Five-A5) with changes agreed to during the discussion. The motion passed unanimously. Mr. Kupferman said the draft Forms and instructions will be forwarded to the Health Actuarial (B) Task Force for its consideration.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
## LTC Experience Reporting Form 1 ($000's)
### Stand-Alone LTC Only

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### Individual

**Direct**
- Current
- Total Inception-to-date

**Assumed**
- Current
- Total Inception-to-date

**Ceded**
- Current
- Total Inception-to-date

**Net (Direct + Assumed - Ceded)**
- Current
- Total Inception-to-date

### Group

**Direct**
- Current
- Total Inception-to-date

**Assumed**
- Current
- Total Inception-to-date

**Ceded**
- Current
- Total Inception-to-date

**Net (Direct + Assumed - Ceded)**
- Current
- Total Inception-to-date
### LTC Experience Reporting Form 2 ($000's)

**Direct Individual Experience - Stand-Alone Only**

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<th>Calendar Year of Peak Issues</th>
<th>% Male Lives Insured</th>
<th>Average Attained Age</th>
<th>$ Earned Premium</th>
<th>$ Incurred Claims</th>
<th># Lives In-force Year End</th>
<th># Terminations</th>
<th># New Lives Insured</th>
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**Stand-alone LTC**

- Current
  - Total Inception-to-Date

**Life/LTC Hybrid Policies and Riders**

- Current (Acceleration only)
- Current (Extended Benefits Policies)
- Total Inception-to-Date (Extended Benefits)
Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2009, and 2010 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.
Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.
**Instructions for Form 1**

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons are exhibited.

**Form 1: Stand-Alone LTC Only**

**Definitions and Formulas**

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Assumed/Ceded Rows**
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

**Column 1 – Earned Premiums**
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

*Health Companies*
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

**Column 2 - Incurred Claims**
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

**Column 3 – Claims Opened**
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

**Column 4 - Claims Closed**
Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2 provides data on direct individual LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current

Current calendar year of reporting.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Comprehensive

Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only

Policy forms that provide institutional coverage only.

Non-Institutional Only

Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.
Column 3 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 4

Form 4 provides data on direct group LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain inforce as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce certificate holders in the block.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.
Column 5 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve.
Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.

Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 is intended to provide data on a state-by-state basis in relation to LTC sales and claims experience. These lines are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on what is primarily a life policy or annuity contract.

Form 5: Hybrid Products and Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state for which data is being reported. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 7 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of remaining death benefit available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of remaining extended benefits available to policyholders with extension of benefit riders.
December 11, 2019

Perry Kupferman – Chair of NAIC Long-Term Care Actuarial Working Group (LTCAWG)
Eric King – NAIC Staff

Sent via Email

Re: LTC Experience Reporting Forms and Instructions Exposed November 11, 2019 by the LTCAWG

Dear Mr. Kupferman and Mr. King,

Thank you for the time you and other regulators have spent on the proposed revisions to the NAIC Long-Term Care Experience Reporting Forms. ACLI and AHIP appreciate the opportunity to provide suggestions/comments regarding the version of the LTC Experience Reporting Forms and Instructions exposed for comment on November 11, 2019.

Form Specific Technical Comments:

Form 1
1) We believe that Form 1 is intended to apply to stand-alone only LTC policies. We request that this be added to the form’s header and/or made clear in the Form 1 instructions.
2) In the Instructions for Column 5 (“# Claims Remaining Open”), we suggest adding “as of the end of the year” to the end of the draft definition so it will read “Open claims are all claims that have not been closed as of the end of the year.”
3) It has been noted by some member companies that current reinsurance agreements may not have been in force in all prior years. It is not clear how “Total Inception-to-date” data should be calculated under “Assumed”, “Ceded” and “Net” when the current reinsurance agreement has not been in place for all prior years. We believe that the “Total Inception-to-date” data is only meaningful for the “Direct” portion of the Form and would suggest that the “Total Inception-to-date” rows be removed in the “Assumed”, “Ceded”, and “Net” subsections for both “Individual” and “Group” business.
4) The Instructions for Column 11 (“Other Reserves”) note that this value should be “The amount reported in annual statement Exhibit 6, Line 2 . . .”. We believe this is not the correct reference. It appears this might be the correct reference for Column 9. Column 11 appears to be Exhibit 6, Line 1 plus Line 3? Since Exhibit 6 is being modified for the 2019 Annual Statement, we suggest reviewing the revised form to assure that the proper references are present for the Instructions.
5) The Instructions for Column 9 (“Active Life Reserves”) read that this is the total of the reserves “held for policyholders who are not currently on claim”. Please note that many insurers continue to hold active live reserves for policyholders that are on claim. We suggest
removing the current definition and inserting a reference to the correct Annual Statement value (which in this case does appear to be Exhibit 6, Line 2.

6) We believe it would make sense for the new instructions for Column 2 ("Incurred Claims") to be shown at the level of detail as the current Form 1 Instructions? We believe the "Incurred Claims" to be illustrated are intended to be the same developed claim amounts as shown in the Current Form 1. These previous instructions provided more detail and would thus allow for less misunderstanding in completing the Form. Please also amend the Instructions for Forms 2, 4 and 5 "Incurred Claims" to refer back to the definition of Incurred Claims for Form 1.

Form 2
1) We believe that Form 2 is also intended to apply to stand-alone only LTC policies. We request that this be added to the form’s header and/or made clear in the Form 2 instructions. (Please note that this same comment is applicable to Form 4.)

2) We recommend some additional clarification of the Primary Issue Year Periods be included in the Instructions. It would be preferable to clarify the intent that the data for a policy form/series can be included 100% in one of the three Issue Year periods based upon the primary issue years of the form. In addition, some companies might prefer to split the experience of a policy form by issue year. Perhaps an additional Definition along the following lines could be added to the Form 2 Instructions:

**Primary Issue Period Splits**
Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

3) In Column 8 on the Experience Reporting Form (“# New Lives Insured”) it appears that the three “Total Inception to Date” cells in the “Primarily 2010 and Later Issues” section should also be X’ed out.

Form 5.
1) We wish to note that the reporting of Column 4 (“Earned Premiums”) is likely to present challenges in the “Life/LTC Hybrid” section. In some policies, the premiums may not be separate for the LTC portion of the policy. It is likely that the data provided from company to company will not be consistent. Can more direction be provided in the Instructions for cases where the LTC portion of the premium is not identifiable?

2) In the Instructions for Column 7 (“# Claims Remaining Open”), we suggest adding “as of the end of the year” to the end of the draft definition so it will read “Open claims are all claims that have not been closed as of the end of the year.”
3) In Column 10 on the Experience Reporting Form (“$ Accelerated Benefits Available”) it appears that the cell for “Current (Extended Benefit Policies)” should also be X’ed out.

4) In the Instructions for Columns 10 and 11 we suggest removing the word “remaining”. This implies that a company would need to compute the remaining benefit available for policies where a claim is in process and add to the total benefits available for policies not currently on claim. Company administrative systems vary, and inforce policy listings may show the full benefit and not the remaining benefit. Keeping the word ‘remaining’ could cause significant difficulties in reporting for some insurers while the difference between full and remaining benefits will likely not be material for most companies.

5) Companies have concern regarding the providing of LTC claims data at the state level. This data is generally not credible. We believe that Form 5 is most useful for showing market share and volume of new sales data. We would suggest either the removal of the state level Incurred Claims, or at the very least the addition of a footnote along the following lines: “Nationwide data is generally viewed as more representative and credible than individual state data.”

**General Instructions**

The instructions for the currently used LTC Experience Reporting Forms contains a lengthy introduction before the individual form instructions are reached. In light of the changes to the Experience Reporting Forms, we believe that this introduction in the Instructions needs to be revisited as well.

We would be happy to answer any questions that the Working Group has regarding these comments and suggested changes.

Sincerely,

Raymond Nelson  
Consultant to AHIP

Jan Graeber  
ACLI
## LTC Experience Reporting Form 1 ($000 Omitted)
### Stand-Alone LTC Only

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<th># Terminations</th>
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### Individual

#### Direct

| Total Inception-to-date |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

#### Assumed

| Current |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

#### Ceded

| Current |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

#### Net (Direct + Assumed - Ceded)

| Current |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

### Group

#### Direct

| Total Inception-to-date |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

#### Assumed

| Current |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

#### Ceded

| Current |                         |                   |                |                |                        |                |                            |                            |                         |                 |                 |

#### Net (Direct + Assumed - Ceded)

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# Long-Term Care Experience Reporting Form 3 LTC Experience Development ($000 Omitted)

**Reporting Year: 20__**

(To Be Filed By April 1)

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### Part 1 - Total (Direct and Transferred) Amount Paid Policyholders

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### Part 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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### PART 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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### PART 1 - Total (Direct and Transferred) Amount Paid Policyholders

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### PART 5 - Present Value of Incurred Claim Liability and Reserve Outstanding at End of Year

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### PART 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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## LTC Experience Reporting Form 4 ($000 Omitted)
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**Stand-alone LTC**
- Current
- Total Inception-to-Date

**Life/LTC Hybrid Policies and Riders**
- Current (Acceleration only)
- Total Inception-to-Date (Acceleration only)
- Current [Extended Benefits Policies]
- Total Inception-to-Date (Extended Benefits)
Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.
Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 3 – Claims Opened

The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed

Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2 provides data on direct individual LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.
Column 3 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in
Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*

Total earned premiums should equal direct earned premiums for LTC business from
Schedule H, Part 1, Line 2.

*Health Companies*

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line
10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and
any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death,
lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-
to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses incurred by a specific year group of claimants. This form is to be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.
Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values, paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year).

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.
**Instructions for Form 4**

Form 4 provides data on direct group LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

**Form 4: Direct Group Experience – Stand-Alone Only**

**Definitions and Formulas**

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of certificates.

**Comprehensive**
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

**Institutional Only**
Certificates that provide institutional coverage only.

**Non-Institutional Only**
Certificates that provide only non-institutional coverage.

**Column 1 – Calendar Year of Peak Issues**
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.

**Column 2 – Third Party Funding**
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

**Column 3 – Average Attained Age**
Unweighted average of the attained ages of all in force certificate holders in the block.

**Column 4 – Earned Premium**
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.
Column 5 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve. Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.

Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 is intended to provide data on a state-by-state basis in relation to LTC sales and claims experience. These lines are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on what is primarily a life policy or annuity contract.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state for which data is being reported. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 7 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
Requests of the LTC Valuation Work Group

- Develop a replacement mortality table for LTC active life reserves
  - Based on the 2012 Annuitant Mortality Table
  - Recommend a margin for conservatism
- Develop a replacement lapse table
  - Recommend a margin for conservatism
- Consider developing tables for valuation on total lives basis as well as active lives basis

Progress Since Fall National Meeting

- Completed review of actual-to-expected lapse on total lives basis
- Completed review of reasonableness of total terminations on total lives basis
- Developed mortality improvement from mid-point of exposure period, 2008 – 2011, to 2020 using scale G2
- Developed margins for lapse and mortality
- Developed lapse tables on an active lives basis

Remaining Tasks

- Develop mortality tables on an active lives basis
- Complete Report
### Death Counts (Total Lives)

By Sex, Risk Class, Attained Age, and Marital Status

<table>
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<tr>
<th>Attained Age</th>
<th>Female Preferred Risk</th>
<th>Female Standard Risk</th>
<th>Male Preferred Risk</th>
<th>Male Standard Risk</th>
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<td></td>
<td>Death Counts (Total Lives)</td>
<td>Death Counts (Total Lives)</td>
<td>Death Counts (Total Lives)</td>
<td>Death Counts (Total Lives)</td>
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</table>

**Note:** For a detailed explanation of the data and how it was calculated, see Attachment Five-B.

---

**Recommended Mortality Tables**

(Total Lives)

**Recommended Marital Status Adjustment Factors for Mortality Table (Total Lives)**
### Recommended Underwriting Class Adjustment Factors for Mortality Table (Total Lives)

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<th>Issue Age Group</th>
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<th>Underwriting Class Adjustment Factor</th>
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<td>50-59</td>
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<td>70-79</td>
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<tr>
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### Recommended Individual Lapse Table (Total Lives)

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<th>Age Group</th>
<th>Lapse Rate</th>
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<tr>
<td>35-39</td>
<td>2.1%</td>
</tr>
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<td>1.0%</td>
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<tr>
<td>60 &amp; Over</td>
<td>0.8%</td>
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</tbody>
</table>

### Recommended Group Lapse Table (Total Lives)

<table>
<thead>
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<th>Age Group</th>
<th>Lapse Rate</th>
</tr>
</thead>
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<td>Under 35</td>
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</tr>
<tr>
<td>35-39</td>
<td>2.1%</td>
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<tr>
<td>40-44</td>
<td>1.9%</td>
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<td>45-49</td>
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<td>60 &amp; Over</td>
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### Recommended Lapse Tables (Total Lives and Active Lives)

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<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60 &amp; Over</th>
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<td>11.2%</td>
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<td>7.8%</td>
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<td>1.5%</td>
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### Recommended Individual Lapse Table (Active Lives)

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</table>

### Data Credibility for Individual Lapses

![Graph showing data credibility for individual lapses](Image)

- Minimum of Number of Individual Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration
- Under 55: 47% Partial Credibility
- 55-59: 45% Partial Credibility
- 60-64: 44% Partial Credibility
- 65-69: 43% Partial Credibility
- 70-74: 42% Partial Credibility
- 75+: 41% Partial Credibility
- Over 80: 40% Partial Credibility

---

### Recommended Group Lapse Table (Active Lives)

<table>
<thead>
<tr>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
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</tr>
</tbody>
</table>

### Data Credibility for Group Lapses

![Graph showing data credibility for group lapses](Image)

- Minimum of Number of Group Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration
- Under 35: 40% Partial Credibility
- 35-39: 38% Partial Credibility
- 40-44: 37% Partial Credibility
- 45-49: 36% Partial Credibility
- 50-54: 35% Partial Credibility
- 55-59: 34% Partial Credibility
- 60+: 33% Partial Credibility

---

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Recommended Mortality Improvement

- The study period is 2008 through 2011
- Recommend to apply improvement trend using the 2012 IAM G2 scale from 2010 to 2020 (11 years)
- Recommended tables represent industry experience as of 2020
- G2 scale applies to both total lives and active lives

Alternatives for Mortality Improvement

- The mortality tables can be made dynamic by continuing to apply the G2 scale to future valuation dates
- For first principle valuation approach, G2 scale can be applied to both active lives and disabled lives

Recommended Margins
#### Recommended Margins

- 10% for mortality
- 15% for lapse
- Same for total lives and active lives

---

#### Actual Total Lives Mortality to Expected (Based on Recommended Tables) By Company

- A 10% margin will result in 7 out of 10 companies with over 100% actual lapses to the new expected.

---

#### Actual Individual Total Lives Lapses to Expected (Based on Recommended Tables) By Company

- A 15% margin will result in 6 out of 9 companies with over 100% actual lapses to the new expected.

---

#### Actual to Expected Mortality Rates

*Expected Based on Recommended Tables*
Actual Total Lives Mortality to Expected By Policy Year

Actual Total Lives Mortality to Expected By Issue Age Group

Actual Total Lives Mortality to Expected By Marital Status and Underwriting Class

Actual to Expected Lapse Rates (Expected Based on Recommended)
Actual Individual Total Lives Lapses to Expected By Policy Year

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<th>Without Margins</th>
<th>With Margins</th>
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</thead>
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<td>100%</td>
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<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>16+</td>
<td>100%</td>
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</table>

Greater actual to expected ratios in later policy years are due to restricting non-increasing pattern in recommended rates by policy year.

Actual Individual Total Lives Lapses to Expected By Issue Age Group

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<td>65-69</td>
<td>125%</td>
<td>124%</td>
</tr>
<tr>
<td>70-74</td>
<td>106%</td>
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Actual Individual Total Lives Lapses to Expected By Marital Status and Underwriting Class

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Actual Group Total Lives Lapses to Expected By Policy Year

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Actual Group Active Lives Lapses to Expected By Policy Year

Actual Group Active Lives Lapses to Expected By Issue Age Group

Actual to Expected Total Policy Termination Rates
(Mortality and Lapse Combined – Total Lives Only)
Actual Individual Total Lives Total Terminations to Expected by Policy Year

Actual Individual Total Lives Total Terminations to Expected by Issue Age Group

Actual Group Total Lives to Expected by Mortality and Lapse

Actual Group Total Lives Total Terminations to Expected by Policy Year
Actual Group Total Lives Total Terminations to Expected by Issue Age Group

Additional Information

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202-785-6931
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.

Data

• Data collected on policies exposed between 1/1/2000 and 12/31/2016
• 18 companies submitted data
• Over 80% of all 2016 LTC Earned Premium
• Data requested was expanded from the previous study. New data collected:
  • Additional underwriting information
  • Expanded benefit information
  • ICD-9-CM/ICD-10-CM claim information

Status Update

• Completed steps
  • Validation and logic checks defined and programmed
  • Exposure calculations defined and implemented
  • Data validation
  • Contributor data has been validated, exposure calculated and initial database built
• To be completed
  • Build final database
  • Review of aggregated results
  • Database released
Deliverables

• A database of claim termination and incidence data including:
  • Report that defines the database and calculations
  • Summary of data collected
  • High level results
• Data will be HIPAA compliant and follow safe harbor reporting rules
  • Results for ages 90+ required to be grouped
  • Other grouping added to satisfy Safe Harbor while maintaining the highest level of detail as the prior study
• Expected completion date: July 31, 2020
  • Four year lag between latest data collected and publication
  • Comparable to past LTC studies

Challenges of the current study

• Heightened awareness of HIPAA compliance by participating companies
• Additional research into HIPAA compliance options
• Contracting between data compiler and contributors
• Data restrictions
• Delays in data collection and reporting phases
Long-Term Care Pricing (B) Subgroup
Conference Call
February 6, 2020

The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Feb. 6, 2020. The following Subgroup members participated: Paul Lombardo, Chair (CT); Steve Ostlund (AL); Perry Kupferman (CA); Benjamin Ben (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); David Yetter (NC); Rhonda Ahrens (NE); David Sky (NH); Anna Krylova (NM); Laura Miller (OH); Tomasz Serbinowski (UT); and Joylynn Fix (WV). Also participating was: Sarah Neil (RI).

1. Discussed LTCI Cash Value Buyouts

Mr. Lombardo said the Subgroup will continue its discussion of pricing considerations for long-term care insurance (LTCI) cash value buyouts (CVBs) to policyholders in lieu of rate increases from its Jan. 6 conference call. He said CVBs offer policyholders an additional option that is beyond the scope of their existing LTCI contracts. He said most LTCI policies were not initially priced assuming CVBs would be offered. He said the amount of the CVB will likely be calculated as a percentage of the statutory reserve held for the given policy and that the percentage used is an important aspect of CVB considerations. He said the percentage needs to be high enough to appeal to policyholders, but not so high that it affects policyholders that continue their LTCI coverage.

Mr. Lombardo said possible factors influencing the CVB take-up rate by policyholders are: 1) the policyholder’s financial situation; 2) the policyholder’s attained age; and 3) the policyholder’s perception of needing long-term care (LTC) in the future. He said state insurance regulators have a responsibility to ensure that the election of CVBs does not result in harm to remaining policyholders or financial harm to insurers due to potential unpriced for increases in claims costs to the remaining block of policyholders. He said he thinks the balance of the statutory reserve that remains after the percentage of it is paid to policyholders electing CVBs should be earmarked for supporting the block of remaining policyholders. Mr. Andersen agreed that these reserve balances should be earmarked.

Mr. Andersen said insurers that pay out CVBs should consider the effect of morbidity on the remaining block of policyholders for subsequent valuations of liabilities. Mr. Lombardo agreed and said he understands “morbidity” to include claim incidence, claim continuance and percent of maximum allowable benefit utilization. Mr. Andersen agreed with the components of morbidity.

Mr. Lombardo said the Subgroup should discuss whether CVBs should be one-time offers and how long after the offer of a CVB will policyholders be given to decide whether to elect it. He said the number and frequency of CVB offers have the potential to influence the degree of antiselection.

Jan Graeber (American Council of Life Insurers—ACLI) said the ACLI will meet with some of its member companies to discuss the issues above, as well as potential legal issues associated with the offering of CVBs. She said there are concerns that a policyholder or representative could sue an insurer if a CVB were elected, and the CVB recipient later required LTC, or that remaining policyholders could sue the insurer in response to rate increases or financial instability resulting from antiselection against the remaining block. She said ACLI members will also discuss potential tax ramifications to policyholders with tax-qualified LTCI policies upon election of a CVB. She said she will report the results of the ACLI member meeting to the Subgroup during a future conference call.

Ray Nelson (America’s Health Insurance Plans—AHIP) said discussions he has had with AHIP member companies indicate companies are interested in possibly offering CVBs and do not want this option to be prohibited. He said AHIP member companies have expressed the same concerns as those identified by the Subgroup.

Mr. Lombardo said he has discussed the possibility of offering CVBs to policyholders with three insurers. He said one insurer has analyzed the issues associated with CVBs and is interested in further consideration, and two insurers have not analyzed CVBs but are interested in considering offering them.

Ms. Neil asked Ms. Graeber and Mr. Nelson if either are aware of insurers currently offering CVBs. Ms. Graeber and Mr. Nelson said they are not aware if any insurers are or are not. Mr. Lombardo asked Ms. Graeber to ask ACLI members at
the upcoming ACLI meeting if any are currently offering CVBs. Ms. Graeber said she will consult with ACLI legal staff to determine if this is information she can share with the Subgroup.

Mr. Lombardo said the concept of CVBs is also being discussed in one of the workstreams of the Long-Term Care Insurance (EX) Task Force and that Subgroup members might assist the Task Force in this effort.

2. Discussed LTCI Hybrid Products

Mr. Lombardo said there have been recent discussions in the Connecticut Legislature concerning the ability of stand-alone LTCI policyholders to convert their policies to some form of hybrid LTCI policy, using some of the accumulated value of the stand-alone policy to offset the cost of the hybrid policy. He asked if others think this proposal is feasible.

Birny Birnbaum (Center for Economic Justice—CEJ) said there may be issues with calculating what value will be assigned to cancelling the stand-alone coverage that will be transferred to the hybrid coverage that are similar to calculating a CVB value.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
Long-Term Care Pricing (B) Subgroup
Conference Call
January 6, 2020

The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Jan. 6, 2020. The following Subgroup members participated: Paul Lombardo, Chair (CT); Steve Ostlund (AL); Perry Kupferman (CA); Marti Hooper (ME); Fred Andersen (MN); William Leung (MO); Rhonda Ahrens (NE); Anna Krylova (NM); David Yetter (NC); Laura Miller (OH); Raja Malkani (TX); Tomasz Serbinowski (UT); and Joylynn Fix (WV).

1. Discussed LTCI Cash Value Buyouts

Mr. Lombardo said the Subgroup will discuss pricing considerations for long-term care insurance (LTCI) cash value buyouts (CVBs) to policyholders in lieu of rate increases. He said he does not believe most LTCI carriers account for the option of CVBs to policyholders in their initial pricing. He said this may subject carriers to antiselection, and they may become financially disadvantaged in the event policyholders elect CVBs.

Mr. Andersen said he and other state insurance regulators have begun a study of the mathematical aspects of the impacts on policyholders who elect a CVB and the effect on the remaining block of policyholders. He said state insurance regulators’ main concern is that the remaining policyholders may be in a worse position after others have opted for CVBs. He said preliminary findings indicate three factors may influence whether CVB election will harm remaining policyholders. He said the first factor is the amount of the CVB, such as if it is calculated as a percentage of held statutory reserves within a given rating cell, where the risk of harm to remaining policyholders increases as the percentage applied increases. He said the second factor is the percentage of policyholders opting for CVBs, with increasing percentages increasing the risk to remaining policyholders. He said the third factor is the degree of antiselection that may occur if healthier policyholders opt for CVBs, resulting in higher-than-anticipated claims costs among the pool of remaining policyholders.

Mr. Andersen said three factors were identified that may contribute to antiselection in the presence of CVBs. He said it is possible that policyholders that elect CVBs tend to be more likely to lapse in general, whether or not a CVB is offered. He said there may be a tendency for policyholders that are aware that they are likely to die soon to elect CVBs, and when such individuals are no longer in the pool of remaining policyholders, the reduction in remaining pool mortality may result in claims costs in excess of those initially priced for. He said there may be a tendency for policyholders that have expectations that they will have lower-than-average long-term care (LTC) claims costs to elect CVBs, and when such individuals are no longer in the pool of remaining policyholders, the reduction in remaining pool morbidity may result in claims costs in excess of those initially priced for.

Ms. Ahrens said the Nebraska Department of Insurance (DOI) is generally not in favor of CVBs, as it is difficult to determine the effect that policyholder election of CVBs will have on the remaining policyholder block’s experience. She said there are other options for policyholders, and the DOI questions what purpose offering CVBs serves. She said CVBs are extra-contractual benefits and do not preserve insurance benefits.

Mr. Kupferman said he thinks the percentage of policyholders that opt for CVBs is very small. Mr. Serbinowski said since the percentage of policyholders that will elect CVBs is likely small, the Utah Insurance Department likely would not prohibit an insurer from offering CVBs.

Mr. Lombardo said that some policyholders that are eligible for CVBs may also be eligible for nonforfeiture benefits (NFBs), and the CVB will likely be much greater than the NFB amount. He asked if the CVB is in lieu of, and not in addition to, the NFB. Mr. Andersen said he believes the CVB is in lieu of the NFB.

Mr. Andersen said he and other state insurance regulators discussed a scenario where the offered CVB is a low percentage of the held statutory reserve, and the insurer expects to experience a financial gain when the CVB is elected. He asked if state insurance regulators should require the insurer to hold this gain as a reserve for the block of remaining policyholders. He said if this is required, state insurance regulators will need to determine how to measure the amount of the gain.
Jan Graeber (American Council of Life Insurers—ACLI) said she will survey ACLI member companies for their input related to offering CVBs to policyholders, and policyholder take-up rates on the various reduced benefit and nonforfeiture options offered. She said she estimates, in general, that 92% of policyholders presented with a rate increase choose to continue coverage at the unmodified increased premium level. Ray Nelson (America’s Health Insurance Plans—AHIP) said he will survey AHIP member companies for the same information.

Mr. Lombardo said the Subgroup will continue to discuss and analyze CVB options.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
**ACADEMY PROFESSIONALISM TALKING POINTS FOR HATF**

**Immediate Past President of the American Academy of Actuaries Shawna Ackerman** said that the Academy will host a professionalism webinar, “In Times of Uncertainty, Professionalism is Certain,” on August 20, and noted that government regulators are invited free of charge. She also highlighted the Academy’s Annual Meeting and Public Policy Forum on November 5-6 in Washington, D.C., the Life and Health Qualifications Seminar, to be held November 9 – 12 in Arlington, VA, and the Academy’s COVID-19 Resource Page.

**Actuarial Standards Board (ASB) Chairperson Kathy Riley** gave an overview of revisions to actuarial standards of practice in the health area. ASOP No. 28, now titled *Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities* is open for comment through November 13, 2020. The ASB is requesting that comments be submitted via the new Comment Template, which is designed to encourage commentators to provide suggested edits and the rationale for those edits to enable the ASB to better understand the commentators’ concerns.

The ASB will review exposure drafts of revisions to ASOP No. 3, *Continuing Care Retirement Communities*, in September, and ASOP No. 18, *Long-Term Care Insurance*, in December.

The comment period on the first exposure draft of a revision to ASOP No. 11, *Reinsurance Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports*, ended on June 30, 2020. Two comments were received, one each from the Academy’s Life Practice Council and Health Practice Council. The ASB is scheduled to review the next version of the ASOP at its December meeting.

With respect to cross-practice ASOPs, ASOP No. 56, *Modeling*, will be effective for work performed on or after October 1, 2020. The ASB began a review of a third exposure draft of the new ASOP on assumptions at its March meeting and will continue the review in September.

In 2014, the ASB had reviewed and approved a revision to ASOP No. 38, now titled *Catastrophe Modeling (for all Practice Areas)*. The revised ASOP No. 38 was held while the Modeling ASOP was developed. The ASOP No. 38 Task Force has reconvened and is reviewing the ASOP in light of the guidance in ASOP No. 56. The ASB expects to review an exposure draft of ASOP No. 38 at its September meeting.

**Actuarial Board for Counseling and Discipline (ABCD) member Godfrey Perrott** reviewed ABCD activity since the Dec. 2019. The complaints the ABCD completed do not raise issues germane to the NAIC, as most were pension specific. The requests for guidance (RFGs) the ABCD has addressed (72) have covered a wide range of issues. In the health practice area, RFGs have covered qualification for the NAIC Health Blank, disclosure (missing data, optimistic assumptions, etc.), steps to resign as Appointed Actuary, and contingent fees.
American Academy of Actuaries
Health Practice Council Highlights
To the National Association of Insurance Commissioners (NAIC)
Health Actuarial Task Force (HATF)
Tuesday, Aug. 4

- The Health Practice Council (HPC) has continued to actively engage policymakers and regulators in the months since the last NAIC national meeting where HATF has met.

- The HPC has, not surprisingly, been actively engaged in work streams to address implications surrounding the COVID-19 pandemic and its impact on health care including the potential effects of COVID-19 on health insurance markets, consumers, and public programs. The HPC has produced two sets of frequently asked questions (FAQs), on the coronavirus’ effect on the individual and small group markets and on Medicaid.

- In addition HPC committee members have been having conversations with public policy makers including congressional members and committee offices, the Congressional Budget Office, and Congressional Research Service.

- The HPC has also been offering informational virtual forums on COVID-19-related issues, including participating in webinars covering cross-actuarial-practice issues and on a focused regulatory perspective on 2021 ratefilings.

- In addition, the HPC hosted a web briefing in late June for policymakers on issues involved in these 2021 health insurance premium drivers and risk mitigation mechanisms. We had previously published issue briefs on those topics.

- Another focus of the HPC is exploring Health Equity. We are planning on a webinar exploring issues involved in that in the next month or so.

- Before the stay at home orders took effect earlier this year, the HPC held its annual Capitol Hill visits, where volunteers and Academy staff met with congressional leadership, and committee and personal offices, along with a number of federal agencies/departments. Much of this year’s Hill discussions focused on recent HPC publications, including Telehealth, Surprise Medical Bills, Long-Term Care Insurance, and Medicaid. The rising costs of health care, especially on prescription drugs, was a topic of discussion in the meetings as well as the implications of recent legislative and regulatory actions on the individual, small, and large group markets.

- In the May/June edition of Contingencies, members of the Social Determinates of Health (SDOH) subcommittee had an article published, “Toward a More Holistic Look at Wellness,” examining a broad array of issues contributing to an individual’s health and wellness. Also, in the same issue, the Health Practice International Committee (HPIC) submitted a published article, “It’s an Opioid World,” a look at the international opioid crisis.

We also have many initiatives under way within the HPC and its committees, including:

- We have exposed for comment a new practice note on ASOP No. 6 (*Development of Age-Specific Retiree Health Cost Assumptions for Pooled Health Plans, Including Applications to Non-Pooled Health Plans*), to provide information for actuaries valuing retiree health benefit plans. Comments on the exposure draft are due to the Academy by September 30, 2020.

- With the exposure period for the Actuarial Memorandum Practice Note now concluded, the drafting group is now reviewing comments received and expects to public a final practice note soon.

- We have multiple projects underway under Long-term Care: including groups working on LTC Actuarial Equivalence and on COVID-19 papers.

- We are developing a paper on Telehealth with a renewed focus now on the impact of COVID-19. We had previously published an issue brief in 2019, but given the experience of the past few months have decided that we need to revisit the topic.

- Other coronavirus possible workstreams underway include a focus on Medicare and on an international comparison study of how different countries have responded to the pandemic.

- Also on the international front, the Academy’s Health Practice International Committee along with the SOA International Section, and the International Actuarial Association Health Section have been compiling we are nearing completion of schematic diagrams, or a grid, if you will, to capture the main features of health financing systems and funding schemes for about 30 countries.

- The Academy’s 2020 Annual Meeting and Public Policy Forum is November 5-6 will feature sessions on the Future of Health Care Delivery as impacted by COVID-19, a session on International Health Funding, and regulatory changes including those precipitated by the pandemic on ACA markets, Medicare and Medicaid.

- Finally, I am pleased to inform you, if you have not already received the news, that Al Schmitz will be the next Academy Vice President, taking over from Audrey Halvorson during the annual meeting.