

Date: 12/8/21

2021 Fall National Meeting
San Diego, California

LONG-TERM CARE INSURANCE MULTISTATE RATE REVIEW (EX) SUBGROUP

Followed by

LONG-TERM CARE INSURANCE (EX) TASK FORCE

Sunday, December 12, 2021
11:30 a.m. – 1:00 p.m.
Convention Center—Ballroom 20 ABC—Upper Level

ROLL CALL

*Task Force members who are also Subgroup members are identified with an asterisk**

Scott A. White, Chair*	Virginia	Chlora Lindley-Myers*	Missouri
Michael Conway, Vice Chair*	Colorado	Troy Downing	Montana
Jim L. Ridling	Alabama	Eric Dunning*	Nebraska
Lori K. Wing-Heier	Alaska	Barbara D. Richardson*	Nevada
Evan G. Daniels	Arizona	Marlene Caride*	New Jersey
Alan McClain*	Arkansas	Russell Toal*	New Mexico
Ricardo Lara	California	Mike Causey	North Carolina
Andrew N. Mais*	Connecticut	Jon Godfread	North Dakota
Trinidad Navarro	Delaware	Judith L. French	Ohio
Karima M. Woods*	District of Columbia	Glen Mulready	Oklahoma
David Altmaier*	Florida	Andrew R. Stolfi*	Oregon
Colin M. Hayashida	Hawaii	Jessica K. Altman*	Pennsylvania
Dean L. Cameron*	Idaho	Elizabeth Kelleher Dwyer*	Rhode Island
Dana Popish Severinghaus	Illinois	Raymond G. Farmer*	South Carolina
Amy L. Beard*	Indiana	Larry D. Deiter	South Dakota
Doug Ommen*	Iowa	Carter Lawrence	Tennessee
Vicki Schmidt	Kansas	Cassie Brown*	Texas
James J. Donelon*	Louisiana	Jonathan T. Pike*	Utah
Eric A. Cioppa	Maine	Michael S. Pieciak*	Vermont
Gary D. Anderson	Massachusetts	Mike Kreidler*	Washington
Anita G. Fox*	Michigan	Allan L. McVey*	West Virginia
Grace Arnold*	Minnesota	Mark Afable	Wisconsin
Mike Chaney	Mississippi	Jeff Rude	Wyoming

NAIC Support Staff: Jeffrey C. Johnston\Eric King

LONG-TERM CARE INSURANCE MULTISTATE RATE REVIEW (EX) SUBGROUP AGENDA

1. Consider Adoption of its Nov. 15 and Sept. 28 Minutes
—Commissioner Michael Conway (CO)

Attachment One



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| 2. Hear Comments on the Exposure of the Multistate Rate Review Framework (Pending Dec. 6 Comment Deadline)— <i>Commissioner Michael Conway (CO)</i> | Attachment Two |
| 3. Consider Adoption of the Multistate Rate Review Framework — <i>Commissioner Michael Conway (CO)</i> | Attachment Three |
| 4. Discuss Any Other Matters Brought Before the Subgroup — <i>Commissioner Michael Conway (CO)</i> | |
| 5. Adjourn into Task Force Session— <i>Commissioner Michael Conway (CO)</i> | |

LONG-TERM CARE INSURANCE (EX) TASK FORCE AGENDA

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| 6. Consider Adoption of its Oct. 29 and Aug. 13 Minutes — <i>Commissioner Scott A. White (VA)</i> | Attachment Four |
| 7. Receive the Report of the Long-Term Care Insurance Financial Solvency (EX) Subgroup— <i>Fred Andersen (MN)</i> | |
| 8. Receive the Report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup— <i>Commissioner Michael Conway (CO)</i> | |
| 9. Consider Adoption of the Multistate Rate Review Framework (Pending Adoption by the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup on Dec. 12)— <i>Commissioner Scott A. White (VA)</i> | Attachment Three |
| 10. Receive the Report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup— <i>Commissioner Jessica K. Altman (PA)</i> | Attachment Five |
| 11. Consider Adoption of the Issues Related to LTC Wellness Benefits Document (Pending Adoption by LTCI RBO (EX) Subgroup on Dec. 7) — <i>Commissioner Jessica K. Altman (PA)</i> | Attachment Six |
| 12. Consider Adoption of the Checklist for Premium Increase Communications — <i>Commissioner Jessica K. Altman (PA)</i> | Attachment Seven |
| 13. Discuss Any Other Matters Brought Before the Task Force — <i>Commissioner Scott A. White (VA)</i> | |
| 14. Adjournment | |

Draft: 11/22/21

Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
Virtual Meeting
November 15, 2021

The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Nov. 15, 2021. The following Subgroup members participated: Michael Conway, Chair (CO); Jimmy Harris (AR); Paul Lombardo (CT); Phillip Barlow (DC); Benjamin Ben (FL); Klete Geren (IA); Dean L. Cameron (ID); Alex Peck (IN); Rod Friedy (LA); Fred Andersen (MN); William Leung (MO); Michael Muldoon (NE); Russel Toal (NM); Jessica K. Altman (PA); Matt Gendron (RI); Michael Wise (SC); Doug Slape (TX); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Michael Walker (WA); and Joylynn Fix (WV).

1. Discussed and Exposed Comments on an MSA Framework Draft

Mr. Conway said the purpose of today's meeting is to: 1) review the latest changes that have been made to the draft combined Long-Term Care Insurance (LTCI) Multistate Rate Review Framework (MSA Framework); 2) address the comments received on the second exposure of the MSA Framework; and 3) expose the draft for a final public comment period in advance of the Fall National Meeting.

Mr. Andersen presented a recommendation (Attachment One-A) from the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. He said the recommendation was in response to a referral from the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup for guidance concerning suggested edits to the Reduced Benefit Options appendix of the draft MSA Framework. He said it is recommended that no changes be made at this time.

Mr. Andersen gave a summary of the changes made to the draft MSA Framework in response to comments received from the Arizona Department of Insurance (DOI) and Financial Institutions (Attachment One-B), the North Carolina DOI (Attachment One-C), the American Academy of Actuaries (Academy) (Attachment One-D-), and the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment One-E and One-F) during the second exposure, using a marked-up version of the draft (Attachment One-G).

Mr. Conway said the combined draft of the MSA Framework discussed during the meeting will be exposed for a third public comment period ending Dec. 6. He said the Subgroup plans to discuss any comments received and consider adoption of the MSA Framework during its Dec. 12 meeting, and then forward it to the Long-Term Care Insurance (EX) Task Force for its consideration.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.

Draft: 10/26/21

Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
Virtual Meeting
September 28, 2021

The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Sept. 28, 2021. The following Subgroup members participated: Michael Conway, Chair (CO); Paul Lombardo (CT); David Altmaier (FL); Andria Seip (IA); Stephen Chamblee (IN); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Russel Toal (NM); Jessica K. Altman (PA); Matt Gendron (RI); Michael Wise (SC); Barbara Snyder (TX); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Lichiou Lee (WA); and Joylynn Fix (WV). Also participating was: Barbara D. Richardson (NV).

1. Discussed Comments on an MSA Framework Draft

Mr. Conway said the purpose of today's meeting is to review the changes that have been made to the Actuarial sections of the draft Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (MSA Framework) in response to the comments received from their first exposure. He said the Actuarial sections have been exposed for a second public comment period ending Oct. 28.

Mr. Andersen gave a summary of the changes to the Actuarial sections of the draft MSA Framework, using a marked-up version of the draft (Attachment One-H) and a summary of received comments (Attachment One-I) as references. He said comments were received from the Washington State Office of the Insurance Commissioner (Attachment One-J), the Vermont Department of Financial Regulation (DFR) (Attachment One-K), the American Academy of Actuaries (Academy) (Attachment One-L), the American Council of Life Insurers (ACLI) and the America's Health Insurance Plans (AHIP) (Attachment One-M), and FinancialMedic LLC (Attachment One-N).

Mr. Conway said several comments were received requesting more specificity on how the Multistate Actuarial LTCI Rate Review Team (MSA Team) will apply either the Minnesota or Texas approach and other technical details of the process. He said the MSA Framework is intended to be a framework for the MSA Team's rate review process, and it will not include every detail of every aspect the MSA Team will consider as it conducts its reviews. He said the MSA Team will apply actuarial judgement in its reviews that is not able to be captured in its entirety in the MSA Framework.

Mr. Conway said the MSA Framework is intended to be a tool for states to use in determining the rate increase each state will ultimately approve, and each state will reserve the right to make a rate increase decision that is not the one recommended in any given MSA Team Advisory Report. He said he hopes the MSA Team Advisory Reports can be used by states to arrive at rate increase approval determinations more expeditiously.

Ms. Richardson asked whether the MSA Team considers the number of policyholders in each state when making its recommendations. Mr. Andersen said this is a non-actuarial issue, and the MSA Team strives to achieve rate equity among all states, irrespective of the number of policyholders in a given state.

Mr. Toal said he supports the concept of rate equity among policyholders in different states. He said this also needs to be balanced with the concepts of reasonableness and affordability. He said rate increases of 150% to 200% are not affordable to policyholders in New Mexico, and the issues of reasonableness and affordability need to be part of the MSA Framework's review process. Mr. Conway said these concerns fall into the non-actuarial considerations category, and he agreed that these issues need to be discussed. Mr. Andersen said the Minnesota method attempts to address reasonableness in that it produces rate increase recommendations lower than those using a loss ratio approach. He said it is important to note that even in light of large rate increases, given the expected increase in claims costs, reasonableness is part of the review process.

Jan Graeber (American Council of Life Insurers—ACLI) said there could be more clarity on how the Minnesota and Texas rate review methodologies will be applied, such as commentary on which methodology better addresses issues such as small remaining blocks of policies and other high-level issues. She suggested that a walk-through of the MSA review process using a sample rate increase filing may be helpful. Mr. Andersen said the MSA Team has researched including more clarity as requested, but it has found that the differences in filings make stating which methodology is preferred for various categories difficult. He said the MSA Team will continue to research these issues. Mr. Lombardo said the MSA Team has not reviewed

many filings at this point, and he noted that the MSA Framework will be updated as needed as more filings have been reviewed. He said at this time, the MSA Team does not have enough information to provide the level of detail that Ms. Graeber requested. Ms. Graeber suggested that the Long-Term Care Pricing (B) Subgroup revisit its document that outlines the Minnesota and Texas methodologies and determine if it can be used to add clarity to the MSA Framework. Mr. Andersen said he agrees with this approach, and he suggested developing some case studies to apply the MSA Framework process to. Mr. Conway said any methodology used in the MSA Framework will be required to produce an actuarially justified result.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is no requirement that insurers return excess premiums collected if experience proves to be better than expected. He said he considers this to be a violation of the principle of reasonableness. He said for the MSA Framework process to be transparent, MSA Team Advisory Reports need to be made publicly available. Mr. Conway said the level of detail for each report that is publicly available will be dependent on a given state's confidentiality requirements.

Mr. Conway said the Operational sections of the MSA Framework have been exposed for a second public comment period, and comments are due Oct. 11. He said after the Oct. 28 comment deadline for Actuarial sections, the Subgroup will meet to discuss comments received on both the Actuarial and Operational sections. He said the Subgroup's ultimate goal is to adopt the final version of the MSA Framework prior to the Fall National Meeting, where it will be presented to the Long-Term Care Insurance (EX) Task Force for its consideration.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.

December 6, 2021

Commissioner Michael Conway
Chairman, NAIC LTC Multi-State Rate Review (EX) Subgroup

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers (ACLI)ⁱ and the America's Health Insurance Plans (AHIP)ⁱⁱ appreciate the opportunity to comment on the third draft of the Actuarial Section of the Long-Term Care Insurance (LTC) Multi-State Rate Review Framework, exposed by the NAIC LTC (EX) Task Force on November 15, 2021.

The ACLI and AHIP fully support the charge of the NAIC LTC (EX) Task Force to develop a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner that eliminates cross-state rate inequities. We applaud the LTC Multi-State Rate Review Subgroup for the time, effort, and thought that were put into the development of a framework to achieve this charge.

As stated in our previous comment letters, insurers best protect their policyholders when they can fulfill the obligations they made to these policyholders. This is accomplished when insurers have some level of predictability in their ability to effectively manage their current and future LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency within the Multi-State Rate Review Process, specifically with respect to the methodology used to calculate the increase recommended by the Multi-State Actuarial Team.

While some fundamental questions outlined in our prior comment letters remain, we recognize that many questions about this new process will need to be addressed over time as regulatory and industry experience evolves. We remain committed to continuing to work with the Task Force and Subgroup to achieve a robust process that is beneficial to both states and industry.

Sincerely,



Jan M. Graeber
ACLI Senior Actuary



Ray Nelson
AHIP Consulting Actuary

ⁱ The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

ⁱⁱ 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.



Memo

To: Commissioner Conway, Chair, Long Term Care Insurance Multistate Rate Review Subgroup

From: Tricia Matson, Partner

Date: December 6, 2021

Subject: RRC comments regarding Long Term Care Insurance Multistate Rate Review Framework

Background

The Long Term Care Insurance Multistate Rate Review Subgroup (“the Subgroup”) exposed a Long Term Care Insurance (LTCI) Multistate Rate Review Framework (“the Framework”) which covers a potential approach to increase consistency of LTCI rate review actions across states and improve efficiency of LTCI rate reviews for insurers. RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the Subgroup members.

RRC Comments

1. Overall, we applaud these efforts. We understand that there are current industry challenges associated with differences in rate approval practices among states and agree with efforts to increase uniformity of those practices while continuing to maintain the individual state decision making authority.
2. Regarding the involvement of and coordination with the Interstate Insurance Product Regulation Commission (“Compact”), it is unclear from the Framework why the MSA Team was determined to be the appropriate body to review the rates, rather than the Compact. It might be helpful to clarify this in the Framework.
3. On page 5, the document indicates that a uniform national system should lead to “more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings.” Based on our experience, current state-based rate reviews are not subject to inaccuracy, so we would suggest removing or rewording this. We believe that a uniform national system has many benefits, but we do not believe that improving accuracy is one of them.
4. Page 5 also states that the MSA Advisory Reports “are only for use by Participating States in considering and evaluating rate filings.” There is also language to minimize misuse of the MSA Advisory Reports by the insurers submitting the filings. It is not clear why the MSA Advisory Reports are shared with the insurers. If they are only for the Participating States, and there are concerns about potential misuse by the insurers, perhaps a better approach would be to provide them only to the Participating States for their use in the ultimate rating decision. This may also reduce risk in the event that the MSA Advisory Report recommendations differ significantly from the final state decision.
5. Regarding the qualifications of an MSA team member on page 7, we recommend adding that some minimum number (and at least one) of the members meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States.

6. Page 8 indicates that an MSA member will likely spend 20 hours per month. With 5 to 7 MSA members, it appears that 20 hours may not be sufficient, depending on the volume of submitted filings. We suggest considering alternative options to add additional supporting resources, spread work among resources, or increase the time commitment of MSA members, in the event needed.
7. Page 10 provides the eligibility criteria for submission of filings. Because certain criteria are somewhat arbitrary (e.g., impacting 20 states and at least 5,000 policyholders), we are in favor of the additional language allowing the MSA Team to apply judgment in considering filings for inclusion that do not strictly meet the criteria. You may also consider whether the criteria might be revised in the future to enable incorporation of more filings, in particular if results are highly beneficial.
8. Regarding the timeframes for completing reviews outlined on page 12, we recognize that precise timeframes are not possible due to the level of uncertainty. However, we suggest outlining some general time constraints, similar to what exists in current state laws (i.e., deemer dates), to improve accountability and enable more robust planning by the Participating States and the insurers.
9. Page 14 indicates that one of the items that may be considered in a feedback survey is the “number of rate proposals approved by the MSA Review Team.” Since the state, and not the MSA Review Team, is the ultimate approving party, we suggest changing “approved” to “reviewed”.
10. On page 15, the Framework notes that the MSA Team’s recommendations may include a goal of achieving the same rate per unit in each state, resulting in higher increases in states that have not approved as many historical rate increases. While such an approach could improve equity/remove subsidization across states, it could also reduce equity/increase subsidization among individual policyholders, since policyholders that stay in force might be subject to “catch up” rate increases thereby subsidizing policyholders that lapsed. We would encourage approaches that focus on reducing inappropriate cross subsidization based on prospective considerations, rather than approaches that simply move inappropriate cross subsidization from one group to another.
11. Regarding Appendix B, it may be helpful to develop templates for carriers to submit information. We have found in our LTC rate filing reviews that the nature and depth of information can vary significantly from filing to filing and use of standard templates may enable the MSA Team to review the filings more efficiently.
12. On page 23, we suggest adding a requirement that the assumption information provided must include sufficient rationale such that another actuary qualified in the same practice area can understand how the assumption was developed, as required by ASOP 41. We specifically mention this because we often find that filings do not include this level of detail, and this information will be important for the MSA Team to review.
13. On page 24, we suggest adding a requirement to provide information about past reserve strengthening and premium deficiency reserves held, to help the reviewers understand if actions taken in reserves are reasonably consistent with the need for premium increases. On this same page, we suggest adding a requirement to provide support for the determination of the maximum valuation interest rate (i.e., the weighted average calculation across issue years).
14. On page 25, we suggest adding a requirement to identify how potential antiselection was addressed in the projection associated with election of Reduced Benefit Options.

15. Regarding Exhibit A, the sample MSA Advisory Report, we suggest including the disclosures required under applicable actuarial standards of practice (ASOPs). For example, ASOP 41, *Actuarial Communications*, requires disclosure of the information date, the applicable law, reliance on others, if any assumptions were determined to be unreasonable or could not be assessed for reasonableness, and that the actuary is qualified to provide the statement of actuarial opinion.

Thank you for the opportunity to provide comments on this important initiative. I can be reached at tricia.matson@riskreg.com or (860) 305-0701 if you or other Subgroup members have any questions.

The following proposed revisions were made since the Nov. 15 exposure draft in response to comments received and are reflected in the December 2021 draft LTCI MSA Framework.

- Page 4, I.D. Benefits of Participating in the MSA Review: Third bullet describing benefits for insurers was deleted in response to comment from RRC.
~~Finally, the consistency of one uniform national system for reviewing rate increase proposals should lead to more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings.~~
- Page 11, IV.E. Feedback to the MSA Team: In #2, replaced “approved” with “reviewed” as suggested by RRC.
- Page 22, Appendix C: Minnesota Approach 2.a.ii edited:
 - ~~Premiums in the formula reflect the actual rate level.~~ To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.

Long-Term Care Insurance Multistate Rate Review Framework

Draft as of December 2021

PREFACE

The Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) was drafted by the Ad Hoc Drafting Group of the NAIC Long-Term Care Insurance (EX) Task Force. The Ad Hoc Drafting Group consists of representatives from state insurance departments in Connecticut, Minnesota, Nebraska, Texas, Virginia, and Washington.

The LTCI MSA Framework was adopted by the NAIC Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance (EX) Task Force on [insert date], and the NAIC Executive Committee and Plenary on [insert date].

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I. INTRODUCTION

A. Purpose

The NAIC charged the Long-Term Care Insurance (EX) Task Force with developing a consistent national approach for reviewing current long-term care insurance (LTCI) rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the Task Force developed this framework for a multi-state actuarial (MSA) LTCI rate review process (MSA Review).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program's rate review team (Pilot Team). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team's approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or rate proposal¹ and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so they will voluntarily utilize the Multistate Actuarial LTCI Rate Review Team's (MSA Team's) recommendations when conducting their own state level reviews of in force LTCI rate increase filings.² Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This MSA framework is intended to communicate the governance, policies, procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the MSA Team's MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how the MSA Advisory Report may affect the insurer's in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the Task Force and be revised as directed by the Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

The MSA Review of an insurer's rate proposal will be available to state insurance departments who are both an Impacted State and a Participating State. These are defined as follows.

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer's in force LTCI premium rate increase proposal is or has been issued.

¹ "Premium rate increase proposal(s)" or "rate proposal(s)" in this document refers only to an insurer's request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review.

² The term "rate increase filing" or "rate filing(s)" in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.

- “Participating State” is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section IE(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/webinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to increase in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an MSA Advisory Report, which state insurance departments may consider when deciding on an insurer’s rate increase filing or to supplement the state’s own review process.

The MSA Review is conducted by a team of state’s regulatory actuaries with expertise in LTCl rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff and Interstate Insurance Product Regulation Commission (Compact) staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD³] States. The NAIC’s electronic infrastructure, SERFF, will be used to streamline the rate proposal and review process. Although the administrative services of Compact staff and SERFF’s Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA Advisory Reports are prepared by the MSA Team. MSA rate proposals are not Compact filings, and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

The MSA Review begins when an insurer expresses interest in an MSA Review being performed for an in force LTCl rate proposal to the MSA Team through SERFF or supporting NAIC or Compact staff. The eligibility of the rate proposal will be reviewed and determined by the MSA Team with assistance, as needed, from supporting staff.

The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply the Minnesota and Texas approaches to calculate recommended, approvable rate increases. While aspects of the Minnesota and Texas approaches may result in lower rate increases than those resulting from loss ratio-based approaches and are outside the pure loss ratio requirements contained in many states’ laws and rules, the approaches fall in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA Team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will document how the proposal complies with the regulatory approach utilized by the MSA Team for Participating States. See Section V for more details on the actuarial review.

Throughout the MSA Review, the MSA Team will provide updates to the insurer. The MSA Team will deliver the final MSA advisory Report to the insurer and address any questions the insurer has about the results of the Review.

Additionally, the review will consider reduced benefit options (RBOs) that are offered in lieu of the requested rate increases and factor in non-actuarial considerations.

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States and insurers that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. The MSA Advisory Report will also indicate whether the recommendation differs from the insurer’s proposal. Participating States can utilize the MSA Advisory Report or supplement their own state’s rate review with it as

³ Certain processes for Impacted vs. Participating States are yet to be determined (TBD).

described in the following Section ID. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

The rate proposal, review process, actuarial methodologies, and other review considerations are detailed within this framework document and accompanying appendices.

D. Benefits of Participating in the MSA Review

Both state insurance regulators and insurers will benefit by participating in the MSA Review in multiple ways. For state insurance regulators:

- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCl rate increase filings in their state. It is recognized that multiple states may not have significant actuarial expertise with LTCl, so participation in the MSA Review will allow those states to build on the specific, dedicated LTCl actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states and actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCl rate increase reviews, states who utilize the MSA Team will have the benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCl rate increase filings in their state.
- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries, which affords them an opportunity to establish LTCl-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a qualified actuary include years of experience under the supervision of another already qualified actuary in that subject matter.
- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state's knowledge base in this area and promoting a more consistent national approach to in force LTCl rate review.

Note that states' use of and reliance on the MSA Advisory Report is expected to increase in the future as the MSA Review continues to be developed and refined, and the benefits of the MSA Review described above become more evident.

Long-Term Care (LTC) insurers will likewise see multiple benefits in participating in the MSA Review:

- First, by utilizing the MSA Review and through the receipt of MSA information and the MSA Advisory Report from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increase filings. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, it has functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states.
- Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the carrier's workload in developing often widely differing filings for states' review.

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state's laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state's regulatory authority, responsibility, and/or decision making. Each state remains ultimately

responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law.

A Participating State's use of the MSA Advisory Report's recommendations with respect to one filing does not require that state to consider or use any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way: 1) eliminates the insurer's obligation to file for a rate increase in each Participating State; or, 2) modifies the substantive or procedural requirements for making such a filing. While encouraged to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

The MSA Advisory Reports, including the recommendations contained therein, are only for use by Participating States in considering and evaluating rate filings. The MSA Advisory Reports or their conclusions shall not be utilized by any insurer in a rate filing submitted to a non-Participating State, nor shall the MSA Advisory Reports be used outside of each state insurance regulator's own review process or challenge the results of any individual state's determination of whether to grant, partially grant, or deny a rate increase.

Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence on insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if certain information and documents related to specific companies that are confidential under the state law of an MSA Team member or a Participating State need to be shared with other state insurance regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement (Master Agreement) between states that governs the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

Confidentiality of the Rate Proposal

Members of the MSA Team and Participating States affirm and represent that they will provide any in force LTCI rate proposal, as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations.

Confidentiality of the MSA Reports

Likewise, members of the MSA Team and Participating States affirm and represent that they will provide any MSA Advisory Report(s), as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations for rate filings.

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The Long-Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed. The Task Force may create one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Task Force will be selected by the NAIC president and president-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.

II. MSA TEAM

The MSA Team comprises state insurance department actuarial staff. MSA Team members are chosen by their skill set and LTCI actuarial experience. The Long-Term Care Insurance (EX) Task Force, or its appointed subgroup, will determine the appropriate experience and skill set for qualifying members for the MSA Team. It is expected that state participants will provide expertise and technical knowledge specifically regarding the array of LTCI products and solvency considerations. The desired MSA Team membership composition should include a minimum of five and up to seven members.

Membership must follow the requirements below and be approved by the chair of the Task Force or the chair of an appointed subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

To be eligible to participate as a member of the MSA Team, a state insurance regulator is required to:

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or LTCI.
- Be recommended by the insurance commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participates as a member of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (or an equivalent Subgroup appointed by the Long-Term Care Insurance (EX) Task Force) and the LTC Pricing (B) Subgroup.
- Be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the Task Force or its appointed Subgroup

As both state insurance regulators and the MSA Review may benefit by developing and expanding specific LTCI actuarial expertise through participation in this process, having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team is critical to the viability of the MSA process. Participation also provides opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI.

Consideration will be given to joint membership where two actuaries within a state combine to meet the criteria stated above.

Consultants engaged by the state insurance department would not be considered for MSA Team membership.

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received

pursuant to the Master Agreement. MSA Team members should communicate any request for public disclosure of MSA information or any obligation to disclose.

- Active involvement within NAIC LTCl actuarial groups.
- Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the chair and vice chair of the Long-Term Care Insurance (EX) Task Force, or its appointed subgroup. Other interested state insurance regulators (e.g., domiciliary state insurance regulators) may be invited to participate on a call at the discretion of the MSA Team or the chair or vice chair of the Task Force or its appointed subgroup.

D. MSA Associate Program

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries that wish to gain expertise in LTCl. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

- As a mentee. The mentee would participate in aspects of the MSA Review. An MSA Team member will serve as a mentor to another state regulatory actuary and provide one-on-one guidance.
- To gain more knowledge and understanding of the Minnesota and Texas actuarial approaches.
- To share their own expertise through feedback to the MSA Team on MSA Advisory Reports to better enhance the overall MSA process.
- To participate on an ad hoc limited basis, i.e., where a regulatory actuary would like to participate but is unable to make the required time commitment.
- To meet the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCl by serving under the supervision of a qualified actuary on the MSA Team.
- To serve as a peer reviewer of the MSA Advisory Reports.

E. Conflicts, Confidentiality, and Authority of the MSA Team

Authority of the MSA Team

Members of the MSA Team serve on a purely voluntary basis, and any member's participation shall not be viewed or construed to be any official act, determination, or finding on behalf of their respective jurisdictions.

Disclosures and Confidentiality Obligations, as Applicable

All members of the MSA Team acknowledge and understand that the MSA Review, including, but not limited to, meetings, calls, and correspondence are confidential and may not be shared, transmitted, or otherwise reproduced in any manner. Additionally, all members of the MSA Team affirm and represent that they will: a) provide any in force LTCl rate proposal with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations; and, b) provide any MSA Advisory Report with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations for rate filings.

Conflict of Interest Avoidance Procedures and Certifications

No member of the MSA Team may own, maintain, or otherwise direct any financial interest in any company or its affiliates subject to the regulation of any individual state, nor may any member serve or otherwise be affiliated with the management or board of directors in any company or its affiliates subject to the regulation of any individual state. All conflicts of interest, whether real or perceived are prohibited and no member of the MSA Team shall engage in any behaviors that would result in or create the appearance of impropriety.

F. Required NAIC and Compact Resources

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected that NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the Long-Term Care Insurance (EX) Task Force will be needed as well. As more experience with rate proposal volumes and average analysis time is gained, the full complement of human resources required will be better understood.

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate increase proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. The material substance of such communication can be documented within SERFF. NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA rate increase proposals at the direction of the MSA Team and as described in this framework.

III. REQUESTING AN MSA REVIEW

A. Scope and Eligibility of a Rate Proposals for MSA Review

The following are the preferred eligibility criteria for requesting an MSA Review of a rate proposal.

- Must be an in force LTCl product (individual or group).
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide.
- Includes any stand-alone LTCl product approved by states, not by the Compact.
- For Compact-approved products meeting certain criteria, the Compact office will provide the first-level advisory review subject to the input and quality review of the MSA.

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

The MSA Team reserves the right to deny a proposal that does not meet eligibility criteria. An insurer will be notified if the proposal for an MSA Review is denied.

An insurer may ask questions for more information about a potential rate proposal through communication to supporting NAIC and Compact staff and the MSA Team. This will be accomplished through a Communication Form that will be available on the Compact web page. Supporting NAIC and Compact staff will work with the insurer to complete the necessary steps to assess eligibility, discuss any technical or other issues, and answer questions.

The insurer will have access to primary and supplementary checklists in Appendix B that provide guidance to the insurer for information that should be included in a complete MSA rate proposal requested through the NAIC's SERFF application.

B. Process for Requesting an MSA Review

As noted in Section IC above, the MSA Review will utilize the Compact's multistate review platform within the NAIC's SERFF application and its format for in force LTCl rate increase proposals. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance regulators:

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless rate increase proposal.
- Instructions containing a checklist for information required to be included in the rate increase proposal, as reflected in Appendix B, will be available to insurers through the Compact's web page or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase proposal is or has been issued. Participating States will have access to view the insurer's rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [TBD].
- Rate increase proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the Impacted States upon receipt of the rate increase proposal with the SERFF Tracking Number.
- The MSA Team may utilize a "queue" process for managing workload and resources for incoming rate increase proposals through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team's review of objections and insurer responses are completed through SERFF.

C. Certification

The insurer shall provide certifications signed by an officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state's decision to approve, partially approve, or disapprove a rate increase filing except when: 1) the individual state is a (Participating/Impacted State [TBD]) that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

Failure to abide by the terms of the insurer's certification will result in the insurer and its affiliates being excluded from any future MSA Reviews, and it will permit the MSA Team to terminate, at its sole discretion, any other ongoing review(s) related to the insurer and its affiliates.

Should the MSA Team exclude any insurer and its affiliates for failure to adhere to its certification, the MSA Team, at its sole discretion, may permit the insurer and its affiliates to resume submitting rate proposals for review upon written request of the insurer.

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication Form, which will be available through the Compact web page. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate increase proposal in SERFF. The MSA Team will be notified, via SERFF, when the rate increase proposal is available for review.

The supporting NAIC and Compact staff will notify (Participating/Impacted States [TBD]) via SERFF or e-mail when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of the MSA Review

The MSA Team shall designate a lead reviewer to perform the initial review of each rate proposal. Once the rate increase proposal is made through SERFF, the MSA Review will resemble a state-specific review process.

The MSA Team will meet periodically to discuss the review and determine any needed correspondence with the insurer. Objections and communications with filers will be conducted through SERFF, like any state-specific filing or Compact filing, to maintain a record of the key review items. Other supplemental communication between the insurer and the MSA Team or supporting NAIC and Compact staff, may occur, such as conference calls or emails, as appropriate.

The timeframe for completing the MSA Team's review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a "queue" process for managing workload and resources for incoming rate increase proposals through SERFF. The timeliness of any necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will affect the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review, and a final MSA Advisory Report with recommendations will be drafted and communicated to state insurance departments within the next month, which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and 2) the insurer will receive sufficient information regarding the MSA Team's recommendation to allow the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with the MSA Team in order to ask questions, and understand the MSA Team's reasoning.

C. Preparation and Distribution of the MSA Advisory Report

Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF "reviewer notes" for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States. Consultants engaged by state insurance department staff to perform rate reviews would be given access to the MSA Advisory Report, subject to the terms of the agreement between the consultant and the Participating State insurance department.

Consultants who are bound by the actuarial Code of Professional Conduct, adopted by the Academy of Actuaries, the Society of Actuaries (SOA) and the Conference of Consulting Actuaries (CCA), should consider whether receipt of the MSA Advisory Report is acceptable under Precept 7 regarding Conflicts of Interest. For other professions, similar consideration should be made if bound by similar professionalism standards.

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States.

The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

The MSA Advisory Report will include standardized content, as reflected in Appendix A, with modifications, as necessary, for any unique factors specific to the rate proposal. The content and format are based on feedback received from state insurance departments and the Long-Term Care Insurance (EX) Task Force during the pilot project.

The content and format of the MSA Advisory Report may be modified in the future under the direction of the Task Force, or an appointed subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback from Participating states and the insurer, through this process.

D. Timeline for Review and Distribution of the MSA Advisory Report

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to holidays or other unexpected events. Note that the MSA Review is intended to occur before filings are made to the state insurance departments, therefore not affecting state insurance departments' required timelines for review. However, use of the MSA Advisory Report by the state is expected to reduce the amount of time required for the state to complete its review.

Pre-Distribution - Share the draft MSA Advisory Report with the insurer. The insurer will be given the opportunity to interact with the MSA Team to ask questions and understand the MSA Team's reasoning.

- Day 1 – Distribution of a draft MSA Advisory Report to all Participating States.
- Day 5-7 – Regulator-to-regulator conference call of all Participating States during which the MSA Team will present the recommendations in the MSA Advisory Report and seek comments from states.
- Day 21 – Deadline for comments on the draft MSA Advisory Report.
- Day 35 – Distribution of the final MSA Advisory Report, with consideration of comments, to Participating States and the insurer.
- Date TBD by the Insurer – Individual rate increase filings submitted to each state insurance department.
- Date TBD by each state's DOI – Approval or disapproval of the rate increase filing submitted in each state.

E. Feedback to the MSA Team

At the direction of the Long-Term Care Insurance (EX) Task Force, or an appointed subgroup, state insurance departments will be requested to periodically provide data and feedback on their state rate increase approval amounts and their state's use of and reliance on the MSA Advisory Reports. The following items may be considered in a feedback survey:

1. The number of rate proposals made with the MSA Review Team.
2. The number of rate proposals reviewed by the MSA Review Team.
3. Information regarding states approval of MSA recommendations.
4. Feedback on additional information states requested.
5. Feedback regarding how the review process and methodology could be improved.

State responses will be confidential pursuant to the Master Agreement, and aggregated results of feedback surveys will not specifically identify state responses. The MSA Team and state insurance regulators welcome feedback from insurers on their experience using the MSA Review Process. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review in achieving the goal of developing a more consistent state-

based approach for reviewing LTCl rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process, improve future reports to better meet participants' needs, and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated feedback results will be shared with Participating States and insurers as determined appropriate.

V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections, and other information provided by the insurer as outlined in Appendix B. The MSA actuarial review process will be evaluated and evolve over time as more rate proposals are reviewed.

The Minnesota and Texas approaches ensure remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The Minnesota approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.

The MSA Team will consider the following in performing their review, applying their expertise and professional judgement to the review, and reviewing the actuarial formulas and results:

- Review insurer experience, insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
 - Validate that the patterns of claims and premium projections over time reasonably align those reflected in the assumptions.
 - Adjust or request new projections of claims and premium to the extent that any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between the MSA Team and the insurer via SERFF.
 - After verifying loss ratio compliance, apply both the Minnesota and Texas approaches for each rate proposal submitted.

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the most appropriate method. The MSA Team's recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches: or using professional judgement, the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In applying professional judgement, (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high. As the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.

The MSA Team will consider how to reflect the differences in the histories of states' rate approvals. Current approach includes:

- The MSA Team’s recommendation results in the same rate per unit in each state following the current rate increase round, leading to higher percentage rate increases in states that approved lower rate increases in the past.
- Analysis of state cost differences affecting justifiable rate increases will continue. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in lower-cost states should receive lower percentage rate increases. Part of the reason is that there was a tendency for people in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.
- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

Consideration of Solvency Concerns

If concerns exist regarding an insurer’s financial solvency and the impact of rate increases on future solvency, each state DOI, by their authority over rate approval, has the flexibility to consider solvency adjustments in these rare instances. In rare, non-typical circumstances, adjustments could be considered within the MSA Review, including consultation with states as part of the MSA Advisory Report comment period.

Follow-Up Proposals on the Same Block

Any subsequent rate increase proposal to the MSA Team on a block of business previously reviewed by the MSA Team needs to involve the development of adverse experience and/or expectations. In the absence of adverse experience or expectation development, the MSA Team will consider a reasonable explanation from an insurer for an increase in credibility of morbidity data of being the reason for a rate increase. Prior rate increases would need to be implemented before the implementation of a subsequent rate increase. The MSA Team will not consider a new rate increase proposal on a block that did not receive the full percentage rate increase requested without the experience, expectation, or credibility criteria noted above. If an insurer did not receive the full percentage rate increase and has no adverse changes in experience or expectations, the insurer should work directly with the applicable state DOI.

B. Loss Ratio Approach

Key aspects of the loss ratio approach to the actuarial review of rate changes include:

1. At policy issuance, pricing based on a lifetime loss ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the *Long-Term Care Insurance Model Regulation* (#641), Section 19 for more details on compliance with loss ratio standards.
2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.
3. The loss ratio approach increases future premiums to a level, referred to as make-up premium, such that the original loss ratio target is once again attained.

4. The loss ratio approach, one of the minimum standards in many states' statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards, such as fair and reasonable rates.
 - a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.
 - b. The loss ratio approach shifts all the risk to the policyholders. If the insurer is allowed to always return to the 60% loss ratio, there may be a lower incentive for more appropriate initial pricing.
5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58%/85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA Team. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. Minnesota Approach

Key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Blended if-knew / makeup approach to address the shrinking block issue.
 - a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
 - b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
 - c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care Pricing (B) Subgroup calls from 2015 to 2019⁴ are incorporated, including the concept that rates will not substantially rise as the block shrinks, as policyholder persistency falls over time.
2. Cost-sharing formula that increases the insurer's burden as cumulative rate increases rise.
 - a. This addition to the insurer's burden moves rates away from a direction that could potentially be seen as misleading. The insurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.
3. Assumption review.
 - a. Verification that the insurer's original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the insurer.
 - b. Verification of appropriateness of current assumptions.
 - i. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.
 - ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the insurer-provided assumptions. This conservatism can be released as credible experience develops.
4. Interest rate / investment return component
 - a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
 - i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.

⁴ NAIC Proceedings including meeting minutes are available from the NAIC Library, <https://naic.soutrounglobal.net/portal/Public/en-US/Search/SimpleSearch>.

- ii. In the Minnesota approach, all factors impacting the business are considered.
 - 1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an insurer would get approval for rate increases even when profits on the block were higher than expected.
 - 2. If interest rates fall, this would tend to lead to higher rate increase approvals.
 - iii. To prevent shifting of “good assets” and “bad assets” to supporting LTC rates and prevent an insurer from increasing rates based on risky investments turned into losses, an index of average corporate bond yields (e.g., Moody’s) is relied on to reflect experience and current expectations.
 - iv. Original pricing typically includes an assumption on investment returns, for which premiums and other positive cash flows are assumed to accumulate. This forms the interest component of the original assumption.
 - v. The original pricing investment return in Section VC(4)iv is compared to the average corporate bond yields in Section VC(4)iii to determine the adversity associated with the interest rate factor.
5. Original Assumption Adjustment
- a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium.”
 - i. This results in a lower rate increase.
 - ii. This adjustment wears off over 20 years from policy issue.
 - 1. The rationale for the wearing off of this adjustment is the assumption that no insurer would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
 - iii. This adjustment is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase).

D. Texas Approach

The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup’s discussions regarding the recoupment of past losses in LTCL rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarially justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.

Key aspects of the Texas approach to the actuarial review of rate changes include:

1. Past losses are assumed by the insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits, the recoupment of past losses to some extent.
2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.
3. Data Requirements for Calculation:
 - a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
 - i. Present Value of Future Benefits (PVFB) under current assumptions.
 - ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
 - iii. Present Value of Future Premiums (PVFP) under current assumptions.
 - iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

1. Note that for all four projections above, the projection period is typically 40–50 years: although, some companies project for 60 or more years.

To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on wavier, on claim, or paid up) regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.

Also, the insurer should identify and explain any estimates or adjustments to the data, as applicable.

4. Assumptions
 - a. Rate increases are commonly driven by a change to the persistency, morbidity, mortality assumption, or a combination of the three.
 - b. Verification that assumption change(s) are supported by credible data.
 - c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the insurer, not the policyholder.

The formula used in the Texas approach is provided in Appendix C.

E. RBOs

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, developed a list of RBO principles to provide guidance for evaluating RBO offerings in Appendix D.

RBOs in the MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal that are extracontractual. The MSA Advisory Report will highlight how the insurer demonstrates the proposed RBOs' reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more detailed assessment specific to their state's requirements. As the MSA Review develops and as the Subgroup continues its work, this area of review may evolve.

Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA Review will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the Task Force will encourage its appointed Subgroup and/or an appropriate NAIC actuarial committee or group to collectively consider new RBOs as they arise. This process will provide for input and technical advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.

F. Non-Actuarial Considerations

The Long-Term Care Insurance (EX) Task Force continues to review and consider non-actuarial considerations affecting states' approval or disapproval of LTCl rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

1. Caps or limits on approved rate changes.
2. Phase-in of approved rate changes over a period of years.

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

Considerations in the MSA Advisory Report

As part of the MSA Review, the MSA Team will identify relevant aspects of the insurer's rate proposal, based on the information provided by the insurer, which may be affected by a state's non-actuarial considerations. Note that the MSA Team will not perform a state-by-state review of each state's non-actuarial considerations, statutes, or practices. Instead, the MSA Team will highlight in the MSA Advisory Report those aspects of the rate proposal that relate to or that may be affected by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those affected aspects of the rate proposal when completing their individual state's rate review. For example, the MSA Advisory Report may highlight:

- If cumulative rate increases are high, as this may affect the cost-sharing formula.
- If a rate proposal is for a block of business where the average policyholder age is predominately 85 or above, as this may affect states that consider age caps.
- If it is determined that the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may affect the potential need for adjustments to the cost-sharing formula.
- Aspects of the coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in its review.

Future Non-Actuarial Considerations

The MSA Review will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the Task Force will encourage its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate increase and the complexity of the rate proposal and the insurer's financial condition. See also the sample MSA Advisory Report in Exhibit A.

1. Executive Summary.
 - a. Overall recommended rate increase, before consideration of different states' history of approvals.
2. Disclaimers.
 - a. Purpose and intent of how states should use the MSA Advisory Report.
 - b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer.

- c. Statement that the in force rate increase filing submitted to the respective states shall be subject to the approval of each state, and each state's applicable state laws and regulations shall apply to the entire rate schedule increase filing.
3. Background on the MSA Review.
 4. Explanation of the insurer's Proposal.
 - a. The explanation will be based on the aspects of the insurer's rate proposal, which may include details as to whether the rate increase submitted for review involved different types of coverages or groupings.
 5. Summary of the MSA Team's rate review analysis, including these aspects:
 - a. Actuarial review.
 - i. The summary of the review and the MSA Team's recommendation will be based on the aspects of the insurer's rate proposal, and may include specific details of the review, for example analysis of projections, assumptions, margins, or other aspects.
 - b. Summary of consideration of differences in the history of state's rate increase approvals.
 - c. Non-actuarial considerations and findings.
 - d. Financial solvency-related aspects and adjustments.
 - e. Review for reasonableness and clarity of RBOs.
 - f. Summary information about the mix of business.
 6. Appendices.
 - a. Summary of the drivers of the rate proposal.
 - b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal.
 - c. Summary of rate proposal correspondence.
 - d. Examples of rate increases if an RBO is not selected.
 - e. Potential cost-sharing formula for typical circumstances.
- B. Appendix B – Information Checklist

At the request of the former Long-Term Care Insurance (B/E) Task Force, the Long-Term Care Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all states. In this context, "checklist" means the list or template of inquiries that states typically send at the beginning of reviews of state-specific rate increase filings.

This document contains aspects of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*⁵ (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0–10% of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual.

Information Required for an MSA Review of a Rate Proposal

⁵ https://www.naic.org/documents/committees_b_senior_issues_160609_ltc_guidance_manual.pdf

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews”⁶ as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. Identify all states for which the product associated with the rate proposal is or has been issued.
2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
 - a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
 - b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.
3. Rate increase history that reflects the filed increase.
 - a. Provide the month, year, and percentage amount of all previous rate revisions.
 - b. Provide the SERFF MSA numbers associated with all previous rate revisions.
4. Actuarial memorandum justifying the new rate schedule, which includes:
 - a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
 - i. The projection should be by year.
 - ii. Provide the count of covered lives and count of claims incurred by year.
 - iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies that should be provided.
 - iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.
5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
 - a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
 - b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.
 - c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
 - d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.
6. Statement that policy design, underwriting, and claims handling practices were considered.
 - a. Show how benefit features (e.g., inflation and length of benefit period) and premium features (e.g., limited pay and lifetime pay) impact requested increases.
 - b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
 - c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

⁶ https://content.naic.org/sites/default/files/inline-files/cmtc_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx

7. A demonstration that actual and projected costs exceed anticipated costs and the margin.
8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
 - a. Provide applicable actual-to-expected ratios regarding key assumptions.
 - b. Provide justification for any change in assumptions.
9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
 - a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
 - b. A comparison of the population or industry study to the in force related to the rate proposal should be performed, if applicable.
 - c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
 - d. Provide the year of the most recent morbidity experience study.
10. Information from the Guidance Manual Question and Answer (Q&A): Morbidity, Lapse, Mortality, Interest.
 - a. Comparison with asset adequacy testing reserve assumptions.
 - i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
 - ii. Additional reserves that the insurer is holding above Health Insurance Reserves Model Regulation (#10) formula reserves should be provided, (such as premium deficiency reserves and *LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) reserves.
 - b. Assumptions Template in Appendix 6 of the Guidance Manual for policies issued after 2017, where applicable.
 - c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.
11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate*:
 - a. Present value of future benefits (PVFB) under current assumptions
 - b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
 - c. Present value of future premiums (PVFP) under current assumptions.
 - d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

*To emphasize, these projections should include only active nationwide policyholders currently paying premium, and they should not include any policyholders not paying premium, regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption or benefit reduction assumption.

- b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.

12. The Guidance Manual checklist items: 1) summaries (including past rate adjustments); 2) average premium; 3) distribution of business, including rate increases by state; 4) underwriting; 5) policy design and margins; 6) actuarial assumptions; 7) experience data; 8) loss ratios; 9) rationale for increase; and 10) reserve description.

13. Assert that analysis complies with Actuarial Standards of Practice (ASOPs), including 18 and 41.

14. Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.
15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
16. Policyholder notification letter should be clear and accurate.
 - a. Provide a description of options for policyholders in lieu of or to reduce the increase.
 - b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
 - c. Explain the comparison of value between the rate increase and policyholder options.
 - d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
 - e. How are partnership policies addressed?
17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

Supplemental Information

As part of the Long-Term Care Insurance (EX) Task Force's pilot project in 2020–2021, the following supplemental information was identified by the MSA Team as beneficial; and, therefore, the Task Force may be requested to assist in the MSA Review.

1. Benefit utilization:
 - a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
 - b. Explain how benefit utilization assumptions vary by maximum daily benefit.
 - c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.
2. Attribution of rate increase
 - a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other.
 - b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
 - c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.
3. RBOs
 - a. Provide the history of RBOs offered and accepted for the block.
 - b. Provide a reasonability analysis of the value of each significant type of offered RBO.
4. Investment returns:
 - a. Provide original and updated / average investment return assumptions underlying the pricing.
 - b. Explain how the updated assumption reflects experience.
5. Expected loss ratio:
 - a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
 - b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.
6. Shock lapse history:
 - a. Provide shock lapse data related to prior rate increases on this block.
7. Waiver of premium handling:

- a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
 - b. Explain how counting is appropriate (as opposed to double counting or undercounting).
8. Actual-to-expected differences:
- a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.
9. Assumption consistency with the most recent asset adequacy testing:
- a. Explain the consistency or any significant differences between assumptions underlying the rate increase proposal and those included in Actuarial Guideline 51 testing.

C. Appendix C—Actuarial Approach Detail

Minnesota Approach

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

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

1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
 2. Apply first principles.
 - a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
 - b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
 - c. Divide by the sum of the PV of an annuity of 1 per year.
 - d. Multiply {b / c} times (1 + originally assumed profit percentage) to attain the original premium.
 - e. This premium provides the basis for comparison against the makeup and if-knew premium.
 3. Replace the original premium with a benchmark premium.
 - a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
 - b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
 - c. The benchmark aspect is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.
- ii. Calculate an estimate of the makeup premium.
1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
 2. Calculate an updated dollar PV of profits for the sample policy using:
 - a. Actual history of premiums and claims.
 - b. Expectations of future claims.
 - c. "Backed into" makeup premium.
 3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
 - a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.
- iii. Calculate an estimate of the if-knew premium.
1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
 - b. Verifying the impact on expectation changes on rates
 - i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
 - ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
 1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
 2. Experience
 3. Impact on LLR of changes in expectations of morbidity.
 4. Industry information and trends (for reasonableness checks).
 - c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
 - i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer's aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.

- ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
 - 1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
 - 2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
 - iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the insurer (after initial attempts to resolve significant differences or gaps).
- 4. Reconciliation of aggregate and sample policy applications.
 - a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
 - b. In other cases, some steps are taken to understand the difference, including additional requests for information.
 - c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
 - d. When reconciliation occurs after rounds of communication, decisions will be made based on the information provided.
- 5. Blending – same for aggregate and sample policy applications.
 - a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
 - b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
 - c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
 - d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.
- 6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.
 - a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
 - i. No haircut for the first 15%.
 - ii. 10% for the portion of cumulative rate increase between 15% and 50%.
 - iii. 25% for the portion of cumulative rate increase between 50% and 100%.
 - iv. 35% for the portion of cumulative rate increase between 100% and 150%.
 - v. 50% for the portion of cumulative rate increase in excess of 150%.
- 7. Reduction for past rate increase:
 - a. Take 1 plus the cost-sharing-adjusted blend amount and divide by 1 plus the previous, cumulative rate increases, then subtract 1. This is the approvable rate increase.
- 8. Summary.
 - a. Review current assumptions.
 - b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.

- c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
- d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
- e. Apply the cost-sharing formula to the blended amount.
- f. Deduct past rate increases.
- g. Example – if:
 - i. The original premium is \$1,000
 - ii. Makeup premium is \$3,000.
 - iii. If-knew premium is \$1,500.
 - iv. 60% of policyholders remain.
 - v. Past rate increases are 50%:
 - vi. Blended amount is:
 1. $\$3,000 / \$1,000 * 0.60 +$
 2. $\$1,500 / \$1,000 * 0.40$
 3. $- 1 =$
 4. $180\% + 60\% - 1 = 240\% - 1 = 140\%$
 - vii. Cost sharing is:
 1. $100\% * 0.15 +$
 2. $90\% * 0.35 +$
 3. $75\% * 0.5 +$
 4. $65\% * 0.4 =$
 5. 110%
 - viii. Deduction for past rate increases results in:
 1. $(1 + 1.1) / (1 + 5) - 1 =$
 2. 40%

Texas PPV Formula

Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to **active, premium-paying policyholders**.

For rate stabilized policies:

$$\text{rate increase \%} = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.58 + .85C}{1 + C} \right) \Delta PV(\text{future earned premiums})}{.85 PV_{\text{current}}(\text{future earned premiums})}$$

Where:

- Δ indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.
- C is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then C = 0.5.

The *current* subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase.

(State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the $\Delta PV(\text{future incurred claims})$ term in the above formula could be multiplied by $(1 + \text{margin})$).

For pre-rate stabilized policies, we use 0.6 in place of 0.58 and 0.8 in place of 0.85:

$$\text{rate increase \%} = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.6 + .8C}{1 + C} \right) \Delta PV(\text{future earned premiums})}{.8 PV_{\text{current}}(\text{future earned premiums})}$$

Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the state insurance regulator by a method other than the PPV approach. In this situation, for a current filing, the state insurance regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.

D. Appendix D—Principles of RBOs Associated with LTCI Rate Increases

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, was charged to *“Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.”* In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
 - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
 - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.
2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
 - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.
3. Clarity of communication with policyholders eligible for an RBO:
 - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
 - Companies should present RBOs in clear and simple language, format, and content, with clear instructions on how to proceed and whom to contact for assistance.
4. Consideration of encouragement or requirement for an insurer to offer certain RBOs:
 - State insurance regulators should evaluate legal constraints, the impact on remaining policyholders and insurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.

5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
 - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases (e.g., providing hand railings for fall prevention in high-risk homes) and identifying the pros and cons of such an approach.

Widely Established RBOs in Lieu of Rate Increases

1. Reduce inflation protection going forward, while preserving accumulated inflation protection.
2. Reduce daily benefit.
3. Decrease benefit period/maximum benefit pool.
4. Increase elimination period.
5. Contingent nonforfeiture (CNF).
 - i. Claim amount can be the sum of past premiums paid.
 - ii. Only receive that benefit if the policyholder qualifies for a claim.

Less Common RBOs for Potential Discussion

1. Cash buyout.
2. Copay percentage on benefits.

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review will likewise develop and evolve to consider the reasonableness of these RBOs. The Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

E. Appendix E—Guiding Principles on LTCL RBOs Presented in Policyholder Notification Materials

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force adopted the following guiding principles to ensure quality of consumer notices of rate increases and RBOs. This section seeks to provide guiding principles in answering this question: *“What are the recommendations for ensuring long-term care insurance policyholders have maximized opportunity to make reduced benefit decisions that are in their best interest?”*

To complete the charge, the Subgroup 1) evaluated the quality of consumer notices and RBO materials presented to policyholders; 2) considered the relevant lessons learned and consumer focus group studies from the liquidation of LTC insurer Penn Treaty Network America; 3) reviewed existing RBO consumer notice checklists or principles from multiple states (i.e., Nebraska, Pennsylvania, Texas, and Vermont); and 4) addressed stakeholder comments on RBO principles.

This document is intended to establish consistent high-level guiding principles for LTCL RBOs presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

Recognizing that each component outlined in these principles will not apply in all circumstances, this section:

- RECOMMENDS that insurance companies recognize these fundamental principles.
- CALLS ON all insurance companies to consider the following principles in communicating RBOs available to consumers in the event of a rate increase.
- UNDERLINES that the following principles are complementary and should be considered as a whole.

Filing Rate Action Letters

Insurers should consider:

- Sending rate actions after the state has approved the rate action filing.
- Making the rate action effective on a policy anniversary date, recognizing that the *Long-Term Care Insurance Model Regulation* (#641) allows for the next anniversary date or next billing date.
- Mailing rate increase notification letters at least 45 days prior to the date(s) a rate action becomes effective, consistent with any applicable state laws and/or regulations.
- Sending rate increase notifications each year for rate increases that are phased-in over multiple years.
- Disclosing all associated future planned rate increases approved by state insurance regulators in the initial and phased-in rate increase notification letters.
- Filing rate action letter templates in the NAIC SERFF rate increase filing to include statements of variability and sample letters highlighting the differences between the communications, consistent with any applicable state laws and/or regulations.
- Presenting innovative options to state insurance regulators prior to filing new RBOs.
 - This enables state insurance regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.

Readability and Accessibility

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
- Presenting the RBOs in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
- Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.
- Using illustrative tools, such as bullet points or illustrations, as appropriate, and graphs or charts enabling a side-by-side comparison.
- Including definitions of complex terms; and if a term, subject, or warning is repeated throughout the communication, consider making the language consistent throughout the document.
- Including a Q&A section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or policyholders for whom English is not a first language.

Identification

Insurers should consider drafting the RBO communication in a way that helps policyholders understand:

- What is happening.
- Why it is happening to them.
 - Ensure the letter does not negatively reference the state insurance department.
- When it is happening.
- What they can do about it.
- How they take action.

Communication Touch and Tone

Insurers should consider:

- Drafting the communication in a way that helps policyholders envision or reflect on the reason(s) why they purchased an LTCI policy.
- Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.
- Presenting RBOs fairly, refraining from the use of bolding, repeating, or emphasizing one option over another.
- Displaying the policyholder’s ability to maintain current benefits by paying the increased premium.
- Using word choices that appreciate how those words could influence a policyholder’s decision.
 - For instance, consider using “now” instead of “must”; or consider using “mitigation options,” “offset premium impact” or “manage an increase” instead of “avoid an increase.”

Consultation and Contact Information

The insurer should consider listing multiple contacts in the communication in an easy-to-identify location to include phone number, email address, and website when available. For example:

- Customer service.
- Lapse notifier.
- Insurance producer.
- State insurance department.
- State Health Insurance Assistance Program (SHIP).

The insurer should consider suggesting policyholders consult a family member or other trusted advisor, such as:

- Lapse notifier.
- Insurance producer.
- Financial advisor.
- Certified personal accountant or tax advisor (in the event cash buyouts are offered).

Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
 - For example, the header could say, “Your Long-Term Care Premiums Are Increasing.”
- Including the RBOs with the rate action letter.
- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which RBO(s) have limited time frames.
- Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.
- Providing enough information in the communication to make a decision.
 - If supplemental materials (e.g., insurer’s website) are provided, they would enhance the policyholder’s understanding, but not be necessary to use when making a decision.

Insurers should consider indicating the window of time to act by:

- Clearly indicating what the policyholder’s premium will increase to and by when.
- Displaying the due date(s) in an easy-to-identify location and repeating it multiple times throughout the document.
- Clearly differentiating due date(s) for each RBO, if available for a limited time.

Insurers should consider including disclosures regarding rate increase history by:

- Disclosing that future rate actions could occur.
- Advising if prior rate actions have or have not occurred to include:
 - Policy form(s) impacted.
 - Calendar year(s) the policy form(s) was available for purchase.
 - Percentage of increase approved to include the minimum and maximum if they vary by benefit type.
- Reminding policyholders that their policy is guaranteed renewable.

Insurers should consider advising policyholders of their current benefits:

- For example, the communication could disclose the policyholder's current benefits to include:
 - Daily maximum amount.
 - Inflation option.
 - Current pool of benefits for policies with a limited pool of benefits.

Insurers should consider personal needs decision-making by:

- Only listing RBOs that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact LTC costs, such as:
 - The average cost of care for in-home care, assisted living, and nursing home care in their area.
 - The inflation rate of the cost of care for in-home and nursing home care in their area.
 - The average age and duration of an LTC claim for in-home and nursing home care.
 - Factors that influence the age, duration, and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
 - Buyout or cash-out disclosures.
 - The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

- Disclosing if the RBOs may not be of equal value and are dependent on the unique situation of each policyholder.

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
 - Daily/monthly benefit.
 - Benefit period.
 - Inflation option.
 - Maximum lifetime amount.
 - Premium increase percentage and/or new premium.
 - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
 - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
 - Current premium.

- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
 - What will happen if they take no action?
 - What will happen if they make no payment before the policy anniversary date?
 - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
 - If they elect the cash buyout, there could be tax implications.
 - If they elect a paid-up NFO, how long will the reduced benefit last if they had a claim?
 - If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
 - Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

When rate actions span over multiple years, insurers should consider:

- Disclosing the full rate increase amount, how it is spread out across multiple years, and all associated future planned rate increases approved by state insurance regulators.
- Specifying if the premium increase referenced is the first, second, third, last, etc.
- Offering CNF based on the full increase amount and offered with each phase of the rate action.
- Notifying policyholders at least 45 days in advance of each phase of the rate increase, consistent with any applicable state laws and/or regulations.

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT⁷

FROM: Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Team
 DATE: [Date]
 RE: ABC Insurance Company – Block LTC1 – Draft of *Initial* MSA Advisory Report

Executive Summary

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 35% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company's block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options (RBOs) may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the actuarially justified Texas and Minnesota approaches. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

Background

⁷ Information contained in this sample report is an example only and is not derived from any actual rate filing.

The MSA Team was formed to assist the Long-Term Care Insurance (EX) Task Force in developing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase proposals as part of a pilot program. The MSA Review became operational on [insert date].

This MSA Advisory Report is related to the rate increase proposal filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team's actuarial analysis is provided below. The intention is that states can utilize this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

The MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer. As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

Insurer's Proposal

ABC Company requests a rate increase of 60% to be approved for inflation-protected products and 40% to be approved for products with no inflation.

In addition, ABC Company is requesting higher rate increases for states that did not grant full approval of prior rate increase requests.

Workstream-Related Review Aspects

Actuarial Review

At the direction of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, the MSA Team applied the Minnesota and Texas approaches to calculate the recommended, approvable rate increases. Aspects of the Minnesota approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states' laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues.
- Elimination of rate increases related to inappropriate recovery of past losses.

Minnesota also has additional unique aspects: 1) consideration of adverse investment expectations related to the decline in market interest rates, 2) adjustments to projected claim costs to ensure the impact of uncertainty is adequately borne by the insurer; and 3) a cost-sharing formula applied in typical circumstances.

Even though these additional aspects are outside the pure loss-ratio requirements, they fall in line with legal provisions that rates shall be fair, reasonable, and not misleading.

The Minnesota approach, including application of the typical-circumstance cost-sharing formula, results in an approvable rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

The Texas approach results in an approvable rate increase of 29% in aggregate.

The MSA Team's recommendation, in consideration of the Minnesota and Texas approaches, is to approve a rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

Consideration of Differences in Histories of States' Rate Increase Approvals

According to the Historical Rate Level Summary, Appendix D in the insurer proposal, past rate increase approvals by state have varied and can be categorized as follows:

- 25 states have granted full or near-full approval of ABC Company's past requests (at or near 55%, cumulative).
- 18 states have granted cumulative approvals averaging 45%.
- Five states have granted cumulative approvals averaging 27%.
- Two states have granted cumulative approvals averaging 15%.

The insurer's stated goal is to bring rates in all states up to an equivalent rate level. Currently, the average annual premium rates for a policyholder range from below \$1,700 in some states (with the lowest past approvals) to over \$2,200 in other states (with the highest past approvals).

The MSA Team's recommendation is based on a goal of rates per benefit unit being uniform between states going forward.

A table of examples of recommended rate increases based on past cumulative approval history is provided in Appendix 2.

Non-actuarial & Valuation/Solvency Considerations

Non-actuarial considerations, including flexibility regarding the phase-in of rate increases, waiting periods between rate increases being coordinated with phase-in periods, and other issues are being discussed at the Task Force and the Subgroup.

Even with future claims potentially being reduced due to COVID-19-related behavioral impact, ABC Company will continue to experience substantial losses on this block.

Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase proposal are consistent with assumptions underlying the reserve adequacy testing.

RBOs – Review for Reasonableness

Unless a rider was purchased, ABC Company policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:

- 1) Extending the elimination period.
- 2) Decreasing the benefit period.
- 3) Reducing future inflation accumulation.

The insurer produced rate tables which demonstrate that the RBOs provide reasonable value in relation to a case of a policyholder retaining full benefits and paying the full rate increase.

Financial Impact for Insurer

The requested rate increase associated with recent adverse development would result in around \$50 million of reduced losses for this block according to information contained in the actuarial memorandum.

Mix of Business

From the insurer's actuarial memorandum:

Enrollees:

- Total enrollees as of date of proposal: 15,000
- Inflation protection: 9,000 (inflation protection) and 6,000 (no inflation)
- Benefit period: 8,500 (lifetime benefits) and 6,500 (limited benefits)

Product type: Expense reimbursement:

- Average issue age: 58
- Average attained age: 75
- Annualized premium: \$30 million; \$2,000 average per policyholder

Appendix 1

Drivers of Rate Increase Proposal – Summary

The primary drivers, summarized in the insurer actuarial memorandum, were lower lapses and longer average claim length. The insurer assumptions were based on actual-to-expected adjustments, based in part by insurer experience that has become more credible in recent years. The assumptions were determined to be reasonable and in line with industry and actuarial averages.

Details Regarding Minnesota Approach

For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:

- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
 - This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
- Blended if-knew / makeup rate cumulative rate increase since issue: 123%
 - $= 0.62 * 177\% + (1 - 0.62) * 36\%$, adjusted for rounding
- Insurer cost share based on Minnesota formula (see Appendix 3): 12%
- Recommended cumulative rate increase since issue: 109%
 - $= (1 - 0.12) * 1.23$, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%
 - $= (1 + 1.09) / (1 + 0.55) - 1$, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
 - Minimum of calculated approval rate of 35% and insurer proposal of 60%.
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the Minnesota approach includes the reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward due to a lack of credible support at extremely high ages, and a general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

Details Regarding Texas Approach

- Insurer Calculation (aggregate): 52%

PPV calculations

- Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%

LHAO Comments

- For the purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.

Texas rate stabilized PPV Formula:

$$\text{rate increase \%} = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.58 + .85 C}{1 + C} \right) \Delta PV(\text{future earned premiums})}{.85 PV_{\text{current}}(\text{future earned premiums})}$$

Reconciliation of Minnesota and Texas Approaches

The Texas PPV calculated amount of 29% aligns well with the Minnesota approach's recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs. non-inflation-protected cells is applied. The MSA Team's recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.

Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.

Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
 - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
 - Reasons for the rate increase, including which pricing assumptions were not realized and why.
 - Statement that policy design, underwriting, and claims handling practices were considered.
 - A demonstration that actual and projected costs exceed anticipated costs and the margin.
 - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
 - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
 - Information (from NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation, "Guidance Manual" Q&A): Morbidity, Lapse, Mortality, Interest.
 - Comparison with asset adequacy testing reserve assumptions.

- Provide actuarial assumptions from original pricing and most recent rate increase filing, and, have the original actuarial memorandum available upon request.
 - Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
 - Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
 - Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.
- Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
- Policyholder notification letter – should be clear and accurate.
 - Provide a description of options for policyholders in lieu of or to reduce the increase.
 - If inflation protection is removed or reduced, is accumulated inflation protection vested?
 - Explain the comparison of value between the rate increase and policyholder options.
 - Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
 - How are partnership policies addressed?
- Supplementary information, based on a list developed by the MSA Team following the review of initial pilot program proposals:
 - Information on benefit utilization.
 - Attribution of rate increase by factor.
 - RBO history and reasonability analysis.
 - Investment returns.
 - Expected loss ratio.
 - Shock lapse history.
 - Waiver of premium handling.
 - Actual-to-expected differences.
 - Assumption consistency with Actuarial Guideline 51 asset adequacy testing.
- Following initial review of the proposal, additional information was requested by the MSA Team related to:
 - Original pricing assumptions.
 - Lapse assumption by duration.
 - Premiums and incurred claims by calendar year based on original assumptions.
 - Distribution of in force by inflation protection.
 - Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
 - Description of waiver of premium handling in premium and claim projections.
 - Commentary on COVID-19 short-term and long-term LTC impact.

Appendix 2

Examples of Rate Increases If an RBO is Not Selected

ABC Company				
Jurisdiction Example*	Past Cumulative Approved Increases	Increase to catch up	Recommended New	2021 Recommended Rate Incr
Example: state with average past approvals	55%	0%	35%	35%
Example: state with lower than average past approvals	27%	22%	35%	65%
*The recommendation for each state is based on the actual past cumulative approved increases in that state.				

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%.
- 25% for the portion of cumulative rate increase between 50% and 100%.
- 35% for the portion of cumulative rate increase between 100% and 150%.
- 50% for the portion of cumulative rate increase in excess of 150%.

Example: if the pre-cost sharing Minnesota approach results in a cumulative 210% rate increase since issue:

- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%
- Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%
- = 15% + 32% + 38% + 33% + 30%
- = 147%

Justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer's solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or proposal.

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit www.naic.org.

Draft: 10/29/21

Long-Term Care Insurance (EX) Task Force
E-Vote
October 29, 2021

The Long-Term Care Insurance (EX) Task Force conducted an e-vote that concluded Oct. 29, 2021. The following Task Force members participated: Michael Conway, Vice Chair (CO); Jim L. Ridling represented by Mark Fowler (AL); Alan McClain (AR); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dana Popish Severinghaus represented by Shannon Whalen (IL); Amy L. Beard represented by Dawn Bopp (IN); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Bob Williams (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); Russell Toal (NM); Barbara D. Richardson represented by Jack Childress (NV); Glen Mulready represented by Andrew Schallhorn (OK); Andrew Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. Adopted the 2022 Proposed Charges

The Task Force conducted an e-vote to consider adoption of the 2022 proposed charges of the Task Force and its Subgroups. A majority of the members voted in favor of adopting the 2022 proposed charges (Attachment Four-A). The motion passed.

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

Draft Pending Adoption

Draft: 8/19/21

Long-Term Care Insurance (EX) Task Force and the
Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
Columbus, Ohio
August 13, 2021

The Long-Term Care Insurance (EX) Task Force met Aug. 13, 2021, immediately followed by a meeting of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.

The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmaier (FL); Colin M. Hayashida represented by Martha Im (HI); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by Shannon Whalen (IL); Amy L. Beard and Scott Shover (IN); Vicki Schmidt (KS); James J. Donelon (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey (NC); Jon Godfread (ND); Eric Dunning and Rhonda Ahrens (NE); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike and Tomasz Serbinowski (UT); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler and Lichiou Lee (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

The following Subgroup members participated: Michael Conway, Chair (CO); Alan McClain (AR); Andrew N. Mais (CT); Philip Barlow (DC); David Altmaier (FL); Doug Ommen (IA); Dean L. Cameron (ID); Amy L. Beard (IN); James J. Donelon (LA); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented by Fred Andersen (MN); Eric Dunning and Rhonda Ahrens (NE); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Andrew Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Doug Slape (TX); Tomasz Serbinowski (UT); Scott A. White (VA); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler and Lichiou Lee (WA); and James A. Dodrill (WV).

1. Long-Term Care Insurance (EX) Task Force

a. Adopted its July 6 Minutes

The Task Force met July 6 and took the following action: 1) adopted its Spring National Meeting minutes; and 2) received the reports of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup.

Commissioner Altman made a motion, seconded by Commissioner Caride, to adopt the Task Force's July 6 minutes (Attachment One). The motion passed unanimously.

b. Heard an Update on Industry Trends

Mr. Andersen said the Valuation Analysis (E) Working Group oversees reserve valuation and related solvency of companies with large long-term care insurance (LTCI) blocks of business. It has reviewed *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) filings this past year. The Working Group interacts with companies and domestic state insurance departments on such matters. In past years, the areas of focus included evaluation of investment return and morbidity incidence improvement assumptions. Mr. Andersen said the key area of focus this year has been on studying the variation of cost-of-care and trends due to the impact of COVID-19 and the aging baby boomer generation. Cost-of-care trends affect companies with policies that include 5% compound inflation protection where often the actual daily cost-of-care assumption is less than the inflation-protected daily maximum benefit stated in the policy. The Working Group plans to monitor trends for that issue over the next several months and years. The Working Group is working with the California Department of Insurance (DOI), which has a team of LTCI actuaries that assist in the AG 51 reviews.

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Commissioner Ridling asked if the Task Force should be monitoring for possible future solvency concerns and what should be looked at during insolvency. Commissioner White said that solvency analysis is ongoing. It is being conducted by the actuarial group through its annual review of insurers' AG 51 filings, and through having discussions with the company and its domestic state insurance regulator if reserves need to be strengthened. Mr. Andersen said the Valuation Analysis (E) Working Group has been performing targeted and broad-based reviews for three to four years and has been engaged with the companies and the NAIC on their work. He invited any of the state insurance regulators who would like to discuss these activities or any ideas for enhancements to this work to contact him or Commissioner White.

c. Received the Report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup

Commissioner Conway said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met June 22 to hear verbal comments on the exposure draft of the operational sections of the LTCI Multi-State Rate Review Framework (MSA Framework). The drafting group has met several times discuss those comments and has identified some key issues yet to be decided. The Subgroup also exposed the actuarial sections of the MSA Framework for a public comment period. Five comment letters were received. The drafting group will continue working on edits to both the operational and actuarial sections in response to the comments to finalize the MSA Framework. Commissioner Conway said the Subgroup anticipates a second exposure draft of both the operational and actuarial aspects of the MSA Framework by the middle of September and will be conducting several meetings this fall.

Director Cameron made a motion, seconded by Commissioner Conway, to receive the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (Attachment Two). The motion passed unanimously.

d. Received the Report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

Commissioner Altman said the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup met July 28, July 22 and May 4. During its May 4 meeting, the Subgroup heard four industry presentations on LTCI innovation and wellness programs. The presenters were invited to assist the Subgroup with identifying potential issues with offering wellness programs to policyholders with in-force LTCI policies. The presentations touched on things insurers need to consider before implementing a wellness program; experiences with and lessons learned from a pilot program offered by an insurer; a hypothetical view of what the future state of in-home long-term care (LTC) services might look like; and issues related to unfair discrimination concerns, rebating concerns, and wellness programs as they relate to tax qualified LTCI policies.

Commissioner Altman said after its July 22 meeting, the Subgroup exposed a document titled *Issues Related to LTC Wellness Benefits* for a public comment period ending Sept. 5. She encouraged state insurance regulators and interested parties to review the document and provide feedback to the Subgroup. The document outlines issues, observations, and next steps for various topics, including:

- Effectiveness of LTC wellness programs.
- Preventions of unfair discrimination related to extra-contractual benefits and costs.
- Consumer confusion over wellness programs.
- Rebating and whether some LTC wellness benefits run afoul of anti-rebating laws.
- Tax considerations for policyholders.
- The regulatory role in approving or evaluating LTC wellness approaches.
- Actuarial considerations of the impact of LTC wellness benefits.
- Data privacy.

Commissioner Altman said the Subgroup received comments on the draft "RBO Consumer Notices Checklist" in July. This checklist is intended to establish a consistent approach to drafting and reviewing LTCI reduced benefit options (RBO) policyholder communications, and to provide an optional tool to use. The checklist can be used by states for guidance and is not required to be used for the review of insurer communications with policyholders. The Subgroup met July 28 to work through the comments received and to make edits to the checklist. The Subgroup plans to meet Aug. 23 to finalize the checklist.

Commissioner Altmaier made a motion, seconded by Commissioner Caride, to receive the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (Attachment Three). The motion passed unanimously.

e. Released the LTCG Actuarial Consulting Group Report

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Commissioner White said the NAIC engaged LTCG Actuarial Consulting Group to conduct a data call of certain insurers to assist the Task Force in evaluating the extent to which state rate review policies and practices have led to cross-state rate subsidization. The public LTCG report (Attachment Four) includes key points in the executive summary and data in different frames. The data call and analysis does show such cross-state rate subsidization does exist. The report took time to deliver as the original work product of LTCG was considered confidential because the information was gathered under Virginia confidentiality statutes. Steps had to be taken to allow it to be shared publicly and to work through some contractual issues with LTCG regarding its scope of work and deliverables. This report is being released to the public for informational purposes only, and the Task Force does not expect further discussion on the matter.

f. Discussed the MSA Framework Timeline and Next Steps

Commissioner White said a timeline for completing the MSA Framework has been developed, which includes processes to receive feedback from both state insurance regulators and interested parties. He said the following timeline is anticipated for the operational aspects of the MSA Framework:

- Discuss pending revisions during today's meeting.
- Aim to complete the next version of the operational aspects of the MSA Framework by Aug. 30.
- Assuming the next draft is completed by Aug. 30, then hold a Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regulator-to-regulator meeting the week of Sept. 6, which will be scheduled soon.
- Pending further edits from the Subgroup, the operational aspects would be re-exposed for a 30-day public comment period the week of Sept. 22, with comments due prior to a Subgroup meeting the week of Oct. 25.
- Hold a Subgroup open meeting the week of Oct. 25 to discuss comments received.
- The drafting group will consider near final comments and produce a third draft version by Nov. 8.

Commissioner White said the following timeline is anticipated for the actuarial aspects of the MSA Framework:

- The Subgroup will hear oral summary comments during today's meeting.
- The drafting group plans to analyze and produce a second draft version and expose it for a 30-day public comment period by the week of Sept. 13, with comments due prior to a Subgroup meeting the week of Oct. 25.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned into the Subgroup meeting.

2. Long-Term Care Insurance Multistate Rate Review (EX) Subgroup

a. Discussed Revisions to the Operational Section of the Draft Multistate Rate Review Framework

Commissioner Conway said the drafting group has met several times over the past two months to work through the comment letters and has made progress. There are a couple key points that the drafting group thinks the Subgroup still needs to evaluate and discuss further, specifically what information in the MSA process and MSA filing should be confidential vs. public. The answer may depend partly on how states' insurance laws and protections apply in general, or specifically to rate filings. Another key issue yet to be finalized is the type and level of detail of information that should be included in a report that is shared with the insurer. Commissioner Conway said he recognizes the value in good communication with the insurer during the review process but still need to address the level of detail that is needed. He said this will be an iterative process with insurers to strike the right balance between transparency and the protection of sensitive information.

Commissioner Conway said the current draft will change, as there needs to be more discussion on these issues. Based on that discussion, further decisions can be made on administrative and logistical questions that were raised in the comments, specifically, the use of the Interstate Insurance Product Regulation Compact (Compact) staff and the System for Electronic Rate and Form Filings (SERFF) to assist in the administration of rate proposals and the process of finalizing the review and approval of the reports. The Subgroup is aiming to produce the next version of the draft by Aug. 30 and meet in regulator-to-regulator session during the week of Sept. 6.

Ms. Ahrens said there were several comments received on the operational aspects of the MSA Framework regarding the need for both insurers and state insurance regulators to participate in the MSA process for it to achieve its goal of more consistency in approving actuarially justified rate requests in a timely fashion. The MSA process is novel concept and through the pilot project, she said the Subgroup is learning with each review how to improve the process for the next review. It is anticipated that this process will evolve rapidly over time. The hope is that both industry and the state insurance departments will also find the benefits of the process and that relying on this process and its reports will become more compelling as experience is gained.

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She said that evolution is something the Task Force and this Subgroup will be closely monitoring and reevaluating to help ensure they are moving towards their goal.

Ms. Ahrens said an important change is the addition of what will be referred to as an “MSA Associate Program,” which is aimed at addressing the concerns of state insurance regulators that more states need to be actively involved in participating in the actual MSA review rather than being limited or that the MSA team may be too small of a group of regulatory actuaries. While there would still be a core team, the proposed mentorship program recognizes that some state insurance departments may lack LTCI actuarial expertise and need involvement in a process like this to help staff to gain LTCI experience. It also recognizes limitations on state insurance departments’ resources but allows for meaningful participation with less time dedication, such as serving as a peer reviewer.

Ms. Ahrens said another key change is the addition of a sample MSA Advisory Report that reflects in more detail the type of information that will be included, understanding that each report will be customized to the filing and that the report may be refined over time.

b. Heard Comments on the Exposure Draft of the Actuarial Section of the Draft MSA Framework

Commissioner Conway said the actuarial section of the MSA Framework was exposed for a public comment period ending July 26. Five comment letters were received. Each commentator was asked to summarize key points from their letter.

Andrew Dalton (American Academy of Actuaries—Academy) summarized the Academy’s comment letter (Attachment Five) by outlining key areas of comments:

- Regarding “actuarial judgement,” the Academy recommends the use of the term “professional judgement.”
- Regarding the decision-making process of the MSA team, the Academy recommends additional information on: 1) how the three actuarial approaches are aggregated; 2) what happens if the Minnesota and Texas approaches conflict; 3) what mechanisms exist for dealing with “catch-up” and “transition” provisions in the Texas approach; 4) how differences in historical rate increases are handled; and 5) how long the MSA recommendation lasts.
- Regarding industry standards and benchmarking, the Academy recommends: 1) consultation with the filing actuary before determinations of “unreasonable or unsupported” assumptions are made; 2) consideration that some insurers use the same assumptions for rate increase and asset adequacy testing, as this may have implications for asset adequacy testing; 3) clarification on “industry average assumptions at the time of original pricing”; and 4) future explanation of the 58/85 test.
- Regarding non-actuarial considerations, these issues can have actuarial implications.
- The Academy’s comment letter includes several editorial points for consideration.

Mr. Dalton said the Academy appreciates the effort in developing the MSA Framework but has concerns that there may be little value if state insurance departments do not follow the MSA recommendations. The Academy recommends ongoing monitoring of state insurance departments’ use of the MSA recommendations.

Mr. Andersen said the letter was helpful and that many of the items for which the Academy is seeking clarification will be addressed in the MSA Framework. Regarding the need for state insurance department participation, he said he hopes that upon implementation of the MSA Framework, that over time, insurers and state insurance regulators will have a greater comfort level with the MSA process and that there will be more interaction with those insurers and state insurance regulators.

Ms. Ahrens said regarding the Academy’s comment that the lowest result would always be the recommendation, in Nebraska, they use elements of both the Texas and Minnesota approach. The intent to having two methods is not to choose the lowest or highest number or to have a prevailing method, but rather to choose the one that makes the most sense for the unique aspects of each rate filing.

Jan Graeber (American Council of Life Insurers—ACLI) summarized the joint comment letter from the ACLI and America’s Health Insurance Plans (AHIP) (Attachment Six). She said the ACLI and AHIP strongly support the work to achieve the Task Force’s charge. She said they view the actuarial section to be at the core of achieving the Task Force charge and that it deserves robust discussion through several rounds of exposure. Ms. Graeber said the ACLI and AHIP comments are high-level, and they look forward to providing more detailed comments in the future.

Ms. Graeber said the comments include a list of questions and issues. She said the MSA Framework should include transparency and consistency. The MSA Framework should include the rationale or criteria that determines the method the MSA team will

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apply. She said carriers need to understand the methodology to be used by the MSA team before the carriers prepare and make rate filings. She highlighted comments in the letter that note that certain provisions of the Texas method were not clearly included.

Ms. Graeber said the 2018 NAIC Long-Term Care (B) Pricing Subgroup's paper, *Long-Term Care Insurance Approaches to Reviewing Premium Rate Increases* was result of deliberate and collaborative effort, where each method was fully vetted. She said any clarifications or modifications to the methodologies in that paper should only be made after the same type of robust discussion and vetting occurs as 2018. She encouraged the Task Force to charge the Long-Term Care Pricing (B) Subgroup or other actuarial group with re-vetting these methods before they are included in the MSA Framework.

Ms. Graeber said within the Minnesota approach, the term "anti-bait and switch adjustment" draws a legal conclusion and recommends the term "original assumption adjustment."

Commissioner Conway said there are issues that remain to be addressed. He said there will be further opportunities for state insurance regulators and interested parties to comment on the MSA Framework and engage in solutions to issues. He said the MSA process will be evolving and the MSA team expects to learn and make improvements over time. He said it is important that the Subgroup keep moving this project forward as Commissioner White described in his discussion of the timeline.

Superintendent Toal said he supports the MSA effort. He said however, that there needs to be a reasonableness test beyond the actuarial assessment. He said a request for rate increases of 157%, 189% and 226% are not reasonable or sustainable to him or for policyholders. He said state insurance regulators need to have discussions with insurers to understand the rate increase and, if necessary, perform multistate examinations.

Commissioner Conway said the reasonableness aspect is in direct response to the fact that the focus cannot only be on the actuarial aspects. He said that some state laws require a reasonableness approach and that other states have caps that need to be considered.

Commissioner White said he believes many members of the Task Force are focused on making sure consumers are not absorbing high rate increases. The Task Force is working on ways to balance that priority with ensuring that insurers are able to pay claims in the future by receiving actuarially appropriate rate increases. He said one of the benefits of the MSA Framework are the methodologies that consider the types of concerns that Superintendent Toal raised. He said, however, that how we address these rate increases for consumers must be consistent from state-to-state. The Texas and Minnesota methods are designed so that insurers cannot recoup past losses. The methods are focused on ensuring the increases are prospective in nature. The Minnesota method also has a cost-sharing element that starts when a rate increase exceeds a certain amount. He said state insurance regulators need to scrutinize the insurers. The Valuation Analysis (E) Working Group is monitoring these insurers and ensuring they hold proper reserves. The data state insurance regulators have available is better than five years ago. Results may reflect that some insurers must adjust reserves for rising costs. When that happens, it is a reasonable consideration for the insurer to request to recoup part of that through rate increases.

Commissioner Richardson asked Ms. Graeber if "transparency" refers to the method specific to a company's review. Ms. Graeber said she is referring to transparency of when the Texas or Minnesota methods are used in the MSA review. In 2018, examples under the two methods had similar results. She said that may not be true now. She said the insurer needs to know which method and criteria will be used to review their filing before they make their rate filing. She said Mr. Ahrens said Nebraska uses aspects of both methods based on the characteristics of the filing. She said insurers are looking for transparency on those criteria. Commissioner Richardson said that if the results of the methods ultimately are different, upfront transparency may not give insurers the results they are looking for. Commissioner Conway said the MSA team is going to apply aspects and consideration of both the Texas and Minnesota approaches, as each will have different characteristics. He said the MSA team will not be able to inform an insurer which approach is applied to an insurer before the filing is made. He said the MSA process is transparent in that it outlines the two approaches that will be used, as opposed to 56 jurisdictions using 56 different approaches. He said both state insurance regulators and insurers will continue to learn and improve this process over time.

Mr. Slape said significant rate increases are difficult, but state insurance regulators need to look at what led up to that rate increase request. If the reason is that insurers delayed making the request, the Texas and Minnesota methodologies require the company to subsidize that. If the reason for the rate increase is because prior rate increases were not approved, state insurance regulators need to reconcile that also. Perpetuating the problem will make it worse. He said this needs to be reconciled in a way that consumers still get the value they purchased and that they are in the best position to make their own decision. Cancellation rates are still low, which indicates consumers still value the product. Both industry and state insurance regulators own some of

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the problem, and hopefully state insurance regulators can find a solution so that regulators are not exacerbating the problem. Commissioner Conway said there is also good work being accomplished around RBOs, which is an additional component to finding a solution.

Superintendent Toal asked Ms. Graeber why an insurer would need to know which methodology the state insurance department would use. The insurer would include in their rate filing what the insurer has determined independently what is a sound and reasonable request. He asked why it would make a difference if the Texas or Minnesota methodology was used on a rate increase review. Ms. Graeber said it adds clarity to the process. Knowing the criteria and considerations will make for a more timely and efficient process if the insurer knows how the MSA team is going to review their filing. Superintendent Toal said he does not agree.

Commissioner Donelon asked if funded consumer representatives have provided comments. Commissioner Conway said no comment letters were received from funded consumer representatives.

Bonnie Burns (California Health Advocates—CHA) said she had comment on the RBO topics, but she does not have the skills to comment on the actuarial topics. She said she is counselling consumers who are receiving the rate increase who are upset over the high rate increase they are asked to pay. The consumers must make the decision to either pay the rate increase or to reduce benefits because they have no other choice. She said the state insurance regulators should keep this in mind when considering the actuarial issues. She said there is no reason an insurer should raise rates on the cost of care because they do not pay claims based on the cost of care; rather, it is a fixed amount. If they have 5% inflation protection, the insurer should have already calculated the cost of that protection. She said another actuarial group indicated cost of care is not driving the increase in premiums. Commissioner Conway said state insurance regulators are concerned about the consumer and have had similar difficult conversations with consumers who are facing rate increases.

Samuel Cuscovitch (FinancialMedic LLC) summarized his comment letter (Attachment Seven). He said his consumer group is a grassroots group looking at LTCI as part of financial independence and retirement issues. He said FinancialMedic reviewed an actuarial paper on “phantom premium” and approximately 250 filings in Connecticut. Based on this, his group determined that what takes place is essentially a “charge back.” FinancialMedic ran models to determine the extent of the charge backs, approximately 40%. He said his group’s comment letter includes an example of such. He said a problem is that the source of the real premium and the rate adjudication method is not disclosed by the insurers. He said his group considers these rate increases to be elder abuse. Without nailing down the rate adjudication method, he is unsure how the NAIC can embark on RBO initiatives or determine that there is cross-state subsidization. He said he thinks the rate adjudication method needs to be solidified and vetted before assuming RBOs or cross-state subsidization are high priorities.

Mr. Andersen said the issue of past losses was a key topic of the public actuarial meetings that spanned four to five years, so he thinks there is a good understanding of that issue, which is reflected in the Texas and Minnesota methodologies. He said when these policies were originally sold, the estimate of benefits was much lower than the actual benefits and the question has been how much of the gap is the responsibility of the insurer vs. passing it on to the consumer. He said even though premiums are higher, the value proposition still works in favor of the consumer. There is still value to the consumer, but now it is more expensive.

Ms. VanFleet summarized the Vermont comment letter (Attachment Eight). She said the comments address the wellness section of Appendix D of the MSA Framework. She said any offer associated with a rate action that involves the collection of data using artificial intelligence (AI) should clearly explain how information will be collected and used to avoid profiting and potential discriminatory actions on behalf of the insurer. Any offer to an insured tied to a rate increase should be supported with data showing why and how the rate impact is directly correlated to the offer. Rate increases add thousands of dollars to the consumer and are often a hardship for elderly consumers on fixed incomes and may not be able to consider their own best interest. The comment letter recommends keeping the wellness program offers separate from implementation of large rate increases (e.g., 10%–15%). Then, there would be no question that the consumer was coerced, rather than persuaded, to the part in the wellness program.

Ms. Lee said summarized the Washington comment letter (Attachment Nine). She said a few key criteria need to be addressed to achieve the maximum value of the MSA process. If the MSA process is not binding, it may affect the goal of nationwide uniformity and defeat the purposes of the MSA process. To minimize the differences across states, more states need to participate in the MSA rate review, and the use of the results should be mandatory. She asked if the rate changes recommended by the MSA team can be implemented by all states and meet existing state laws and rules. If not, she asked if this invalidates the actuarial work of the MSA team. Some states have capped an LTCI rate increase regardless of actuarial justification. If the

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MSA team recommends a higher rate increase than a particular state's capped rate increase, the actuarial assumptions may no longer be valid. Also, those states without a rate cap will be continuing to subsidize the states with a rate cap. She said a key issue to address is if the MSA review can meet the proprietary or confidentiality requirements of the participating states. MSA rate reviews will be done by drawing on staff support from various state insurance departments. She asked if the MSA team can effectively maintain confidentiality and meet individual state's proprietary information law. She highlighted other comments in the letter regarding the actuarial considerations, specifically that the MSA report should not conflict with various states' laws, rules, and procedures, and that the NAIC should conduct a study to determine whether the Minnesota and Texas approaches are consistent with states' laws and rules. She said the methods in the MSA Framework are somewhat different from the review performed in Washington.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.

Draft: 12/8/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
December 7, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Dec. 7, 2021. The following Subgroup members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier (AK); Jimmy Harris (AR); Emily Smith (CA); Frank Pyle (DE); Andria Seip (IA); Eric Anderson (IL); Karen Dennis (MI); Fred Andersen (MN); Jill Kruger (SD); Michael Markham (TX); Tomasz Serbinowski (UT); Anna Van Fleet (VT); Lichiou Lee (WA); and Joylynn Fix (WV).

1. Adopted a Draft LTC Wellness Program Issues Document

Commissioner Altman presented a version of a draft long-term care (LTC) wellness program issues document (Attachment Six) that reflects edits made in response to comments received (Attachment Five-x) during its second public exposure for comment. Mr. Andersen gave an overview of the document and provided a summary of comments and edits made to the draft exposure.

Mr. Andersen made a motion, seconded by Director Wing-Heier, to adopt the document. The motion passed unanimously.

Commissioner Altman said the document will be forwarded to the Long-Term Care Insurance (EX) Task Force for its consideration.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

Draft: 12/8/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
November 19, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Nov. 19, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Jimmy Harris (AR); Emily Smith (CA); Susan Jennette (DE); Doug Ommen (IA); Stewart Guerin (LA); Kevin Dyke (MI); Carter Lawrence (TN); R. Michael Markham (TX); Tomasz Serbinowski (UT); Elsie Andy (VA); Anna Van Fleet (VT); and Sharon Daniel (WA).

1. Adopted the RBO Consumer Notices Checklist.

Ms. Van Fleet and Ms. Logue presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Five-x) that incorporates comments received on the draft, with notes on the proposed treatment of each comment. The Subgroup, interested state insurance regulators, and interested parties discussed and agreed to changes to items 16, 18, and 42. These changes were incorporated into a final version of the Checklist (Attachment Seven).

Mr. Serbinowski made a motion, seconded by Ms. Van Fleet, to adopt the final version of the Checklist. The motion passed unanimously.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

Draft: 10/29/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
October 19, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Oct. 19, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Emily Smith (CA); Frank Pyle (DE); Doug Ommen (IA); Eric Anderson (IL); Karen Dennis (MI); Fred Andersen (MN); Gretchen Brodkorb (SD); Carter Lawrence (TN); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); and Melanie Anderson (WA).

1. Discussed Comments Received on a Draft RBO Consumer Notices Checklist.

Ms. Van Fleet presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Five-x) that incorporates comments received on the draft, with notes on the proposed treatment of each comment.

Ms. Van Fleet said discussion at the next meeting will focus on questions 16 and 42. Commissioner Altman said the Subgroup will schedule another meeting to continue discussion of the comments on the Checklist using the version that reflects revisions made today.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

Draft: 10/28/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
October 4, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Oct. 4, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Emily Smith (CA); Frank Pyle (DE); Doug Ommen (IA); Eric Anderson (IL); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Carter Lawrence (TN); Barbara Snyder (TX); Tomasz Serbinowski (UT); Scott A. White (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. Discussed Comments Received on a Draft LTC Wellness Program Issues Document

Commissioner Altman presented a version of a draft Long-Term Care (LTC) Wellness Program Issues document (Attachment Five-x) that reflects edits made in response to comments received (Attachment Five-x) during its public exposure for comment. She also presented a summary (Attachment Five-x) of the comments received. Mr. Andersen gave an overview of the document and the summary of comments.

Bonnie Burns (California Health Advocates—CHA) asked how wellness program benefits will be offered to policyholders. Mr. Andersen said the benefits are likely not included in the original policy contract, and they will likely be offered through a mutual agreement between the insurer and policyholder to new contract terms. He said this will be like how reduced benefit options (RBO) are made available to policyholders.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that a standardized template be used for collection of data needed for wellness program implementation and the data collection be facilitated using a national statistical agent.

Anitha Rao (Neurocern) said she is concerned that the standards of care used by insurers offering wellness programs for providing care to policyholders may not be the same as those used by the medical community.

Commissioner Altman said the document will be re-exposed for an additional public comment ending Nov.4.

2. Responded to a Referral from the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup

Mr. Andersen presented a comment (Attachment Five-x) submitted by the Vermont Department of Financial Regulation in response to an exposure for public comment by the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup of Operational sections of a Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (MSA Framework). He said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup referred the comment to the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup for a recommendation on whether to include the additional language proposed in the MSA Framework.

The Subgroup determined that it will recommend that the proposed language not be added to the MSA Framework at this time. However, if the Multistate Actuarial LTCI Rate Review Team (MSA Team) is presented with a rate increase filing that includes the issue addressed in the comment, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup requests that the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup make a referral that includes details of the offering's connection to the rate increase request.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

Draft: 10/8/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
September 27, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Sept. 27, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Emily Smith (CA); Frank Pyle (DE); Doug Ommen (IA); Eric Anderson (IL); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Carter Lawrence (TN); Barbara Snyder (TX); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. Discussed Comments Received on a Draft RBO Consumer Notices Checklist.

Ms. Van Fleet presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Five-x) that incorporates comments received on the draft, with notes on the proposed treatment of each comment.

Ms. Van Fleet said discussion at the next meeting will focus on questions 6, 7, 25, and 49. Commissioner Altman said the Subgroup will schedule another meeting to continue discussion of the comments on the Checklist using the version that reflects revisions made today.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

Draft: 9/8/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
August 23, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Aug. 23, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Perry Kupferman (CA); Susan Jennette (DE); Andria Seip (IA); Dana Popish Severinghaus (IL); Rich Piazza (LA); Karen Dennis (MI); Rhonda Ahrens (NE); Larry D. Deiter (SD); Brian Hoffmeister (TN); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. Discussed Comments Received on a Draft RBO Consumer Notices Checklist.

Ms. Van Fleet presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Five-x) that incorporates comments received on the draft, with notes on the proposed treatment of each comment.

Commissioner Altman said the Subgroup will schedule another meeting to finish discussion of comments on Checklist questions 6, 7, 25, and 49.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

Issues related to LTC wellness benefits

Adopted by LTCI Reduced Benefit Options (EX) Subgroup - 12/07/2021

Objective:

The objective of this paper is to increase clarity to regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.

Background:

Stand-alone long-term care insurance is a unique industry, in that higher-than-expected claims' costs have resulted in substantial rate increases for consumers and financial losses and in some cases solvency concerns for insurance companies.

Firms are developing technological and other approaches that could be used by insurance companies to potentially prevent, delay, or lower the severity of LTC claims and improve health outcomes in a space called "LTC wellness". Examples of these early, pre-insurance-claim interventions include:

- Fall prevention programs;
- Home modification consultations, analysis, and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Improvements in cognitive impairment prevention and early diagnosis, potentially involving technology supplemented by a physician's cognitive risk evaluation.

In light of systemic, LTC-related financial challenges, insurance companies, insurance regulators, and tech firms are interested in working together to explore some of these claim cost-reducing innovations. Here are some potential barriers to increased adoption of these new approaches and how those barriers could potentially be addressed, with details provided below the list:

1. Analysis of effectiveness
2. Unfair discrimination
3. Consumer confusion
4. Rebating
5. Tax considerations
6. Regulatory role in approving or evaluating LTC wellness approaches
7. Actuarial considerations
8. Data privacy
9. Other considerations

Details:

1. Analysis of effectiveness

- a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
 - i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
 1. Expenses vary - in many cases are upfront and significant.
 2. The financial impact on claims cost is typically unknown and down the road.
 - ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
 - iii. Some companies are concerned about regulatory reaction to these changes.
- b. Current observations
 - i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
 - ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow, and it is difficult to implement control trials.
 1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
 - iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.
 - iv. Effectiveness may increase or decrease if targeting certain policyholders.
 - v. Development of experience showing effectiveness will be a work in progress.
- c. Addressing of Issues
 - i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.

- ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
- iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.
- d. Next steps
 - i. Regulators engage with insurance companies to learn of recent developments.
 - ii. Research public programs' data on effectiveness of LTC wellness programs to see if Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used. Also, look into potential independent living / senior facility wellness experience as well as health and life insurance wellness experience.
 - iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies are applying 3 to 4 pilot programs and finding success, it would be good news regarding broader, future efforts.
 - 1. Facilitate the sharing of general results (i.e., not individual policyholder data) among those insurance companies in a way that is within the legal and regulatory boundaries.
 - iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios, including one where claims costs continue to increase.

2. Prevention of unfair discrimination related to extra-contractual benefits and costs

- a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete populations within the broader group of policyholders?
- b. Current observations
 - i. There may be state anti-discrimination and bias-related legal issues to address if certain policyholders are targeted, including through Big Data, to receive extra benefits.
 - 1. For instance, if older policyholders have less of an online footprint than younger policyholders, how would this impact the accuracy of the targeting of LTC wellness benefits or otherwise introduce bias?
 - 2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific conditions are based on age or the health of the policyholder, this seems like normal value-added products and services for loss prevention and not an example of unfair discrimination.
 - a. Issues to address are likely related to creating a clear framework for compliance related to the use of data analytics and artificial intelligence.
- c. Addressing of issues
 - i. Equality: How policyholders are offered wellness initiatives could be unfairly discriminatory.

1. Policyholders of “the same class and of essentially the same hazard” must be treated equally. See NAIC Model Unfair Trade Practices Act (#880) (“Model Law”).
2. How may an insurer “classify” policyholders post underwriting? Regulators may need to provide guidance on how to classify policyholders.
 - a. What is fair? The insurers will need to provide justification.
 - i. For example, under the Model Law the availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory.
 - b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program’s overarching goals?
 - c. May classification be made by product form?
- ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
 1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
 - a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
 - b. Initial selection of participants may be the most important for antidiscrimination. That selection for pilots should consider including, but not limited to, a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected, as appropriate to the wellness initiative.
 2. Would a random selection of policyholders be unfair?
 3. Should policyholders be given the option to participate in a wellness initiative?
 - a. Must *all* policyholders be given the option to participate?
 4. How much time/data is needed to prove the initiative is valuable?
 5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.
 - a. Even if benefits are available to all those who utilize, the initiatives may be limited in application depending on a policyholder’s specific circumstances.
- iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
 1. Does it limit who can participate based on the medium and cost of the equipment or technology? For example:
 - a. Does it require access to a computer or internet for online participation?
 - b. Does it require access to a smart phone, texting minutes, etc., to use an app?

- c. Does it require access to roads, pools, sidewalks?
 - d. Does it require technical skills to use software or hardware?
 - e. Will insurers utilize different communication methods, such as phone, text, e-mail, or mail?
 2. Does any such limitation require alternatives for those unable to participate in the initiative?
- iv. Uniformity: If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?
 1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
 2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.
 - a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.
 3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?
- d. Dependencies
 - i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
 1. Analyzing Effectiveness
 2. Actuarial Impacts
 3. Rebate Standards and Limitations
 - a. What if an insurer offers the service at a cost (full or portion) for the policyholder(s) after the pilot?
 4. Regulatory Evaluation
- e. Next steps
 - i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

3. Consumer confusion

- a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.
- b. Addressing of issues:
 - i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion

than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.
- ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.
- iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont's sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.
- iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and

discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

- v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: <https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html>) . This builds trust through human contact with medical professionals.
 - 1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.
- vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

4. Rebating

- a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).
- b. Addressing issues:
 - i. NAIC Model Law. The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service

meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

- ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins, or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.
 1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state’s rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:
 - a. **Alaska:** Statutorily excludes “a reward under a wellness program established under a health care plan that favors an individual” from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. *See* AK Stat § 21.36.110.
 - b. **Maine:** Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. *See* Me. Stat. tit. 24-A, § 2163-A.
 2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative

would be permissible under each relevant jurisdiction’s rebating law and if there are any state specific requirements for offering such an initiative.

- iii. Trends in State Law. Notwithstanding the variation in individual state’s laws and if and how they have been amended or interpreted, there does appear to be a general trend that “services are not prohibited if they are directly related to the insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.
 - iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, where the initiatives do not begin at the moment the policy is issued, and where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer’s share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.
- c. Next steps:
- i. Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either:
 - 1. adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or
 - 2. take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health.
 - ii. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

5. Tax considerations

- a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
- b. Current observations
 - i. In order for a contract to be a “qualified long-term care insurance contract” (QLTCI) as defined in 26 USC 7702B, it must satisfy a number of definitional requirements, including that such a contract must provide insurance coverage only of qualified long-term care services and it generally cannot provide a cash value. There may be adverse tax consequences for consumers if a contract provided benefits that are inconsistent with the definitional requirements.
- c. Addressing issues:
 - i. If a QLTCI contract meets the statutory definition, it is treated as an accident and health insurance contract. See 26 USC 7702B(a)(1). The NAIC is addressing the addition of wellness benefits to QLTCI contracts, and it is understood that insurers would only offer such benefits where this could be done without forfeiting the contract’s tax qualified status. Wellness benefits may include provision of home assessments to identify risks which could lead to a chronic illness such as tripping hazards, installation of ramps and railings, caregiver training for family members and sharing information regarding local LTC providers to those in need or anticipating assistance.
 - ii. While not exactly on point, two interpretive letters* from the Internal Revenue Service responded to questions from a taxpayer regarding the inclusion of riders to QLTCI that 1) “allow access to information pertaining to health, wellness and long term care that promotes and encourages a healthy lifestyle,” and 2) allow participation in voluntary incentive programs that are based on periodic health assessments and other medical criteria evidencing health living and could result in premium discounts or increases in benefits.
 - iii. The interpretive letters observe that 26 USC 7702B was enacted to provide incentive for individuals to take financial responsibility for their long-term needs and therefore generally provides favorable tax treatment with respect to QLTCI and qualified long-term care services meeting the statutory requirements. The Code defines “qualified long-term care services” as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services which are required by a chronically ill individuals and are pursuant to a plan of care prescribed by a licensed health care practitioner. The IRS further observed that, in essence, the rider allows the contract to be implemented based on the risk profile of the insured. The IRS held that the inclusion of the rider in a QLTCI contract will not cause the contract to be treated as providing insurance coverage other than of qualified long-term care

services. * The guidance contained in the interpretive letters is directed only to the requesting taxpayer(s) and may not be used or cited as precedent.

d. Next steps:

- i. Insurers and policyholders could benefit from federal guidance regarding tax qualification of broad classes of QLTCI, including QLTCI combo products. Such guidance would clearly articulate:
 1. Safe harbor product features that would not be inconsistent with the tax qualification requirements for QLTCI;
 2. That the safe harbors are not exhaustive of permissible wellness and other features for reducing the risk of chronic illness or severity of any future chronic illness; and
 3. That the IRS may supplement safe harbor guidance as appropriate, and that taxpayers may utilize the private letter ruling process of clarifying the treatment of particular features not covered by safe harbors.

6. Regulatory role in approving or evaluating LTC wellness approaches

- a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
- b. Current observations:
 - i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
- c. Addressing issues
 - i. Idea:
 1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
 - a. These issues include company plans to accumulate data on programs' effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.
 2. States retain the right to conduct back-end reviews, targeting any critical areas of regulatory focus.
 3. Companies and regulators need to ensure that this approach is in compliance with existing state laws.
 - a. The NAIC Model Unfair Trade Practices Law appears to contemplate either a "provide notice and opportunity for objection" approach or a "documented criteria must be maintained by the insurer and produced to the regulator upon request" approach, depending on the circumstances.
 - ii. Considerations:

1. Balance between holding companies accountable while not creating a burden that could prevent or slow up companies from pursuing beneficial programs.
 2. There may be mixed policies regarding pre-approval or filing of documentation by state. An effort to make any filing process as efficient as possible for regulators and companies should be pursued to avoid any unconstructive burdens.
 3. Companies being alerted that documentation must be available would likely ensure they at least attempt to address each of the issues prior to implementing a program.
 4. Would states be interested in being provided notice of development of a new wellness program? Would states want to be notified of every change in or addition to a program? In what form would the notification occur?
 5. Would a state have a right to object to an aspect of a program? If the objection leads to elimination of the program in that state, would that lead to other concerns, e.g., discrimination?
 6. Would development of a uniform LTC wellness template help creating uniformity in how states interact with companies offering programs?
 7. Need to determine consequences for a company that does not maintain the required documentation.
- iii. After experiencing several companies' pilot programs and identifying actual problem areas (as opposed to hypothetical issues), it is possible regulators will want to pursue a targeted pre-approval process or up-front receipt of documentation. That could be decided at a later date.
- d. Next steps
- i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.
 - ii. Consider developing a template that a company could fill in with narrative explanation of how they have considered identified issues in development of a LTC wellness program. An efficient manner to have this information received by interested regulators resulting from a single company filing (perhaps through SERFF or an NAIC portal) can be pursued.

7. Actuarial considerations

- a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?
- b. Current observations
 - i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.

- ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.
 - c. Addressing of Issues
 - i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.
 - ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
 - iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States' LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.
 - iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.
 - d. Next steps
 - i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy

- a. Issue: utilization of consumers' data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of Big Data or artificial intelligence to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third-party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
 - i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.
- b. Current observations
 - i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.

- ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.
 - iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.
 - iv. States' continuous adoption of data and privacy regulations will need to be available for insurers to assess the compliance of their wellness initiatives.
- c. Addressing of issues
- i. Data Use to Identify Wellness Initiatives:
 - 1. Policyholders' considerations:
 - a. Confusion about why they are being solicited for the initiative.
 - b. Suspicion about the motivation of the insurer.
 - c. General lack of awareness that data is being collected, and what data is being collected.
 - d. General lack the awareness or understanding on how data is collected and used.
 - e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
 - f. Will the policyholder know what data is going to be used prior to participation?
 - g. Should the policyholder have the option to "opt in/out" of their data being used internally for other initiatives or for external sale or use?
 - h. Should policyholders have the ability to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information?
 - 2. Insurer considerations:
 - a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
 - b. How should insurers use clear and concise notice about the collection, use, and disclosure of personal information?
 - c. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
 - d. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
 - e. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?

- f. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
 - g. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder's needs or preferences?
 - h. When using third party data providers, what screening or data protection programs are in place?
 - ii. Data Use During Wellness Initiative Development:
 - 1. Should insurers purchase policyholder specific information from third party data sources?
 - a. Data collected during purchases, search history, television programming, etc.
 - b. Should it always be headless, anonymized, or deidentified?
 - 2. When considering big data, are there unacceptable "correlations"? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
 - 3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
 - 4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder's claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
 - 5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
 - 6. Does the insurer have procedures in place to notify the policyholders of a potential breach?
 - iii. Wellness Results Data Use:
 - 1. Should the results be sold? Aggregate vs specific demographic information?
 - 2. Should insurers use the results internally for cross marketing other wellness initiatives?
 - 3. Should the policyholder be notified and have the option to "opt in/out" of letting the insurer use the data?
 - 4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
 - 5. How should the data be shared, if at all, with other vendors or service providers?
 - 6. How long will the data be retained? Will the data be destroyed or disposed?
- d. Dependencies

- i. Unfair Discrimination
- ii. States' adoption of wellness initiatives could make it difficult to implement a program uniformly.
- e. Next steps:
 - i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
 - ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
 - iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
 - iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
 - 1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
 - v. Can new contracts be written with evergreen access to some private data?

9. Other considerations

- a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
- b. Current observations
 - i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
 - 1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
 - ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
 - iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
- c. Next steps
 - i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?
 - ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.
 - iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.

- iv. Regulatory guidance may help innovators engage in this space.

10. Miscellaneous topics

- a. How will insurers report on issues and learnings?
- b. This document will likely need to be updated with new learnings or issues.
- c. Continuous collaboration with insurers regarding issues or new initiatives will likely be needed.
- d. Note that there are hybrid products that contain wellness benefits. However, the scope of this document is wellness associated with stand-alone LTC insurance policies, which tend to have more volatile financial profiles than hybrid products.

Checklist for Premium Increase Communications

Adopted by the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup 11/19/21

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

The Long-Term Care Insurance (EX) Task Force (Task Force) adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators who consider the checklist excessive, deficient, or not focused on issues specific to consumer experiences in their state are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and complaints, improve the quality of consumer communications, and ensure that consumer communications:

- Read in a clear, logical, not overly complex manner.
- Present options fairly and without subtle coercion.
- Include appropriate referrals to external resources, definitions, disclosures, and visualization tools.

The Task Force RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.

Checklist for Premium Increase Communications

Insurer name:	
Date of filing:	
Product form:	
Tracking number(s) SERFF <i>rate</i> filing:	
Tracking number(s) SERFF <i>form</i> filing:	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all required materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all new innovative RBO options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Do reviewers understand any variable information that appears in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Were state-specific or contract-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification Y before effective date. PA posts filed rate increase details on their website.	
Yes	No	N/A	READABILITY AND ACCESSIBILITY	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Are all technical insurance terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Is the communication in an easily readable font? For example: Is the type at least 11-pointtype?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Does the communication use headings to help the reader find information easily?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Are tables, charts, and other graphics, easy to read and understand? (See question 18 for reference).	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are the grade level and reading ease scores appropriate according to state readability standards?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are reduced benefit options clear and not misleading? For example: Are there side-by-side illustrations of options compared with current benefits?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>16. Does the communication include diminished contrast features that may make it harder to read? Examples include:</p> <ul style="list-style-type: none"> • Use of Italics • Narrow margins (top and bottom less than 1.5 inches) • All caps (all bold is acceptable) • Difficult to read text (fonts other than Sans Serif or Courier) • Different colors throughout • Small font <p>Reviewers should aim to review these communications in the size and contrast in which a consumer would see them; a print test may be beneficial.</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. If FAQs are included, are they succinct and easy to understand?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>18. Does the communication include notice that policyholders with disabilities and policyholders for whom English is not a first language can request ongoing accommodations that will enable them to read online and written materials and notices?</p> <p>For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.</p>	
Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the communication answer what is happening?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Does the communication answer why the consumer is receiving a rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Does the communication reflect negatively on the Department of Insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Does the communication indicate when the rate increase will be effective?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Does the communication clearly indicate the policyholder has options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description	

			of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Does the communication clearly explain that the consumer is not being singled out for the increase?	
Yes	No	N/A	COMMUNICATION TOUCH AND TONE	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Does the communication remind consumers to reflect on the original reason they bought the policy?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication express an understanding of the difficulty of evaluating choices?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Are the options represented fairly? Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded when the other options are not.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider demonstrating immediacy by using the word "now and avoiding words like "must." Consider "manage an increase" instead of "avoid an increase."	
Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Are website links accurate and functional?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial advisor, producer, state SHIP program (where applicable) with the state-specific name of the program or trusted family member?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the Insurer encourage consumers to consult the Department of Insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?	
Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the number of options presented reasonable? If there are more than 5, engage with insurer to understand what is being presented	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Is the right to reduce coverage at any time of a policyholder's choosing clear? Are the instructions about how to do that clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?	
Yes	No	N/A	UNDERSTANDING OPTIONS – PAST RATE ACTIONS	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?	
Yes	No	N/A	UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication indicate what the reader must do to elect an option and provide a deadline to do it?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. If options are only available during the decision window, is that limitation clear to consumers?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. Does the communication indicate what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?	
Yes	No	N/A	UNDERSTANDING OPTIONS – CURRENT BENEFITS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication include all the following applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. If current benefits have an inflation option, does the communication clearly explain the impact that changes to this inflation option may have on benefits now and in the future?	
Yes	No	N/A	UNDERSTANDING OPTIONS – PERSONAL DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown options that are not available to them)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of care?	

Yes	No	N/A	UNDERSTANDING OPTIONS – VALUE OF OPTIONS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Is the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options clear that there is a reduction in the current policy's LTC benefits? The narrative does not have to include the dollar value for CNF.	
Yes	No	N/A	UNDERSTANDING OPTIONS – IMPACT OF DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. If dropping inflation protection results in the loss of accumulated benefit amount, is that clearly explained?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55. For phased-in increases: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first rate increase or will be available during each phase of the rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. For phased-in increases, are there communications sent at least 45 days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Does the communication disclose that all reduction options require careful consideration and may not be equal in value?	