

Date: 8/3/21

*2021 Summer National Meeting
Columbus, Ohio*

LONG-TERM CARE INSURANCE (EX) TASK FORCE

Followed by

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

Friday, Aug. 13, 2021

3:00 – 4:30 p.m.

Greater Columbus Convention Center—Union Station Ballroom—Level 1

ROLL CALL

*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	Doug Slape*	Texas
James J. Donelon*	Louisiana	Johnathan T. Pike*	Utah
Eric A. Cioppa	Maine	Michael S. Pieciak*	Vermont
Gary D. Anderson	Massachusetts	Mike Kreidler*	Washington
Anita G. Fox*	Michigan	James A. Dodrill*	West Virginia
Grace Arnold*	Minnesota	Mark Afable	Wisconsin
Mike Chaney	Mississippi	Jeff Rude	Wyoming

NAIC Task Force Support Staff: Jeffrey C. Johnston/Jane Koenigsman/Eric King

LONG-TERM CARE INSURANCE (EX) TASK FORCE AGENDA

1. Consider Adoption of its July 6 Minutes
—*Commissioner Scott A. White (VA)* Attachment One
2. Receive the Reports of its Subgroups

- A. LTCI Financial Solvency (EX) Subgroup
—*Fred Andersen (MN)*
- B. LTCI Multistate Rate Review (EX) Subgroup
—*Commissioner Michael Conway (CO)* Attachment Two
- C. LTCI Reduced Benefit Options (EX) Subgroup
—*Commissioner Jessica K. Altman (PA)* Attachment Three
- 3. Release the LTCG Actuarial Consulting Group Report
—*Commissioner Scott A. White (VA)* Attachment Four
- 4. Discuss its Timeline and Next Steps—*Commissioner Scott A. White (VA)*
- 5. Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Scott A. White (VA)*
- 6. Adjourn into Subgroup Session—*Commissioner Scott A. White (VA)*

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

- 7. Discuss Revisions to the Operational Section of the Draft Multistate Rate Review Framework (4/9/21 Draft)—*Commissioner Michael Conway (CO) and Rhonda Ahrens (NE)*
- 8. Hear Comments on the Exposure Draft of the Actuarial Section of the Draft Multistate Rate Review Framework (6/10/21 Draft)
—*Commissioner Michael Conway (CO)* Attachment Five
- 9. Discuss Any Other Matters Brought Before the Subgroup
— *Commissioner Michael Conway (CO)*
- 10. Adjournment

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Draft: 7/12/21

Long-Term Care Insurance (EX) Task Force
Virtual Meeting
July 6, 2021

The Long-Term Care Insurance (EX) Task Force met July 6, 2021. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, represented by Sydney Sloan (CO); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by John Reilly (FL); Colin M. Hayashida (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Dana Popish Severinghaus (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt (KS); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented by Fred Andersen (MN); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Rhonda Ahrens (NE); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler (WA); Mark A. Fable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. Adopted its Spring National Meeting Minutes

Commissioner Altman made a motion, seconded by Superintendent Toal, to adopt the Task Force's April 9 minutes (*see NAIC Proceedings – Spring 2021, Long-Term Care Insurance (EX) Task Force*). The motion passed unanimously.

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

Mr. Andersen said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met June 22 to discuss comments received on the exposure draft of the operational sections of the Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (LTCI MSA Framework).

Mr. Andersen said during the call, Michigan provided comments that included, among other issues:

- Further clarification is needed regarding the role of the Interstate Insurance Product Regulation Commission (Compact).
- The benefits of the Multi-State Actuarial LTCI Rate Review (MSA) process to states will only be realized if most states use the process and rely on the MSA review results.
- Michigan agrees that the governing body for the MSA team should be the Long-Term Care Insurance (EX) Task Force, but it believes there needs to be a regulator-to-regulator technical group like the Financial Analysis (E) Working Group or the Valuation Analysis (E) Working Group that oversees the analytical process and formally approves the MSA Advisory Reports.
- Many states, including Michigan, may be unable to keep the MSA Advisory Report confidential if it is relied upon in the rate determination, as state confidentiality provisions often do not extend to rate review authority.

Mr. Andersen said a joint comment letter was received from the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP). He said their comment letter included, among other issues:

- Transparency of the MSA process is critical to its success. Insurers should receive the MSA Advisory Report to have meaningful conversations with state insurance regulators before the MSA Advisory Report is finalized. Insurers need to know which states relied on the MSA Advisory Report, and to what extent, in making their rate increase determinations.
- A majority of both insurers and states need to participate in the MSA process to ensure its success.
- There needs to be a balance between adequate insurer confidentiality and providing enough information to stakeholders in MSA rate reviews.

Mr. Andersen said a comment letter was received from the American Academy of Actuaries (Academy). He said the Academy's comment letter included, among other issues:

- The MSA team should be supervised by actuaries qualified in LTCI, and they should be members of the Academy to help ensure compliance with Actuarial Standards of Practice (ASOPs).
- Participation of an adequate number of states is needed for the MSA process to be successful.
- The MSA process should be streamlined to collect all necessary rate review information without duplicate requests to insurers from states.

Mr. Andersen said the Subgroup found all the comments to be helpful, and it instructed the drafting group to address the comments. The drafting group will continue working on edits to the operational draft in response to the comments, and the Subgroup will re-release it for a short comment period when it is ready. The next version is expected by the Summer National Meeting.

Mr. Andersen said the first draft of the actuarial aspects of the LTCI MSA Framework was released for a 45-day public comment period ending July 26. The draft provides complete details on how the MSA team will evaluate a submitted rate proposal under the Texas and Minnesota actuarial methodologies.

Commissioner Richardson made a motion, seconded by Superintendent Toal, to receive the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup. The motion passed unanimously.

3. 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 May 4. During this meeting, the Subgroup began work on its charge of, "potential development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care services, including evaluation of the suitability of and regulatory barriers to proposed options."

Commissioner Altman said 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 issues that 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 the Subgroup exposed a draft Reduced Benefit Options (RBO) Consumer Notices Checklist for a 30-day public comment period ending July 21. The checklist is intended to establish a consistent approach to drafting and reviewing LTCI RBO policyholder communications. The checklist can be used by states for guidance, and it is not required to be used for the review of insurer communications with policyholders. The next meeting of the Subgroup is July 22.

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

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

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Draft: 7/12/21

Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
Virtual Meeting
June 22, 2021

The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met June 22, 2021. The following Subgroup members participated: Michael Conway, Chair (CO); Paul Lombardo (CT); Philip Barlow (DC); Benjamin Ben (FL); Stephen Chamblee (IN); Andria Seip (IA); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Rhonda Ahrens (NE); Russel Toal (NM); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Andrew Dvorine (SC); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); and Mike Kreidler (WA). Also participating was: Perry Kupferman (CA).

1. Discussed Comments on a Framework Draft

Mr. Conway said the Subgroup received comments on an exposure of the operational sections of a draft Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (Framework) from the Michigan Department of Insurance and Financial Services (DIFS), the American Academy of Actuaries (Academy), the American Council of Life Insurers (ACLI), and America's Health Insurance Plans (AHIP). He said the Subgroup also exposed the actuarial sections of the Framework with comments due July 26, and another meeting will be held to discuss comments received on the actuarial sections.

Mr. Conway said the Subgroup has been discussing how the Advisory Reports (Reports) produced by the Multi-State Actuarial LTCI Rate Review Team (MSA Team) will be kept confidential, whether they will be kept confidential, and whether they should be kept confidential. He said as states rely on the Reports in making rate increase decisions, it will be necessary to make public the aspects of the Reports state insurance regulators relied upon to inform interested parties of the reasoning behind rate increase decisions.

Ms. Dennis gave a summary of comments submitted by the Michigan DIFS. She said Michigan seeks further clarification regarding the authority of the Interstate Insurance Product Regulation Commission (Compact) to accept and maintain filings under the MSA review. She said if the Compact infrastructure is being used simply to facilitate sharing and monitoring among states, Michigan recommends that a separate System for Electronic Rate and Form Filing (SERFF) area be created outside of the Compact that permits the submission of MSA filings without accidentally falling under the authority of the Compact.

Ms. Dennis said Michigan has concerns that the MSA review process may duplicate rate review efforts made by states if the work of the MSA Team is not coordinated with individual states. She said many states, including Michigan, may be unable to keep the Reports confidential if they are relied upon in the rate determination, as state confidentiality statutes often do not extend to rate review authority. She said the benefits of the MSA process to states will be realized only if the majority of states use the process and rely on the MSA review results.

Ms. Dennis said Michigan agrees that the governing body for the MSA Team and process should be the existing Long-Term Care Insurance (EX) Task Force, but it suggested that there needs to be an active regulator-to-regulator technical group, similar to the Financial Analysis (E) Working Group or the Valuation Analysis (E) Working Group, to oversee the analytical process and formally approve the Reports.

Mr. Conway said the Subgroup agrees that the success of the MSA process depends on having enough states participate, and the Subgroup will continue to research and address issues related to the confidentiality of the Reports. He said the Subgroup will continue work on developing a structure for governance of the MSA process.

Jan Graeber (ACLI) gave a summary of comments (Attachment **XX**) submitted by the ACLI and AHIP. Mr. Conway asked if the ACLI and AHIP are requesting that the Reports' confidentiality be based on each state's respective confidentiality laws. Ms. Graeber said that depends on the granularity of the contents of the Reports. She said any information that is normally treated as confidential in a rate filing should not be in a public version of the Reports.

Andrew Dalton (Milliman) gave a summary of comments (Attachment **XX**) submitted by the Academy. Ms. Ahrens said she agrees that at least one key member of the MSA Team should be a member of the Academy, but she also envisions the MSA process as a vehicle for developing actuarial resources through mentoring people that are not yet Academy members. Mr. Kupferman said rate increases on group LTCI blocks should be reviewed under the MSA process. Mr. Conway said the

Subgroup will discuss the inclusion of group blocks in the review process, and he does not think their review was intended to be excluded.

Mr. Conway said the Subgroup will continue working on edits to the operational sections of the draft in response to the comments, and it will then re-expose it for additional comment.

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

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Draft: 7/29/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
July 28, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met July 28, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Sarah Bailey (AK); Perry Kupferman (CA); Susan Jennette (DE); Andria Seip (IA); Dana Popish Severinghaus (IL); Rich Piazza (LA); Larry D. Deiter (SD); Brian Hoffmeister (TN); 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 RBO Consumer Notices Checklist.

Ms. Van Fleet presented comment letters received (Attachment, Attachment, Attachment, Attachment) in response to an exposure of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist). She presented a version of the draft (Attachment) that incorporates the comments, with notes on the proposed treatment of each comment.

Discussion of the comments ended with question 39 of the Checklist. Commissioner Altman said the Subgroup will schedule another meeting to finish discussion of the comments.

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

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Draft: 7/27/21

Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
July 22, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met July 22, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Lori K. Wing-Heir (AK); Perry Kupferman (CA); Trinidad Navarro (DE); Andria Seip (IA); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Rhonda Ahrens (NE); Larry D. Deiter (SD); Carter Lawrence (TN); Tomasz Serbinowski (UT); Scott A. White and Thomas J. Sanford (VA); and Anna Van Fleet (VT).

1. Exposed an LTCI Innovation and Wellness Program Issues Draft

Mr. Andersen presented a draft document (Attachment) that discusses issues related to long-term care insurance (LTCI) wellness programs. He said the Subgroup wants to receive public feedback on the document, have collaborative discussions about key issues, and revise the document accordingly. He said the Subgroup intends to provide clarity on the key issues by the end of the year.

Mr. Andersen gave an overview of the draft's background section, Section 1, Section 3, and Section 7. He said industry tax experts and the federal government will be consulted to add to Section 5. He said Section 6, Section 7, and Section 9 are still being developed. Mr. Sanford gave an overview of Section 2 and Section 4. Ms. Logue gave an overview of Section 8.

The Subgroup agreed to expose the document for a 45-day public comment period ending Sept. 5.

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

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Draft: 6/7/21

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

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met May 4, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Lori K. Wing-Heir (AK); Perry Kupferman (CA); Trinidad Navarro (DE); Andria Seip (IA); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Larry D. Deiter (SD); Carter Lawrence (TN); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); and Joylynn Fix (WV).

1. Heard Presentations on LTCI Innovation and Wellness Programs

Mr. Andersen said the purpose of the meeting is to help identify potential issues with offering wellness programs to policyholders with in-force long-term care insurance (LTCI) policies. He said the Subgroup plans to identify all such issues and begin addressing the issues over the following few weeks with the assistance of state insurance regulators and interested parties. He said the primary goal of implementing wellness programs is to improve policyholder health and lower claim costs for insurers, leading to fewer and lower rate increases and less insurer financial distress.

Vince Bodnar (Bain Capital Insurance) said he has been working with several carriers on thinking through various wellness program offerings and will give an overview of where industry stands with implementing these programs. He said wellness programs are common with health insurance (HI) and that LTCI wellness programs are not the same as those for HI. He said LTCI is generally purchased by younger people and kept for decades before it is used. He said there is much known through initial underwriting about an LTCI policyholder's health at issue, but much less is known decades later at the time when claims are likely. He said LTCI carriers do not have much information about what sorts of interventions are helpful for LTCI policyholders, so they must look to other programs, such as Medicaid Managed Long Term Services and Supports (MMLTSS) and continuing care retirement communities (CCRC) for ideas that may be transferrable to LTCI. He said another handicap for carriers is that there are no long-term care (LTC) provider networks similar to those for HI. He said there are roughly 200,000 to 300,000 people on claim nationwide out of approximately 6,000,000 policyholders, so the volume needed to support provider networks is not available.

Mr. Bodnar said interest in wellness programs has increased greatly over the past two years. He said most carriers now have staff assigned to investigate wellness program issues and are beginning to offer pilot wellness programs to policyholders. He said a recent Intercompany Long Term Care Insurance (ILTCI) conference featured an LTCI wellness track, which included nine different sessions.

Mr. Bodnar said industry has been careful about what these programs are called so there is not a perception that these are efforts to avoid paying claims. He said the programs are being portrayed as ways to enhance policyholder health and to help them age in place if so desired.

Mr. Bodnar said there is an emerging provider service landscape that has made itself known over the past year or so. He said it is composed of providers that already serve MMLTSS and CCRC customers. He said there are also emerging financial technology, InsurTech and health technology providers that are showcasing technology and data analytic services for wellness programs. He said carriers are becoming aware of these providers and what services are offered.

Mr. Bodnar said some carriers are just beginning to become aware of what services can be provided, while others are farther along and are conducting pilots for working wellness programs. He said currently active pilots can be divided into two categories. He said the first focuses on the pre-claim population. He said pilots of this type tend to be holistic in their approach and do not center on any particular service, but rather they reach out to policyholders to assess their needs with home modifications or durable medical equipment. He said these programs usually divide their policyholder populations into a control group that is not offered the program and a test group that is offered the program. He said the second category is for the on-claim population, and they are designed to provide coordination of care for the claimant. He said these pilots are most concerned with those receiving care at home and minimizing transfers from home care to more expensive facility care. He said several of the carriers offering these pilot programs have received positive feedback from policyholders.

Charlie Philbrook (John Hancock) said one of his responsibilities at John Hancock is the company's LTC wellness offering, the Living Independently and Falls-free Together (LIFT) program. He said it is a pilot program that has been in operation for a few years and is nearing its end. He said offers for the program are mailed to policyholders, followed with phone calls to them to increase participation. He said mailings were limited to policyholders ages 85 and older, as they are more likely to experience falls than younger policyholders. He said once the offer is accepted, a health coach visits the policyholder for a face-to-face assessment, with the primary goal of improving the insured's physical environment. He said this includes looking for loose rugs and other slip and fall hazards, grab bars in the bathroom, and shower seats. He said the program has evolved to where questions are asked about nutritional and sleep habits, but the focus is still mainly on the insured's physical environment. He said an action plan is then provided to the insured that lists ways to improve the physical environment, and then follow-up calls are made every three months to check on progress towards completing the plan. He said the program ends after one year. He said the assessment and action plan are free to the insured, but any modifications to their home are the insured's responsibility.

Mr. Philbrook said the LIFT program began in 2008 when John Hancock and another carrier partnered with a vendor and participated in a pilot program that was funded by the U.S. Department of Health and Human Services (DHHS). He said roughly 1,000 policyholders participated in the pilot, and the program ended and was not reinstated until three years ago when it was resumed by John Hancock.

Mr. Philbrook said the success of the pilot is measured in terms of if a positive impact is made on customers' lives and if a positive impact is made on John Hancock by delaying claims by making home environments safer. He said nothing but positive feedback about the program has been received from customers. He said the health coaches gain the insureds' trust, and there are stories of insureds wanting to speak with a health coach more frequently than every three months. He said despite all the positive feedback, only about 10% of eligible insureds enroll in the program. He said this acceptance rate is common with other insurers offering similar programs.

Mr. Philbrook said it takes at least five years for experience to emerge that will enable an insurer to measure the impact on claims that a wellness program may have. He said an insurer should examine reductions in claim incidence over the first year or two, and then examine impacts to claim continuance over the next four or five years. He said John Hancock is only just beginning to scratch the surface of its pilot claims experience, as the program has only been operational for about three years.

Mr. Philbrook said there is the possibility of downside risk from a wellness program to an insurer in the form of decreased mortality due to better insured health and fewer policyholder lapses due to the enhanced insured engagement created by the program.

Mr. Philbrook said John Hancock is examining whether there are increases in claim duration that may be caused by delaying claim incidence.

Mr. Philbrook said three things have been learned from the pilot program. He said the program was likely too narrowly focused on the insureds' physical environments. He said more effort should be made by John Hancock to assist in implementing the action plan, such as installing grab bars in the insured's home, or setting up home meal deliveries. He said there was a selection bias in that healthier insureds tended to enroll in the program more often than the less-healthy ones, and it is unhealthy people that will benefit most from a wellness program.

Mike Gugig (Transamerica) said he will give an overview of what the future state of home care might look like in the next few years, particularly given rapid technological advances. He said he wants to give a sense of how care coordinated between providers and insurers may work but be clear that insurers cannot accomplish this on their own. He said enabling policyholders to continue to live in their homes instead of transferring to an assisted living facility is beneficial to both the insurer and the policyholder. He said the majority of policyholders prefer to remain in their homes. He said a 2018 AARP study found that 77% of adults aged 50 and over in the U.S. want to remain in their homes as long as possible as they age, but only 50% of those surveyed realized that in-home LTC options are available.

Mr. Gugig said if Transamerica is able to establish a safe home setting for provision of LTC services, he thinks policyholders will react positively and will have a better quality of life. He said using home care results in lower benefit payments, which leaves more in the pool of money available to the insured if they do ultimately need to receive institutional care. He said lower claims costs also benefit the insurer and remaining policyholders in that lower claims costs result in less need for rate increases.

Mr. Gugig said in situations where family members are providing informal LTC, there is a risk of the burden being so great that they decide that the insured will have to be placed in a facility. He said offering the option of home care can prevent the insured's transition to institutional care.

Mr. Gugig said many studies show that caregivers, both professional and unpaid, are negatively affected by the current state of home care. He said when caregivers experience burnout, the likelihood of the patient transferring to facility care greatly increases. He said providing support for caregivers is critical, and his hypothetical future state of home care includes technology that will allow caregivers to take a break. He gave an example of an 85-year-old woman who is cognitively impaired but not so severely that she is unable to do anything for herself. He described this individual as being right at the point of being eligible to go on claim. He asked what can be done to ensure she remains in her home as long as possible and what can be done to ease her caregiver's burden. He proposed developing a systemic approach to care that will ease burdens on patients and caregivers using a set of technologies that will monitor patients and alert caregivers when necessary. He said some examples are the use of simple technologies to determine if the patient is using water in the bathroom as an indication of whether they are getting out of bed, electrical monitors to determine if the refrigerator is being opened or an oven has been used, and door and window sensors to determine if doors or windows have been opened at an unusual time. He said geofencing can be used as a virtual fence to alert caregivers if the patient has left their home. He said bed monitors can determine when the patient left the bed. He said a single application can be used to integrate all of these monitoring technologies into one place. He said ridesharing or state disabled transportation services can also be incorporated into the application and that using these services can ease the burden on the caregiver of transporting the patient to medical and other appointments.

Mr. Gugig said increasing the prestige of paid caregivers' positions, pay for this work and creating opportunities for career growth can help create a better future state of home care. He said one way to expand the role of paid caregivers is to train them in the use of patient monitoring technologies and make them the point of contact for patient alerts.

Mr. Gugig said the coordination of care between policyholders, insurers and care providers is essential to the success of the future state of home care services.

Nolan Tully (Faegre Drinker Biddle & Reath LLP) said unfair discrimination concerns, rebating concerns and tax qualification issues as they relate to LTCI wellness program offerings are items state insurance regulators and lawmakers need to address. He said it is important to remember that underwriting of an insured depends on some level of discrimination, but the key element is that this discrimination is not unfair. He said all wellness interventions are not appropriate for all policyholders. He gave the example of a fall prevention program being appropriate for an 85-year-old but not a 60-year-old. He said programs aimed at preventing or delaying the development of cognitive impairment should generally be targeted towards younger policyholders. He said carriers he has worked with are sensitive about how they introduce wellness programs, how they develop pilot programs and how they identify which policyholders are the best fit for program participation. He said that the carrier community has rolled out programs using broad consent, with policyholders having to opt into a program, and that he has not seen any carrier contemplate or move forward with a program that did not require a policyholder to affirmatively opt-in. He said programs have also been implemented that do not target any one group of policyholders, but rather they wait for any policyholder to enroll without prompting.

Mr. Tully said an important element of these programs is their reliance on technologies such as artificial intelligence (AI), predictive modeling and logarithmic computing. He said the carrier community is careful that the technological components of these programs are devised and implemented in a nondiscriminatory way, and these elements continue to be monitored for non-permitted discrimination throughout the program pilots. He said input from the regulatory community on discrimination issues will make it easier to structure pilots and their implementation.

Mr. Tully said the proposed amended Section 4 H of the NAIC *Fair Trade Practices Act* (#880) as it relates to rebating has had a significant positive impact on wellness program development. He said there are a number of specifically excepted rebating practices that are helpful to wellness program implementation, and he encourages state legislatures and state insurance regulators to adopt the proposed changes.

Mr. Tully said Section 7702 B of the federal Internal Revenue Code sets forth the triggers that are required to be present in a tax-qualified LTCI policy. He said a tax-qualified policy must count severe cognitive impairment or requiring substantial assistance with two or more activities of daily living (ADLs) as triggers for LTCI benefit eligibility. He said by the time this threshold has been reached, it is too late to intervene in a way that will materially prevent further deterioration. He said there are many wellness programs that can be beneficial to the policyholder, but they will need to be in effect before the eligibility triggers have been reached, possibly decades prior. He said he thinks resolving these issues will require engagement with the federal government and the U.S. Department of the Treasury (Treasury Department).

Mr. Andersen said in addition to the issues discussed today, difficulty for insurers in evaluating the effectiveness of wellness programs on claim cost reduction, data privacy issues, and general fairness and reasonableness of the offerings all need to be considered. He said another issue for state insurance regulators is their role in preapproving and reviewing proposed programs, and what the review process will look like. He said there is a large number of ideas for wellness programs, and state insurance regulators will need to be cautious of focusing on only a few of these ideas at the risk of excluding others.

Ms. Altman said there are many startup companies currently leveraging data analysis, and data integrity and how data is used are important considerations. She asked how the presenters are considering these issues as they form new partnerships with these companies. Mr. Bodnar said conversations he has had with carriers indicate that data privacy is a large concern to them, and this concern has created something of a barrier to carriers partnering with vendors. He said the vendors are used to having access to more data for other health insurance applications than is generally available from LTCI policies. He said carriers have no hard knowledge of what interventions are effective, and they need more information on what causes an insured to go on claim. He said often the reason for going on claim is a social issue rather than a medical one, and data related to social issues is needed to make intervention models effective. He said building the predictive analytic structure needed for this is important, but he said he has not seen much progress toward this. Mr. Tully said he has seen the same thing and that carriers are focused on these issues when developing pilot programs. He said what is seen in the pilots will govern how data privacy issues are addressed with vendors for future programs. He also said carriers should ensure that the results of data collection and analysis do not produce unintended results. Mr. Gugig said he understands that carriers have been performing data security due diligence before partnering with vendors.

2. Asked for Volunteers for an RBO Consumer Notices Checklist Drafting Group

Ms. Altman said the Subgroup plans to resume work on the Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) it had begun working on last year. She asked for volunteers to join a drafting group to revise the Checklist before it is exposed for public comment.

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

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Attachment Four

LTCG Report

The background of the slide features a black and white photograph of a tall, cylindrical lighthouse situated on a rocky island. The lighthouse has a glowing light at the top, and the sky is overcast. The right side of the slide is overlaid with a dark blue, semi-transparent geometric shape that contains the text.

NAIC LTC Data Call Workstream #6 Suggested Public Presentation

Matt Morton FSA MAAA
Kirill Grin ASA MAAA

June 25, 2021

LTC Data Call Agenda

Executive Summary	<p>Takeaways on the current level of rate differences among state policyholders from the analysis performed on data collected from 19 carriers across 50 states.</p>
Scope	
Data Collection	
Analysis	
Cumulative Approved	
Rate Increase	
Rate Increase Approvals	
Cost of Care	

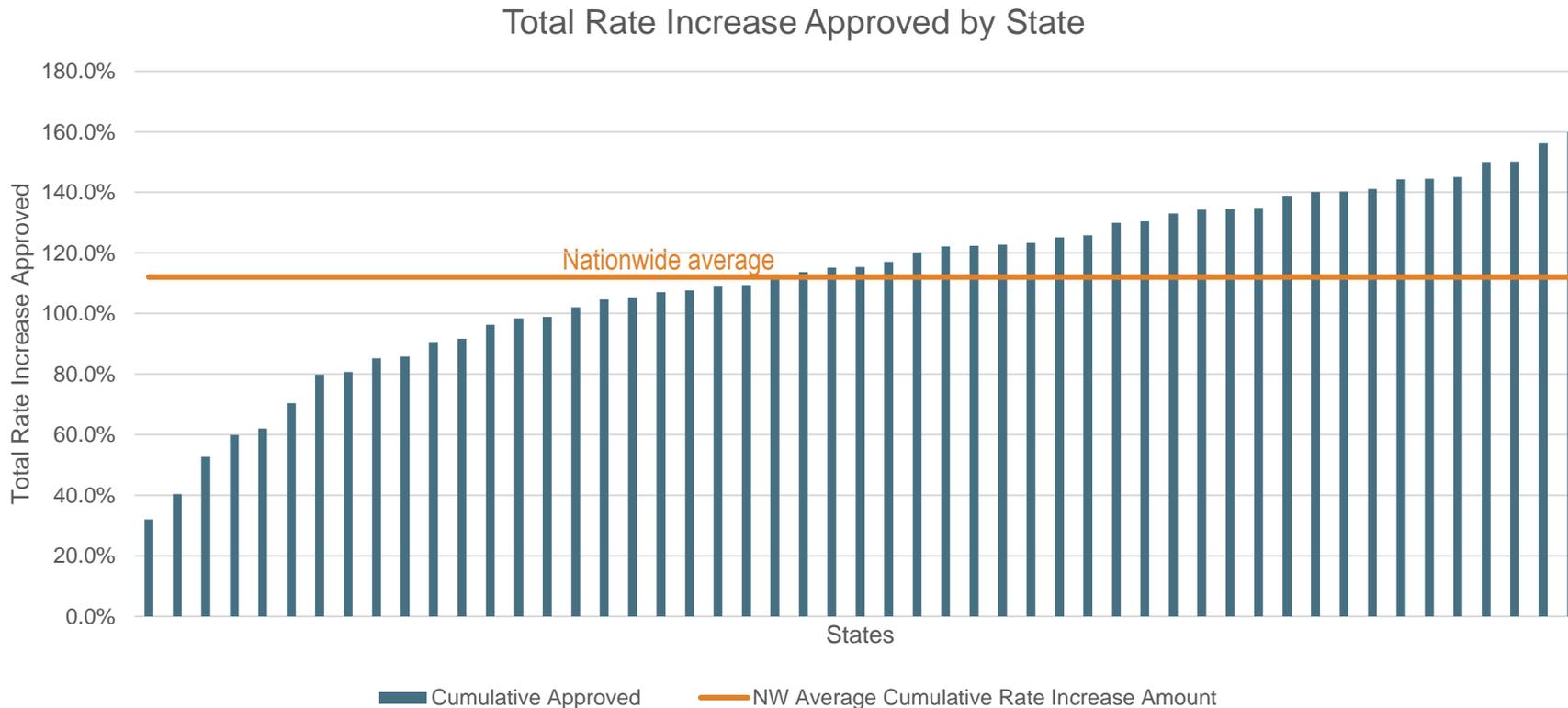
Executive Summary – Key Takeaways

1. LTC rate increase approval disparities exist between states.
2. Premium inconsistencies exist among states as premium per policy varies greatly. Average premium ranges from \$1,755 - \$3,656, despite similar benefit distributions.
3. The cost of long-term care services does not appear to be the primary predictor of a state's LTC claim experience.

Executive Summary – Key Takeaways

Question:

Are LTC rate approvals consistent by state?



Outcome:

Evidence suggests inconsistent rate approval levels by state

1. Data from 19 carriers and 50 states.
2. About 1/3 of industry.
3. 3,500+ approved rate increases.

See Cumulative Approved Rate Increase section for further detail

Executive Summary – Key Takeaways

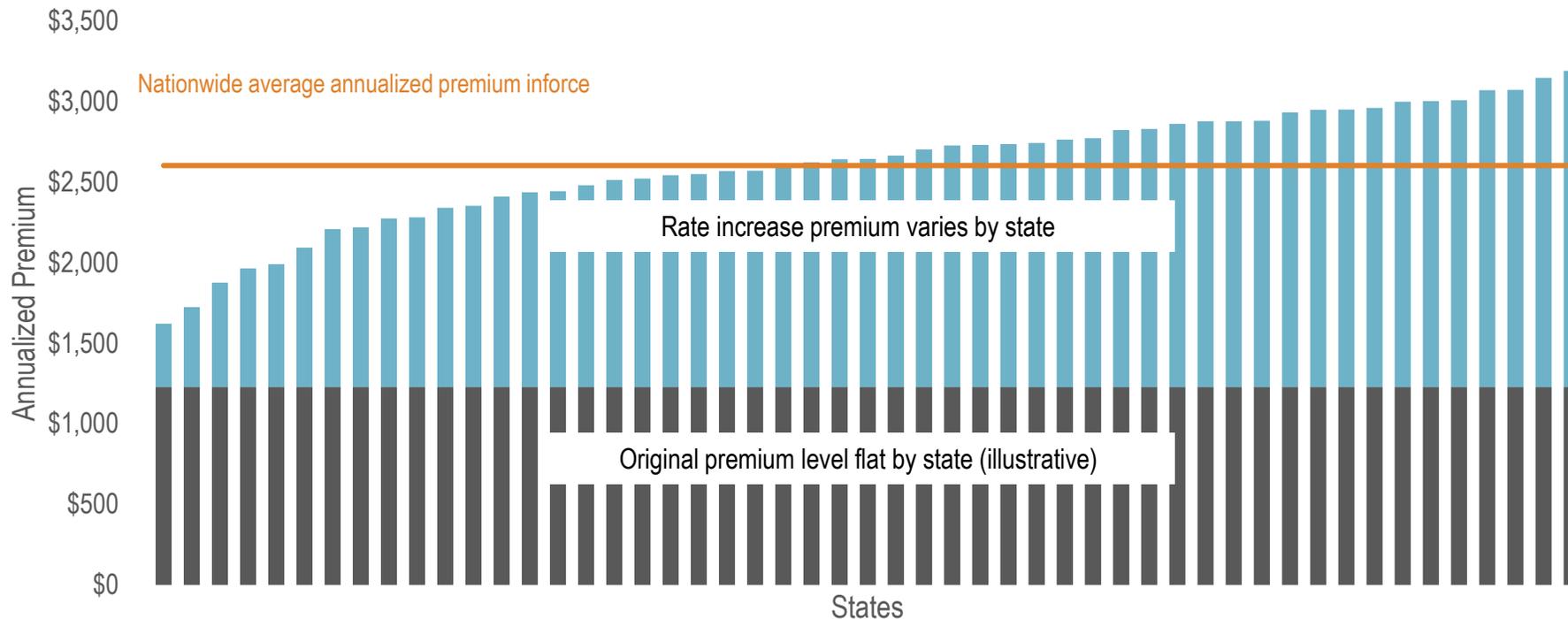
Question:

How much premium is attributable to rate increases?

Outcome:

Illustration uses actual rate increases and a theoretically level nationwide original premium.

Annualized Premium Inforce by State Demonstration



1. Impact of state specific cumulative approvals on annualized premium based on nationwide averages.
2. Nationwide average annualized premium inforce is \$2,603.
3. Nationwide average cumulative approved rate increase is 112%.
4. Illustrative original premium levels.

*For demonstration purposes only

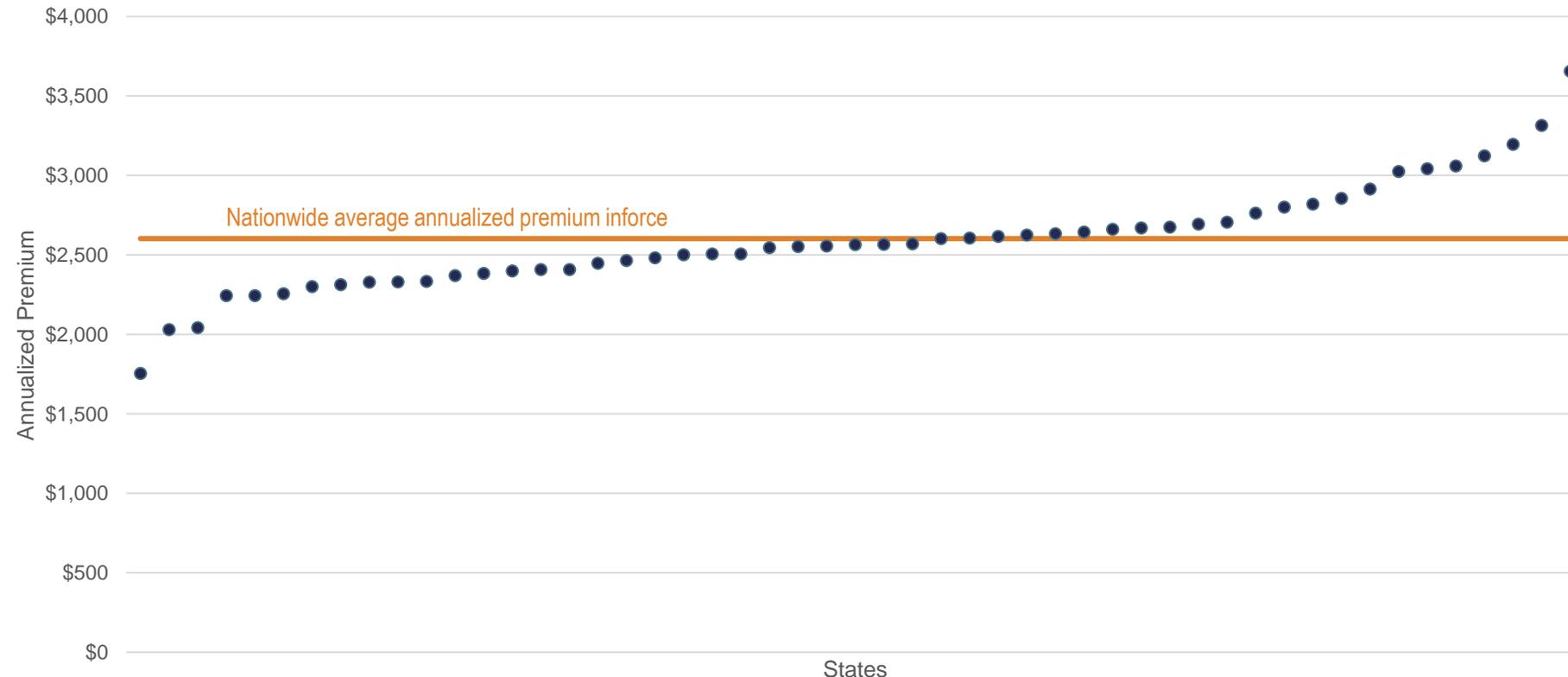
Executive Summary – Key Takeaways

Question:

Are premium levels for inforce policies consistent?

Outcome:

Evidence suggests consumers are paying different premiums by state, despite similar benefit structure distribution



See Data Collection section for support and further detail

1. The average annualized premium by state ranges from \$1,755 - \$3,656.
2. Average nationwide annualized premium inforce is \$2,603.
3. Benefit distribution mix is a partial contributor to differences by state.

Executive Summary – Key Takeaways

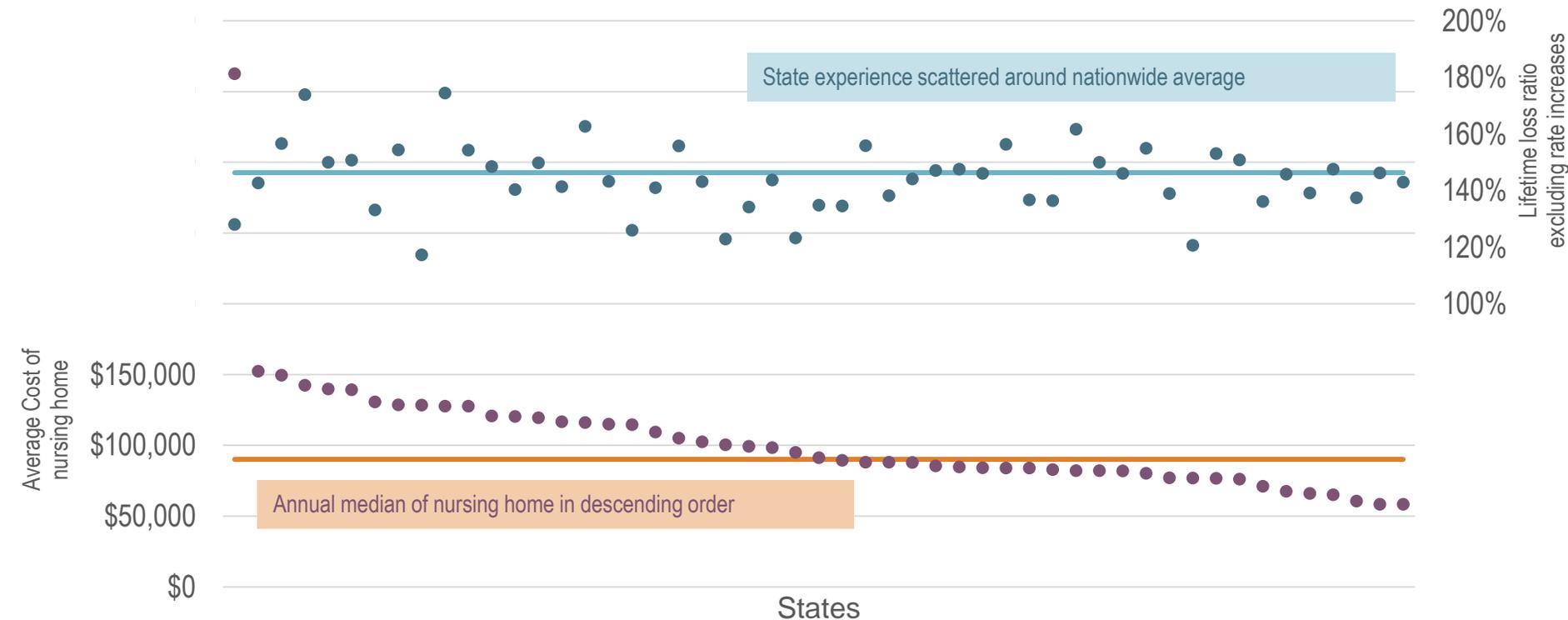
Question:

Does the cost of LTC services in a state drive insurance experience?

Outcome:

The cost of a nursing home does not appear to be a primary predictor of state LTC experience.

1. No clear pattern of lifetime loss ratio by state as current cost of care decreases.
2. Nursing home costs based on 2019 Genworth cost of care study (other care settings available in later section).



See the Cost of Care section for further detail

A grayscale photograph of a tall, cylindrical lighthouse situated on a rocky, mountainous island. The lighthouse has a glowing light at the top, and the sky is overcast. The image is partially obscured by a large, dark blue, semi-transparent geometric shape that covers the right side of the frame.

Supporting Documentation

LTC Data Call Agenda

Executive Summary	Outline of purpose and goal of NAIC Workstream #6.
Scope	
Data Collection	
Analysis	
Cumulative Approved Rate Increase	
Rate Increase Approvals Cost of Care	

Project Scope

- Assist the NAIC Long-Term Care Insurance Task Force and with the help of and under the authority of the Virginia Bureau of Insurance, with facilitating a Long-Term Care Information Data Call with respect to a designated group of long-term care insurers in order to accumulate, analyze and describe to Commissioners the current level of rate differences among state policyholders.

Purpose Of Documentation

- This report summarizes and analyzes the data collected from all carriers for their most rate increased blocks. Data for carrier's largest blocks was collected and reviewed, but not used in the analysis herein.
- State specific experience is compared against nationwide averages for the following:
 - Number of rate increase approvals
 - Cumulative approved rate increase amount
 - Lifetime loss ratios
 - Cashflows including impact of rate increases on lifetime earned premium
 - Cost of Care

LTC Data Call Agenda

Executive Summary	Summary of data collected as well as inforce statistics on both the largest blocks and most rate increased blocks of business as collected in this Data Call.
Scope	
Data Collection	
Analysis	
Cumulative Approved Rate Increase	
Rate Increase Approvals	
Cost of Care	

Data Collected

- 19 Insurers have submitted data for their most rate increased blocks as well as largest blocks, if different. Data collected includes 27 LTC blocks of business.
- Over 2.5 million inforce policies provided (about 1/3 of industry).
- Over 3,500 approved rate increases.
- Approximately \$50 billion of active life reserves.
- The information and analysis contained in this report are based on this collected information. No external information was used to support this analysis with the exception of the 2019 Genworth Cost of Care Survey.

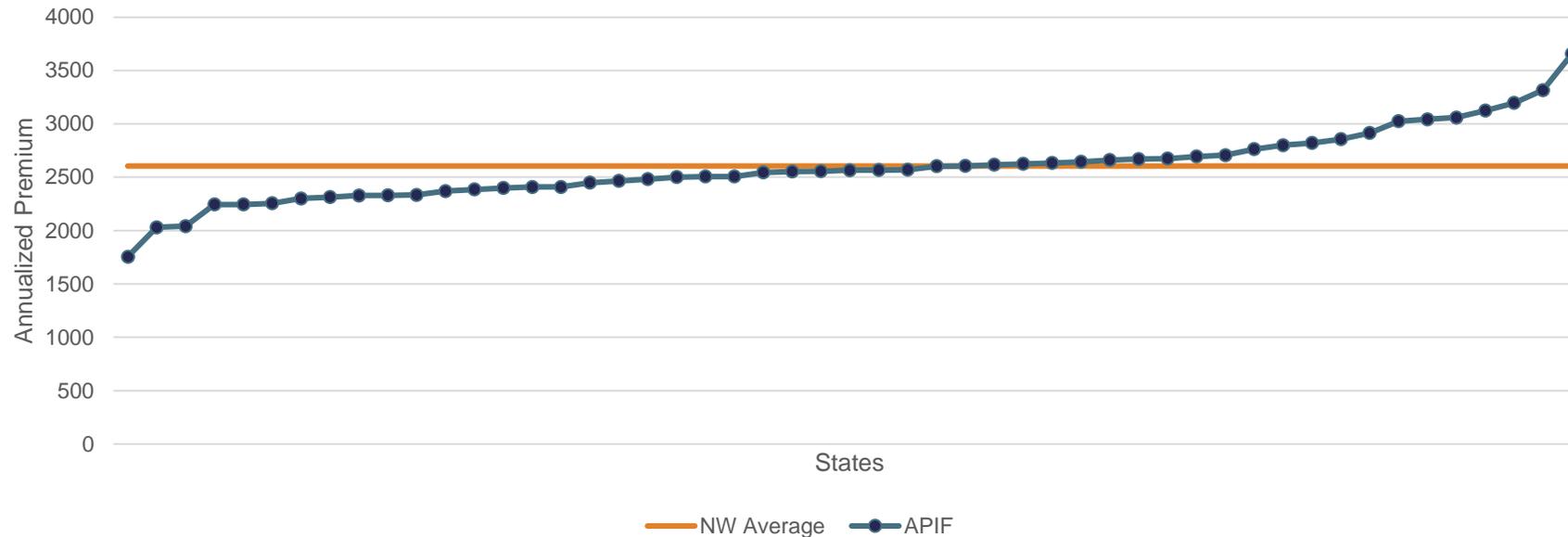
Inforce Statistics

	Most Rate Increased Blocks	Largest Blocks
Average Attained Age	74.8 Range:72.7–76.8	70.8 Range:68.6–72.6
Average Inforce Policy Count	23.8k Range:1.5k–136.7k	37.2k Range:2.3k–67.3k
Average Inforce Annual Premium	\$2,603 Range:\$1,755-\$3,656	\$1,952 Range:\$948-\$3,174
Average Lifetime Loss Ratio w/o Rate Increases	146.3% Range:117.3%-174.5%	120.0% Range:96.2%-153.1%
Average Lifetime Loss Ratio w/ Rate Increases	121.7% Range:97.3%-158.8%	100.6% Range:78.2%-140.0%
NW Present Value of Historic Earned Premium*	\$79.6B	\$67.3B
NW Present Value of Historic Incurred Claims	\$47.8B	\$29.0B
NW Present Value of Future Earned Premium*	\$27.1B	\$35.2B
NW Present Value of Future Incurred Claims	\$82.0B	\$74.1B

- Average Inforce statistics across all states for both the most rate increased and largest blocks as applicable. The data for the blocks submitted by carriers that are both most rate increased and largest, are included in both columns above.
- Of all inforce policies for the most rate increased blocks, over 70% have an inflation rider and over 35% have a lifetime BP.
- Top 10 states by inforce make up around 50% of total nationwide inforce as well as present value of lifetime earned premiums and incurred claims collected.
- Only the data associated with the most rate increased blocks was used in the analysis herein. Data associated with the largest block was reviewed, but not ultimately used for this analysis.

*Includes all approved rate increases

Annualized Premium Inforce by State



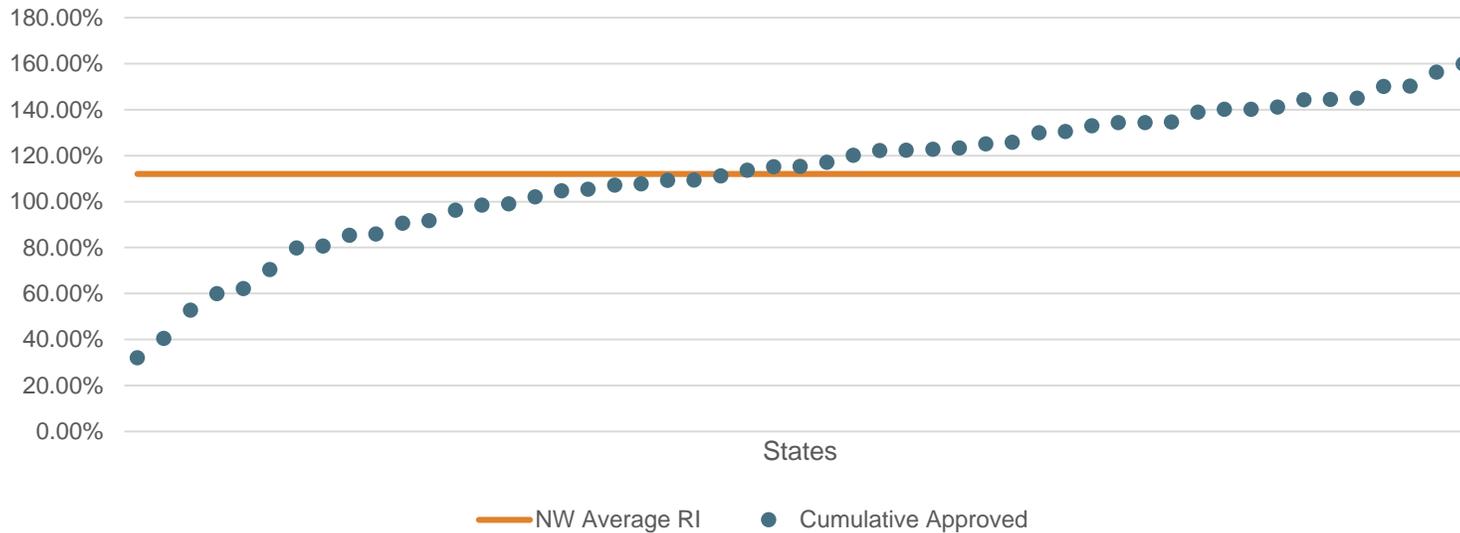
- Average nationwide annualized premium inforce is \$2,603.
- The average annualized premium inforce varies from \$1,755 - \$3,656 on the most rate increased blocks of business across all states. In general, the average annualized premium varies pretty significantly for states with similar distributions of policy characteristics implying policyholders in some states are paying more than policyholders in other states for, generally, the same benefits.
 - For 45 states over 60% of all inforce policies have an inflation rider.
- For 34 states over 30% of all inforce policies have a lifetime benefit period. For these states, the average annualized premium inforce varies from \$2,042 - \$3,315.

LTC Data Call Agenda

Executive Summary Scope Data Collection Analysis	Summary of state specific cumulative rate increase amounts as well as average approved number of rounds compared to nationwide averages.
Cumulative Approved Rate Increase	
Rate Increase Approvals Cost of Care	

Analysis: Cumulative Approved Rate Increase

Each states cumulative rate increase relative to national average



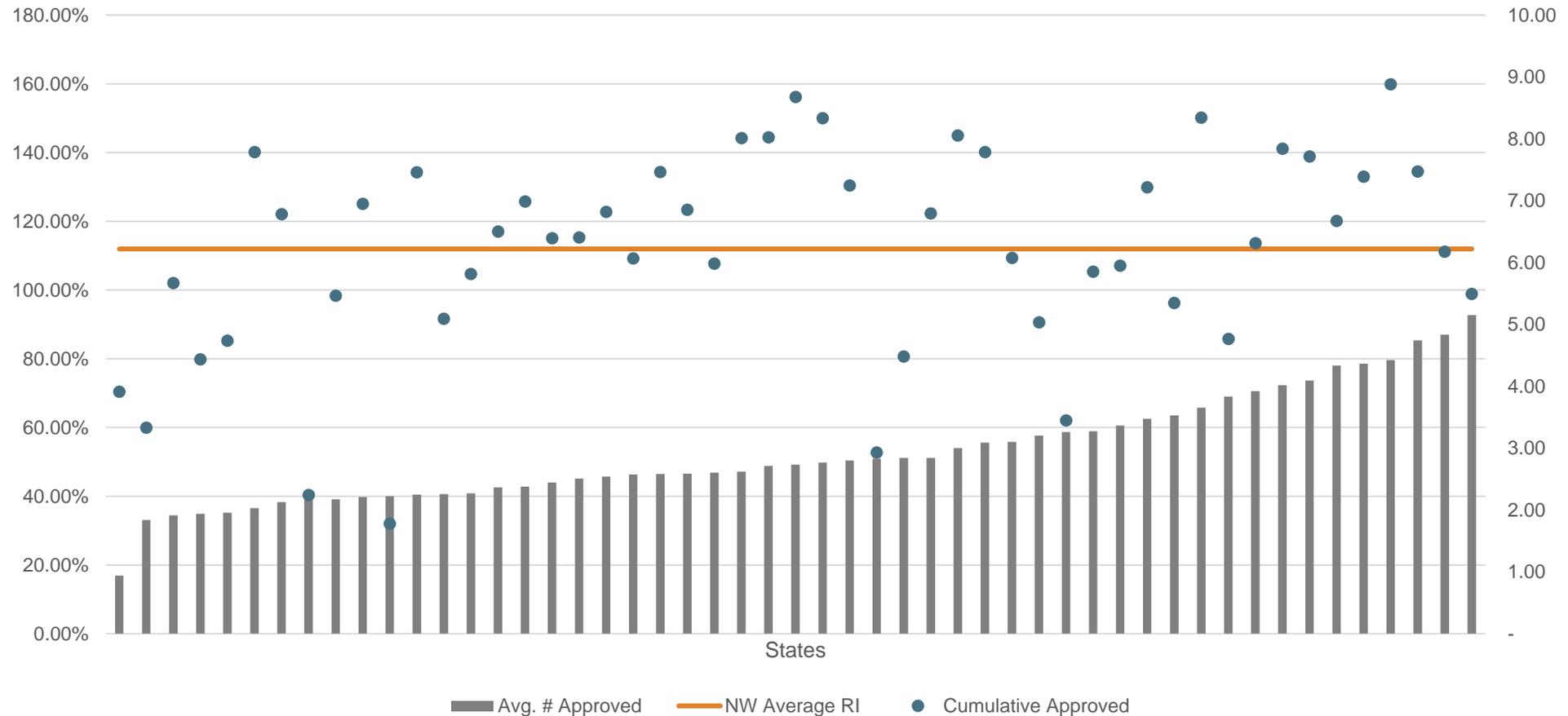
Nationwide average

States with lower
cumulative amounts

States with higher
cumulative amounts

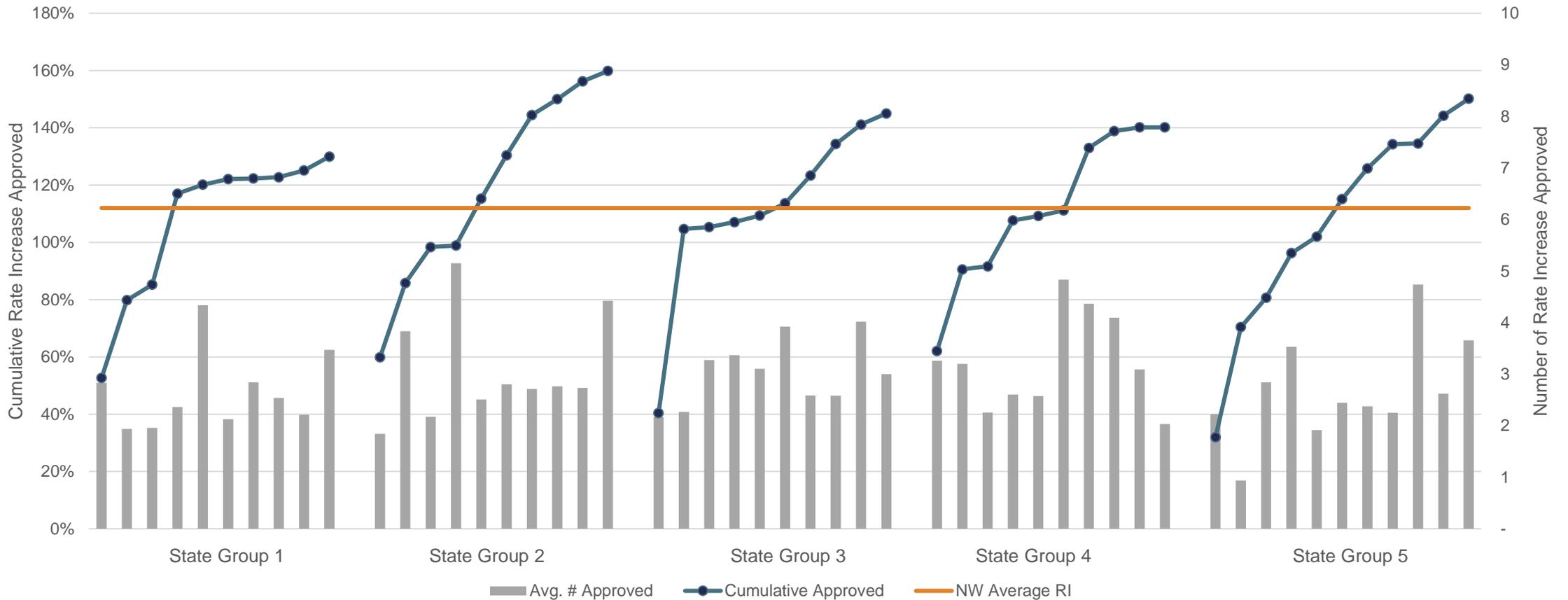
This does not consider timing of approvals

Analysis: Cumulative Approved Rate Increase



Number of approvals not only driver for states with higher cumulative amounts

Analysis: Cumulative Approved Rate Increase

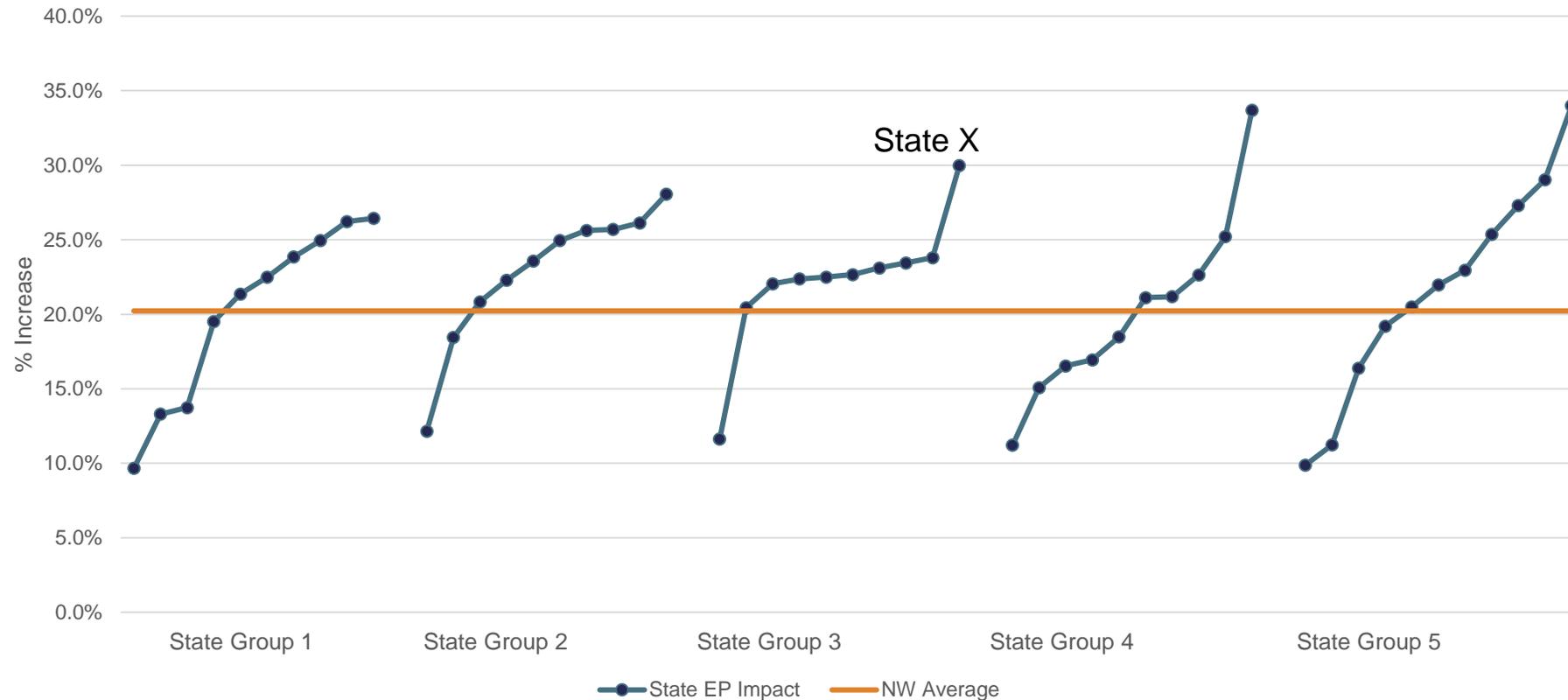


States bucketed into 5 groups by size indicate similar patterns.
 Group 1 includes states with most inforce and Group 5 includes states with least inforce.

LTC Data Call Agenda

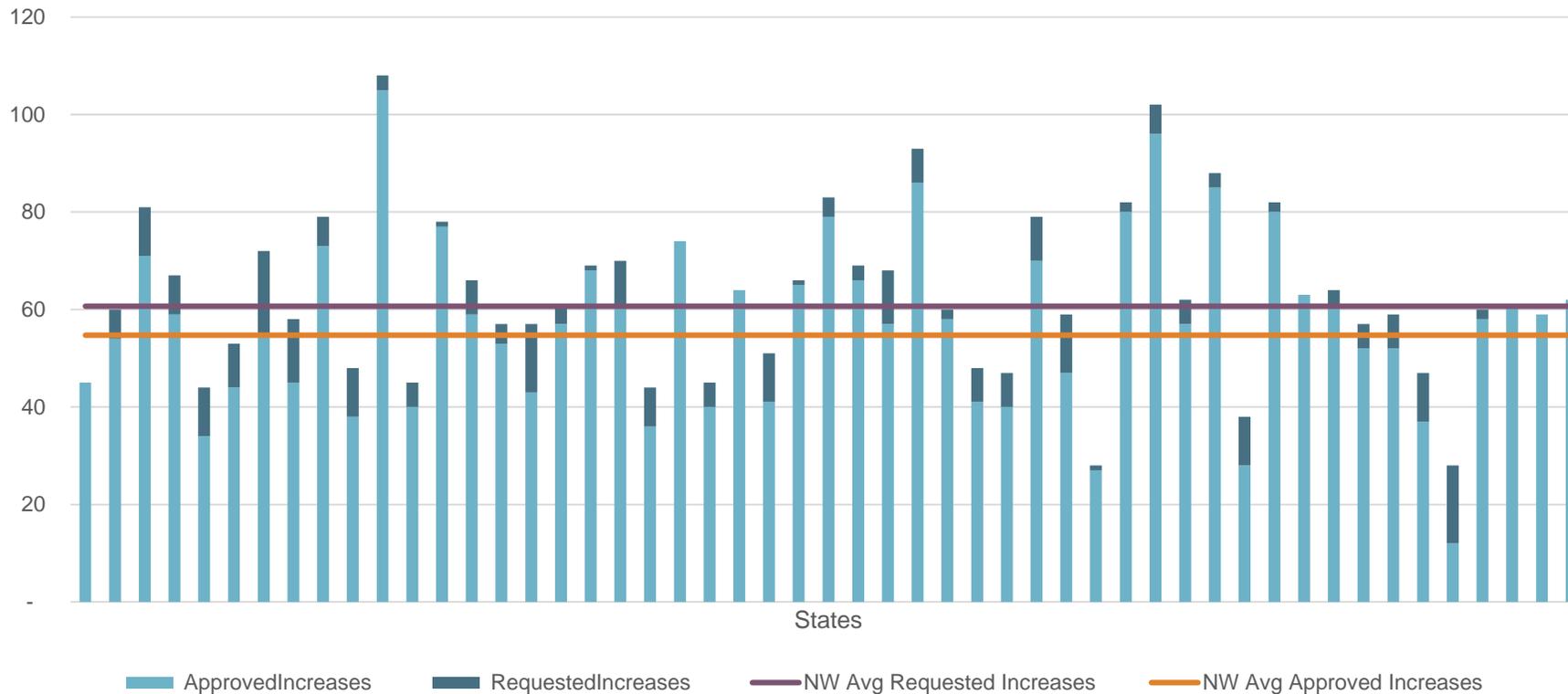
<p>Executive Summary</p> <p>Scope</p> <p>Data Collection</p> <p>Analysis</p> <p> Cumulative Approved Rate Increase</p>	<p>Summary of state specific rate increase approvals and policy lifetime impact of rate increase approval amounts relative to original rates.</p>
<p>Rate Increase Approvals</p>	
<p>Cost of Care</p>	

Lifetime Premium Impact



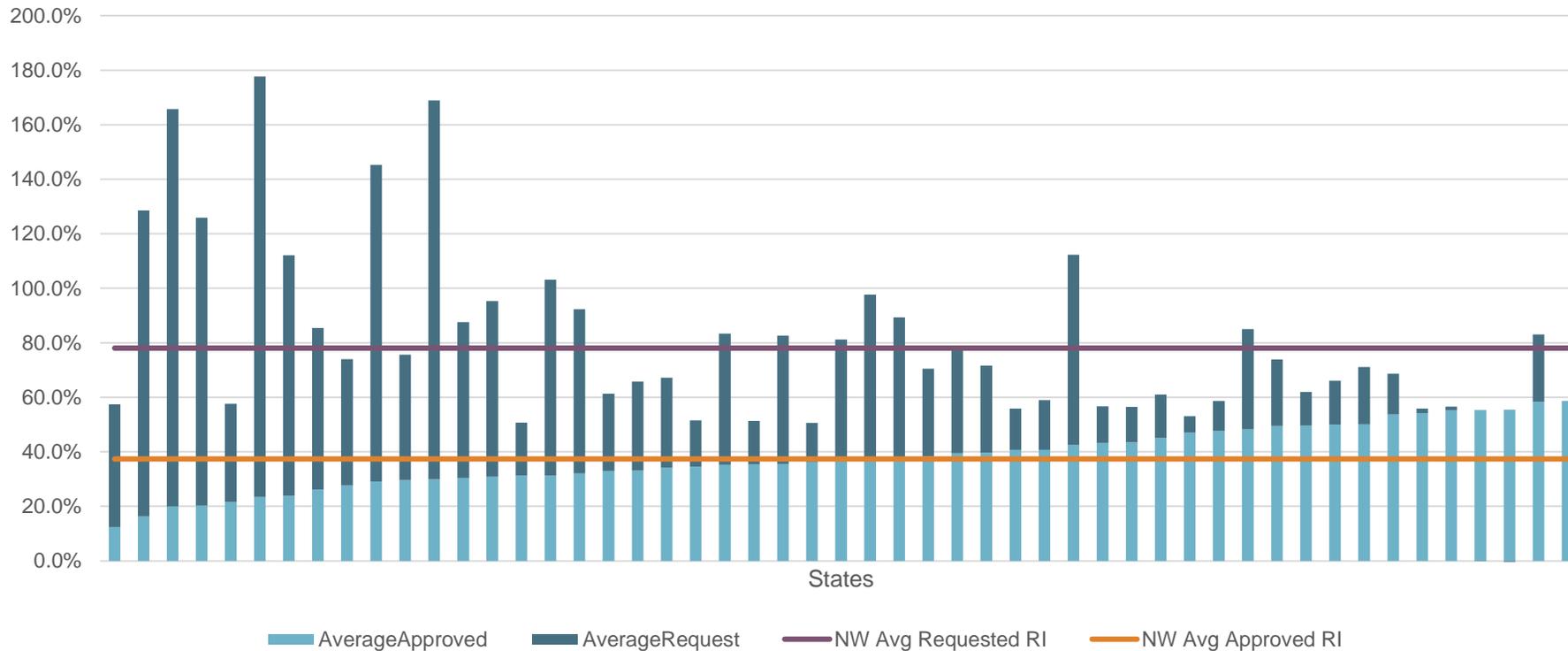
- States bucketed into 5 groups by size
- States ranked by inforce and policy lifetime impact of rate increase approval amounts relative to original rates.
- Example, premium paid by State X policyholders over the life of policies (past and future) will be 30.0% higher than original levels.
- Average impact of rate increase on nationwide lifetime premium is 20.2%.
- This does consider timing of approvals. Early approvals have bigger impact.

Average Number of Requested and Approved Rate Increases



- The number of requested and approved rate increases by state.
- Average Nationwide number of requested increases is 61.
- Average Nationwide number of approved rate increases is 55.

Average Single % Requested and Approved Rate Increases



- Average % of requested and approved rate increases by state.
- Average single Nationwide requested rate increase amount is 78%.
- Average single Nationwide approved rate increase amount is 37%.
- Average cumulative Nationwide approved rate increase is 112%.

LTC Data Call Agenda

Executive Summary	Summary of cost of care by state based on the most recent Genworth Cost of Care Report. Compare cost of care with state specific loss ratios, average annualized premium, and cumulative approved rate increase amounts.
Scope	
Data Collection	
Analysis	
Cumulative Approved Rate Increase	
Rate Increase Approvals	
Cost of Care	

Analysis: Cost Of Care By State

- We reviewed the annual median cost of care rates from the 2019 Genworth Cost of Care Survey for the following:
 - Semiprivate room in a nursing home
 - Adult day care
 - Home health aide
- Genworth Cost of Care Report: <https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf>
- For each site of care and by state, we compared the annual median cost of care rates to lifetime loss ratios, annualized premium inforce, and cumulative approved rate increase amount.
 - In every scenario we did not see a clear correlation between state specific experience and state specific annual median cost of care rates

Additional Observations

- The annual median cost of a semi-private room in a nursing home for 5/10 top states by inforce volume were lower than the nationwide average.
- The annual median cost for an adult day care for 7/10 top states by inforce volume were lower than the nationwide average.
- The annual median cost of homecare services for 5/10 top states by inforce volume were lower than the nationwide average.
- Over 5/10 top states by inforce volume had lower 5 year annual growth rates for cost of care when compared to nationwide averages. This includes nursing home, adult day care, and homecare services.

Reliance and Limitations

- The analysis provided in this document are based on work developed by Long Term Care Group, Inc. ("LTCG") from data collected from insurers in response to the NAIC Data Call Workstream #6. The document has been prepared in accordance with a statement of work dated March 5, 2020 between the National Association of Insurance Commissioners ("NAIC") and LTCG. They may not be referenced or distributed to any other party without the prior written consent of LTCG. Matthew Morton, FSA, MAAA and Kirill Grin, ASA, MAAA are the actuaries responsible for the findings contained in this document. They are members of the American Academy of Actuaries and meet its Qualification Standards for issuing such findings.
- In developing these results, LTCG relied on information that was supplied by the NAIC and the contributing companies. LTCG staff reviewed the information being relied upon for reasonableness but performed no audits or independent verification of such information. To the extent that there are material errors in the information provided, the results of the analysis will be affected as well.

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Attachment Five

- MSA Framework Actuarial Section
Exposure Draft
- Comment Letters

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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 Team will consider the following in performing their review, applying their expertise and judgement to the review as well as reviewing the actuarial formulas and results.

- Review company experience, company 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 match those reflected in the assumptions.
 - Adjust or request new projections of claims and premium to the extent any underlying assumptions are deemed unreasonable or unsupported by the MSA Team.
 - After verifying loss ratio compliance, apply the Minnesota and Texas approaches, which ensure remaining policyholders do not make up for losses associated with past policyholders.

In developing a recommendation, the MSA Team will apply regulatory actuarial judgment, for instance when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience.

The MSA Team will consider how to reflect the differences in the histories of states' rate increase 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 will continue on state cost differences impacting justifiable rate increases. 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.

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. 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.

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 company is allowed always to return to the 60% loss ratio, there is low incentive for responsible 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 LTC pricing subgroup calls from 2015 to 2019 are incorporated, including that rates will not substantially rise as the block shrinks (as policyholder persistency falls over time).
2. Cost-sharing formula that increases the company burden as cumulative rate increases rise.
 - a. This addition to company burden moves rates away from a direction that could be seen as misleading. The company 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 company's original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the company.
 - b. Verification of appropriateness of current assumptions.
 - i. A combination of credible company experience, relevant industry experience, and regulatory judgment is applied.
 - ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the company-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.
 - 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 a company 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 to prevent a company from increasing rates based on risky investments that turned into losses, an index of average corporate bond yields 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 iv is compared to the average corporate bond yields in iii to determine the adversity associated with the interest rate factor.
5. Anti-bait and switch 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 company 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 bait & switch, where, e.g., a company would underprice a product, gain market share, and then immediately request 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 LTCI 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 company 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 to some extent, the recoupment of past losses.
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).
 - (Note that for all 4 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 company 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, or 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 company, not the policyholder.

The formula used in TX approach is provided in Appendix C.

E. Reduced Benefit Options (RBO)

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

1. RBOs in 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. The MSA Advisory Report will highlight how the company 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 process develops and as the LTCI RBO (EX) Subgroup continues its work, this area of review may evolve.

2. Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA review process will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review process 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 LTCI (EX) 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 LTCI (EX) Task Force continues to review and consider non-actuarial considerations impacting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

- Caps or limits on approved rate changes
- Phase-in of approved rate changes over a period of years
- Waiting periods between rate change requests
- Considerations of prior rate change approvals and disapprovals

- Limits or disapproval on rate changes based solely or predominately on number of policyholders in a particular state
- Limits or disapproval on rate changes based on attained age of the policyholder
- Fair and reasonableness considerations
- Impact of the rate change on the financial solvency of the insurer

3. Considerations in 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, that may be impacted 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 impacted by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those impacted 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 impact 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 impact states that consider age caps
- If it is determined the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may impact the potential need for adjustments to the cost-sharing formula
- Aspects of coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in their review

2. Future Non-Actuarial Considerations

The MSA review process 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 LTCl rate filings, the LTCl (EX) 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.

APPENDIX C—ACTUARIAL APPROACH DETAIL

A. 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 company experience, relevant industry experience, and regulatory judgment 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. Premiums in the formula reflect the actual rate level.
 - 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 5 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. Company-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 issues 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) were 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 bait & switch.
 - 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 target 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 company'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 result 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 company (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 does now occur 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 company 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 one plus the cost-sharing-adjusted blend amount and divide by one plus the previous, cumulative rate increases. Then subtract one. 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. $\$3,000 / \$1,000 * .60 +$
 2. $\$1,500 / \$1,000 * .40$
 3. $- 1 =$
 4. $180\% + 60\% - 1 = 240\% - 1 = 140\%$.
 - vii. Cost sharing is:
 1. $100\% * .15 +$
 2. $90\% * .35 +$
 3. $75\% * .5 +$
 4. $65\% * .4 =$
 5. 110%
 - viii. Deduction for past rate increases results in:
 1. $(1 + 1.1) / (1 + .50) - 1 =$
 2. 40%.

B. 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 = .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. (Regulators may wish to consider the addition of margin to the rate increase. For example, the ΔPV(future incurred claims) term in the above formula could be multiplied by (1 + margin)).

For pre-rate stabilized policies, we use .6 in place of .58 and .8 in place of .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 regulator by a method other than the PPV approach. In this situation, for a current filing, the regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.

APPENDIX D—PRINCIPLES FOR REDUCED BENEFIT OPTIONS (RBO) ASSOCIATED WITH LTCI RATE INCREASES

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (“LTCI RBO (EX) Subgroup”) of the LTCI (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.

A. 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 a company to offer certain RBOs:
 - Regulators should evaluate legal constraints, the impact on remaining policyholders and company 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.

B. 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.
 - i. Claim amount can be sum of past premiums paid.
 - ii. Only receive that benefit if the policyholder qualifies for a claim.

C. 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 process will likewise develop and evolve to consider the reasonableness of these RBOs. The LTCI (EX) 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.

APPENDIX E—GUIDING PRINCIPLES ON LTCI REDUCED BENEFIT OPTIONS PRESENTED IN POLICYHOLDER NOTIFICATION MATERIALS

In 2020, LTCI RBO (EX) Subgroup of the LTCI (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 LTCI RBO (EX) 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 of 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 long-term care insurance reduced benefit options 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 reduced benefit options available to consumers in the event of a rate increase.
- **UNDERLINES** that the following principles are complementary and should be considered as a whole.

A. 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 regulators in the initial and phased-in rate increase notification letters.
- Filing rate action letter templates in the NAIC System for Electronic Rate and Form Filing (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 reduced benefit options.

- This enables regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.

B. 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 reduced benefit options 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 question-and-answer section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language.

C. Identification

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

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

D. 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 a long-term care insurance policy.
- Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.
- Presenting reduced benefit options 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 "mitigation options," "offset premium impact" or "manage an increase" instead of "avoid an increase."

E. Consultation and Contact Information

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

F. 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 reduced benefit options with the rate action letter.
- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which reduced benefit option(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:

- 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 reduced benefit options 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 long-term care 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 a long-term care 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 nonforfeiture option, 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 regulators.
- Specifying if the premium increase referenced is the first, second, third, last, etc.
- Offering contingent nonforfeiture 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.



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July 26, 2021

Commissioner Scott A. White, Chair
Commissioner Michael Conway, Vice Chair
Long-Term Care Insurance (EX) Task Force
National Association of Insurance Commissioners (NAIC)

Attn: Jane Koenigsman, Senior Manager, Life and Health Financial Analysis

Re: Exposure Draft: Long-Term Care Insurance (LTCI) Multistate Rate Review Framework

Dear Commissioners White and Conway:

The American Academy of Actuaries¹ Long-Term Care Reform Subcommittee appreciates the opportunity to offer comments on the actuarial sections of the [exposure draft Long-Term Care Insurance Multi-State Rate Review Framework](#) (Framework) released June 10, 2021.

We previously provided comments on the operational aspects of the Framework in our [letter](#) dated May 24, 2021. We appreciate the NAIC LTC Insurance (EX) Task Force's consideration of our previous comments and the opportunity to discuss them with the LTCI Multistate Rate Review (EX) Subgroup during its June 22, 2021, meeting.

This letter provides our comments on the actuarial aspects of the Framework, grouped into four themes, plus some additional comments at the end. We welcome the opportunity to discuss the comments provided in this letter during any future meetings of the task force or subgroup.

Actuarial Judgment

The actuarial review sections of the Framework address the necessary application of judgement in reviewing rate increase requests. The term is variously modified in the draft document as “regulatory actuarial judgment” or “regulatory judgment.” Qualified actuaries performing an MSA Review would use their professional judgment as defined in Actuarial Standard of Practice (ASOP) No.1.²

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² Actuarial Standards Board; Actuarial Standard of Practice No. 1, [Introductory Actuarial Standard of Practice](#); March 2013.

2.9 PROFESSIONAL JUDGMENT

Actuaries bring to their assignments not only highly specialized training, but also the broader knowledge and understanding that come from experience. For example, the ASOPs frequently call upon actuaries to apply both training and experience to their professional assignments, recognizing that reasonable differences may arise when actuaries project the effect of uncertain events.

We suggest that the Framework consistently adopt the term “professional judgment” when referring to the actuarial work of the MSA Review Team. The actuaries on the MSA Review Team may be guided by ASOP No.41³ regarding appropriate communications and disclosures when issuing an actuarial opinion in an MSA Advisory Report. Specifically, disclosures may be necessary where material assumptions or methods are specified by applicable law (statutes, regulations, and other legally binding authority) or selected by another party.

Decision-making Process of the Multi-State Actuarial (MSA) Team

The Framework outlines three main approaches to calculating a justified rate increase: 1) loss ratio approach (including the 58%/85% standard for rate-stabilized business); 2) Minnesota approach; and 3) Texas approach. Other than a statement that the 58%/85% standard would produce the maximum allowable increase for relevant blocks (which is consistent with rate stability regulation), it is unclear how the results from the different approaches will generate the rate recommendation of the MSA Review Team. We suggest that additional information be provided regarding the decision-making process of the MSA Review Team. Some questions and considerations that currently exist are:

- What happens if the Minnesota and Texas approaches are in conflict whether a rate increase is justified or if the approaches produce materially different results? The two approaches differ in their structures, with the Minnesota approach looking at past and future impacts and including non-actuarial provisions through cost-sharing, while the Texas approach is geared toward ensuring only future impacts are captured.
- The discussion of the Texas approach does not explicitly discuss the “catch-up” and “transition” provisions outlined as part of the Prospective Present Value approach in the NAIC LTC Pricing Subgroup document *Long-term Care Insurance Approaches to Reviewing Premium Rate Increases*, approved by the Long-Term Care Actuarial (B) Working Group in 2018. Was the omission of these provisions (outside of the last paragraph in Appendix C) intentional?
- In both the Minnesota and Texas approaches as specified, it is not clear how a company would account for a prior rate increase which was reduced and/or delayed due to lack of credible experience or for another reason. It can be very difficult in future filings to achieve a requested rate increase after a regulatory reduction in prior years.

³ Actuarial Standards Board; Actuarial Standard of Practice No. 41, [Actuarial Communications](#); December 2010.

- How are past rate increase approvals considered across states? Is the time value of money considered where two states may be at the same current rate level, but one approved prior increases many years earlier than the other state?
- If the MSA Review provides a recommended rate increase (e.g., 40%) and a participating state approves a significantly lower increase (e.g., 10%), for how long may a company and/or a state regulator rely on the original MSA recommendation when submitting or reviewing a follow-up filing to achieve the recommended rate level? What is the process for the company to submit a follow-up filing for the remaining rate increase? Does the follow-up rate increase request go through the MSA Review again? Would the time value of money be considered in the review of the follow-up request?

The subcommittee appreciates the detail provided in the Framework to date and recognizes the significant effort in documenting this information. However, the answers to some of the questions above may be crucial to ensuring that companies and actuaries submitting LTC rate increase filings have the knowledge needed about the MSA Review process to be comfortable using the option.

Industry Standards and Benchmarking

Section V.A indicates that assumptions in a rate increase filing may be “deemed unreasonable or unsupported” by the MSA Review Team. We suggest that the MSA Review Team contact the filing actuary to provide additional support for his or her actuarial assumptions, if necessary, prior to deeming them “unreasonable.” If an actuarial assumption is deemed unreasonable or unsupported, it may have implications for the use of a similar assumption in a company’s asset adequacy testing and/or *Actuarial Guideline LI* analysis. We note that “Fair and reasonableness considerations” is listed in Section V.F (Non-Actuarial Considerations). This is a broad and not-well-defined category allowing wide latitude in regulatory decision-making regarding the results of an analysis, distinct from the justification of actuarial assumptions.

Section V.C.1(c) cites “concepts discussed in public NAIC LTC pricing subgroup calls from 2015 to 2019,” which provides inadequate documentation to include in a regulatory procedure document. Rate filing actuaries may not be aware of the content of past calls. We suggest citation to particular documents, such as adopted summaries or minutes of the referenced calls, if available.

Section V.C.5(a) refers to “industry-average assumptions at the time of original pricing” for LTC products. Where are these averages reliably to be found? How are variations in product, carrier, distribution channel, and other factors taken into account? What level of deviation from these averages (in one or more assumptions) would be considered “out of line” and trigger the use of “benchmark premium,” rather than actual original premium, in the MSA Review Team’s review process? Recognizing that regulators who approved a company’s original product and rate filings had the opportunity to review all relevant assumptions at the time of filing, and may not have enforced or suggested the use of industry averages at that time, it may not be appropriate to determine benchmark premiums with 20/20 hindsight uniformly for all product filings and company characteristics.

For rate-stabilized business, the draft states that the 58/85 test “would produce the recommended rate increase” if lower than the Minnesota and Texas approaches. Why would these approaches potentially override and reduce the recommended rate increase, when the rate stability model was already intended to address the issues with loss ratio regulation described in the preceding paragraph of the Framework?

Non-Actuarial Considerations

The Framework contains various non-actuarial considerations that may be contemplated as part of the rate recommendation. We believe it is important to recognize that many of these considerations, while listed as non-actuarial, have actuarial aspects or implications.

For example, the phase-in of a rate change over a period of years necessitates a higher cumulative rate increase to have the same financial impact as a single rate increase. Similarly, if limitations are imposed on when a company can file a future rate increase, such as a rate guarantee period, a future request may need to be higher due to the cost of waiting.

Caps or limits on rate increase approvals that are not based on actuarial considerations likewise increase the size of future rate increases. In this situation, where necessary premium rate increases are delayed, policyholders pay higher premiums, and the ultimate necessary premium level increases due to the delays in approvals.

It should also be noted that the Minnesota and Texas approaches, while primarily actuarial in presentation, already include decisions based on non-actuarial considerations, such as specific cost-sharing provisions and disallowing interest rate deviations as a reason for a rate increase.

Finally, we believe that the MSA Review process may ultimately add little value if its actuarial conclusions are frequently overridden at the state level by non-actuarial considerations. The task force may wish to consider the degree of commitment demonstrated by Participating States when evaluating the success of the MSA Review program in meeting the NAIC’s objective of “developing a consistent national approach for reviewing current LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner.”

Additional Items

There is a potential interaction between the NAIC’s Reduced Benefit Options workstream and the MSA Review. Appendix E, “Guiding Principles on LTCI Reduced Benefit Options Presented in Policyholder Notification Materials,” suggests that insurers should consider “disclosing all associated future planned rate increases approved by regulators” in their rate increase notification letters. Will the existence of an MSA Review report with a recommended cumulative rate level impose any obligation on an insurer to disclose the likelihood of future rate increases to reach this level? How would any such disclosure apply to Participating and/or non-Participating states?

The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance:

- Section V.B.4(b) states that the loss ratio method results in “low incentive for responsible pricing.” Practicing LTC pricing actuaries are responsible for compliance

with all relevant actuarial standards of practice, and a company has incentives to price appropriately. Most companies would prefer to receive premium sooner rather than later. Additionally, there are the costs associated with filing and implementing a rate increase and the impact on policyholders of premium adjustments.

- Section V.C.2(a) refers to “a direction that could be seen as misleading.” Subparagraph (a) could be deleted entirely without affecting the definition of the Minnesota approach.
- Section V.C.5, “anti-bait and switch adjustment,” where we suggest a less pejorative term could be used. In the context of a rate increase review, see our comments above regarding industry standards and benchmarking. The concern regarding potential deliberate underpricing to boost market share, expressed in subparagraph 5(a)(iii), is best addressed in the context of an initial rate review by regulators.

In our May 24 comment letter, the subcommittee reserved comment on Appendix B of the April 9 Framework draft until its information requirements could be considered in context with exposure drafts of the Actuarial Review section. We now offer the following comments:

- Item A.1. should provide clarification for the desired issue state for group products (i.e., master group policy issue state or certificate issue state).
- Some items from subsections A and B are at least partially duplicative. Specifically, items regarding attribution of rate increase, waiver of premium handling, and assumption comparisons to asset adequacy testing are repeated in both locations.
- We encourage Participating States to agree that the listing of information for an MSA Review (as outlined in Appendix B) is exhaustive. If no further requests for information are needed as part of a specific state review, the filing process could be streamlined for both filers and reviewers.

Conclusion

Thank you for the opportunity to provide input on the development of the actuarial aspects of the MSA Review process. The subcommittee thanks members who participated in the drafting of this comment letter, including J. Patrick Kinney, MAAA, FSA; Mike Bergerson, MAAA, FSA; Greg Gurlik, MAAA, FSA; Aaron Wright, MAAA, FSA; Ali Zaker-Shahrak, MAAA, FSA; Sisi Wu, MAAA, FSA; P.J. Beltramini, MAAA, FSA; Gordon Trapnell, MAAA, FSA; Jim Glickman, MAAA, FSA, FCA; Zenaida Samaniego, MAAA, FSA; and Perry Kupferman, MAAA, FSA.

We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics. If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Andrew H. Dalton, MAAA, FSA
Vice Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

CC: Eric King, Health Actuary, NAIC

July 26, 2021

Commissioner Michael Conway
Chairman, NAIC LTCI Multi-State Rate Review (EX) Subgroup
Colorado Insurance Department

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers¹ (ACLI) and the American Association of Health Insurance Plans² (AHIP) strongly support the work of the NAIC Long-Term Care (EX) Task Force in achieving its charge of developing a consistent national approach for reviewing long-term care (LTC) rates and identifying options for consumers to modify benefits when faced with a premium increase on their LTC policy. As stated in our May 24th comment letter on the Operational Section of the LTC Multi-State Rate Review Framework (Framework) document, we recognize the commitment of state insurance commissioners and LTC subject matter experts from state insurance departments and appreciate the time and effort afforded to this critically important work.

The Actuarial Section is the core of the Framework document and worthy of a comprehensive review and robust discussions with all stakeholders to achieve the best possible result. While we are making good progress, we believe that several rounds of exposure, review and discussions will be required to finalize a document that is consistent with the Task Force charge. We have offered only high-level comments on this exposure and anticipate that we will share more detailed comments once our initial questions have been addressed.

Executive Summary

Our comments to this first exposure of the Actuarial Section of the MSSR Framework focus on transparency with respect to the methodologies used by the MSA Team.

It is important to remember that not only will the MSRR process be used to recommend actuarially justified rate increases on existing legacy blocks of business; it will be applied to business that is being sold today.

¹ 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.

²

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.

Insurers best protect their policyholders by fulfilling the obligations they made to them. This is accomplished when insurers have some level of predictability in their ability to manage their LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency within the MSA Review Process, specifically regarding the methodology used to calculate the increase recommended by the MSA Team. When insurers understand the methodology the MSA Team will use to calculate rate increases, they can make informed decisions about their business now that will ensure they can fulfill their obligations to policyholders years into the future.

Our comments are focused on Section V. - Actuarial Review and Appendix C – Actuarial Approach Detail. We have also provided a general comment with respect to Appendix E – Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials.

Section V Actuarial Review and Appendix C – Actuarial Approach Detail

Our comments to this section of the Framework are guided by the Task Force charge to:

*Develop a consistent national approach for reviewing LTCI rates that **results in actuarially appropriate increases** being granted by the states **in a timely manner** and **eliminates cross-state rate subsidization**.*

Insurers need a clear understanding of how their businesses will be regulated – today and into the future. The Framework must be evaluated based on its impact both on legacy blocks of business and new business that will be developed and sold in the future. The Framework does not currently contain the rationale or criteria that will determine which method the MSA Team will apply to a particular filing. As a result, we request clarification on the following fundamental questions and issues:

1. Will the MSA Team apply just one method based on the characteristics of the block or will all methods be used in the calculation of a rate increase? If all methods will be used, will the MSA Team recommend a blend of the results? Or will they recommend the lowest percentage?
2. What public policy issue is each methodology designed to address (e.g. certain issues with aging or shrinking blocks)?
3. How will each methodology address the inequity between policyholders in states that have routinely capped or delayed increases and those that have not? The MSA's Actuarial Review standards/recommendations for participating states should include an acknowledgment that the recommendations for rate approvals do not reflect lifetime rate inequalities resulting from inconsistencies in the amount and/or timing of historical rate approvals between states, even on policies that offer identical coverage. We believe that the standards should encourage states to work

with filing companies to address these inequities and that the MSA Team should continue to assess this issue to determine if more specific guidance is appropriate.

4. Will the MSA Team apply their “regulatory actuarial judgement” to recommend an increase percentage that is different (higher or lower) than that produced by the Minnesota or Texas approaches?
5. In the example proposed (where there’s less-than-credible older-age morbidity) what actions would the MSA Team take?
6. The description of the Minnesota methodology includes a focus on underlying assumptions and indicates that the reviews are benchmarking to industry-average assumptions. How are those assumptions calculated? Will they be provided to companies? Similarly, what is the “average corporate yield bond” index that will be used under the Minnesota method?
7. The “anti-bait and switch adjustment” under the Minnesota method appears to suggest the insurers intentionally underpriced LTC products. How would the MSA Team make this determination? How are the “industry-average assumptions at the time of original pricing” determined? Are product and underwriting differences accounted for? How far from the industry average is considered reasonable? Wouldn’t such assumptions only be considered unreasonable in hindsight considering the product was originally approved by the state insurance department?
8. The Minnesota Approach accounts for changes in interest rates; the Texas Approach explicitly does not. How do these conflicting approaches achieve similar results? The same is true in cases of solvency concern – the document states that the cost-sharing formula in the Minnesota Approach can be adjusted. How will the cost-sharing formula be adjusted? How is solvency accounted for in the Texas Approach?
9. Will the MSA Team recommendation reflect any non-actuarial considerations or is the document simply acknowledging their existence?
10. A clear distinction needs to be made between non-actuarial considerations that should inform the MSA Team’s recommendations (like company solvency) and non-actuarial considerations that states might apply to the MSA Team’s recommendation (rate caps, phasing, age limits). The former should be a factor in the MSA Team’s regulatory actuary judgment. To achieve The Task Force’s goal of a consistent national approach to rate actions, the MSA Team should seek to discourage the latter (unless required by a clear state statutory mandate).

11. A primary goal of MSA Review Process is to achieve an adequate rate level for policyholders in all states. As proposed, the process gives states the discretion to continue to apply state-specific non-actuarial restrictions and caps on rate increase amounts. While we recognize the independence of each state’s authority, we note that allowing states to impose artificial rate caps on what the MSA Team has determined to be an actuarially justified rate likely will perpetuate the historical discrepancies between states, which will not address cross-state inequities. It will also undermine the Task Force’s charge to develop “a consistent national approach” to achieve “actuarially appropriate increases.”

12. The Framework states that the MSA Team’s review of rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. In addition, the MSA Team will apply the Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup’s paper – *Long-term Care Insurance Approaches to Reviewing Premium Rate Increases (“NAIC Pricing Subgroup’s Paper”)*, to calculate recommended, approvable rate increases. In reviewing the methodologies, we noticed that specific components of the Texas method are not clearly included. In addition, there were changes or additions to adjustments made to the Minnesota method. The NAIC LTC Pricing Subgroup’s paper was the result of a deliberate and collaborative effort on the part of regulators and industry in 2018, during which each method was fully vetted. We believe that any kind of change to the methods outlined in that document should occur only after the same robust discussion and review. For example:
 - a. Under the Texas method, the catch-up and transitional provisions are not clearly included. As outlined in the NAIC LTC Pricing Subgroup’s Paper, we believe these are valid and important adjustments that should be considered when applying the Texas method. The catch-up provision is intended to account for necessary additional premiums in a new rate increase related to assumptions provided to the department at the time of a previous rate increase request that were not approved in conjunction with the prior filing(s). Likewise, the transition provision, for pre-rate stability products and other products where the last rate increase request was voluntarily reduced by the company, provides the ability to make a single filing to provide the full amount of premium necessary to meet the actuarial certification.

 - b. With respect to the “anti-bait and switch adjustment” under the Minnesota method, we strongly disagree with the inclusion of this adjustment. We believe the name itself draws a legal conclusion and submit that any reference to this type of adjustment should be categorized as an “original assumption adjustment”.

13. Finally, as mentioned in our previous comment letter, we encourage the subgroup to include a formal trigger to review and amend the Framework annually.

Appendix E – Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials

We appreciate the subgroup’s acceptance of many of our recommended changes now reflected into Appendix E. However, there are a few suggestions made in our May 24th letter that were not accepted by the subgroup. We welcome the opportunity to discuss further refinements to this document as the work evolves.

CONCLUSION

We share your fundamental objective of ensuring that policyholders receive the benefit of their insurance policies when they need it. Maintaining a guaranteed renewable product, with limited or no rate adjustment flexibility, is not sustainable, so we appreciate the MSRR subgroup’s hard work and analysis to identify and develop key parameters for a process to assess and approve actuarially justified rate increases. Success of this initiative would help to ensure market stability, which will support the willingness of current LTC carriers to stay, and hopefully will motivate others either to return or to join.

Thank you for the opportunity to provide these comments. We will submit more detailed comments once the Framework document is exposed in its entirety.

ACLI/AHIP welcomes the opportunity to discuss our comments with you and would be pleased to participate in additional discussions regarding the issues and perspectives included in this letter.

Sincerely,



Jan M. Graeber
Senior Actuary, ACLI



Ray Nelson
AHIP Consulting Actuary

Response to NAIC's LTCI MSA Framework document

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"Any business built on non-disclosure of information vital to its customers will not survive - and will not deserve to survive over the long term" -- Joe Belth, The Insurance Forum

Introduction

FinancialMedic, LLC has chosen to respond to NAIC's LTCI MSA Framework document dated June 10th, 2021. The firm is noted for its work product in the FIRE (Financial Independence Retire Early) field. We develop intellectual property for a holistic, integrated financial planning (FP) systems that includes substantive mathematical modeling over a wide range of personal financial domains.

The firm recognizes Long Term Care (LTC) as a valid risk in FIRE planning and have conducted extensive research in LTC and LTC Insurance (LTCI). The outcome of this research is embedded within our operational FP system. As part of this consumer driven effort, our firm published [LTCI Rate Adjudication & Neutrality](#) © Oct 2019, a treatise on LTCI industry pricing practices. This publication along with two years of data mining form the basis of the response within.

Our LTCI knowledge and experience represented here are a thumbnail of our complete industry coverage and only confines itself to subject matter of the Actuarial Review.

Overview

Considering that the LTCI Industry is 3 decades old, one should be shocked to learn of a Draft paper of the industry methods of rate adjudication. What is shocking is to also witness this debate in 2018, a paper from the American Academy of Actuaries (AAA)¹ with no resolution since or sense of urgency. Meanwhile, affected stakeholders² are shocked & angry by the parabolic scaling of rate increases over the past 3 years particularly in certain state jurisdictions. There are spurious claims of industry insolvency without evidence except for isolated cases.

Our firm is very familiar with the Loss Ratio Approach (LRA) discussed in **Section V, Actuarial Review**. For a client who has legacy LTCI, we are called upon to project its contractual performance within the confines of our FIRE application. Our LTCI Individual Case Basis (ICB) modeling must necessarily include similar logic pieces of morbidity incidence, duration, and situs modeling. A technical paper describes data and methods to the level of programmatic repeatability enabling an ICB decision support system. We believe we are the only firm capable of such analysis.

Historically, our clients have been concerned about premium projections as increases are perceived to know no bounds. Right out of the research gate in June 2019 we noted legacy LTCI's premium projection toxicity using LRA, such that one could debate whether this product falls within the definition of insurance as a *risk hedge*. On the contrary, LTCI ownership has become a financial risk to the many seniors on fixed income due to its unfair pricing.

We use the term *Fair Pricing* to mean Repricing In Accordance with Level Premium Precepts, the basis on which this product was sold. The technical definition and methodology is described in the earlier cited paper.

¹ [Considerations for Treatment of Past Losses](#), American Academy of Actuaries, Oct 2018

² We consider primary affected stakeholders are policyholders, state government (Medicaid), federal government (Medicaid), and the Long-Term Support Services (LTSS) sector.

Loss Ratio Approach, the main culprit

Addressing Actuarial Review, **Loss Ratio Approach**, Section B, point 4, quoting:

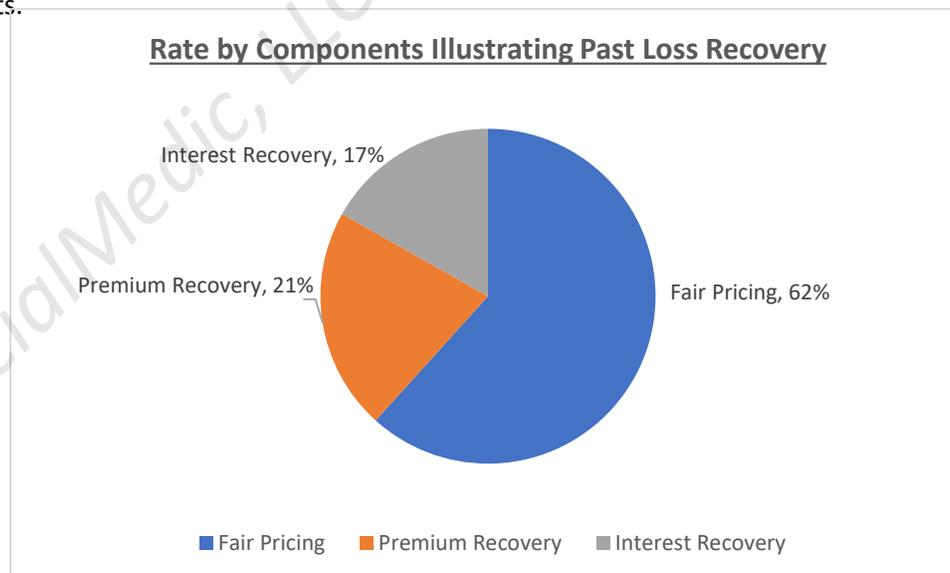
“The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA team. **However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards such as fair and reasonable rates.**

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 company is allowed always to return to the 60% loss ratio, there is low incentive for responsible pricing.

The admission that past losses, known as premiums that were insufficient since inception, confirms our independent findings. We find evidence that some regulators reject the past loss theory without foundation of data science and accounting practices. We add that it is not merely the principal of past underpricing that is subject to recapture. The LRA is based on present value (PV) calculations, thus the shrinking number of policyholders (SNOP) are also charged interest based on the carrier's discount rates, as though signing an LTCI contract involved a hidden lending arrangement.

Typical example (2021): A recent rate increase for a large carrier expands SNOP premiums to 4.02x original premium though the book remains considerably under-priced using LRA (at an LLR of 111%). Through standard accounting procedures, the new premium is calculable and allocatable to 3 distinct components.



We do not see recovery of principal and its interest being reported in narratives or financial statements from LTCI actuaries in carrier filings or regulatory final dispositions. This non-disclosure misleads all LTCI stakeholders. We note that the expanding pie in premium growth in rate filings 2020+ are mainly due to the two recovery components while Fair Pricing remains static.

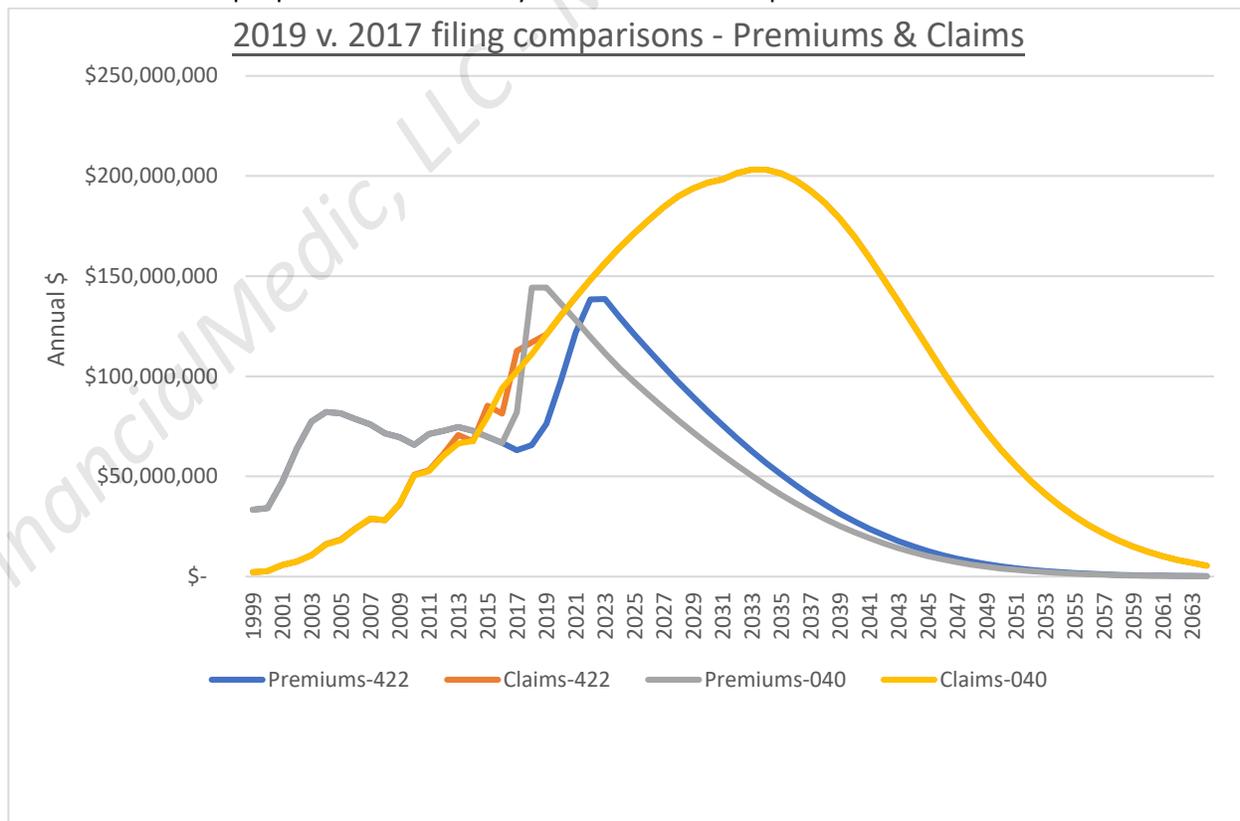
The Texas Approach

Our firm agrees with what the Texas Approach is designed to address, **Section D**, points 1 and 2, quoting:

1. Past losses are assumed by the company 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 to some extent, the recoupment of past losses.
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.

Point 3 describes a general methodology of looking at forward “deltas” (both present value premiums & claims, along with rate history) as the primary drivers of rate changes. **Appendix C, Section B** provides a formula that allowed our firm to back test with a small code snippet to our LTCI processing subsystem that already had a forensic analysis capability.

We encountered cases where the future claim “delta” was small relative to future premium “delta” such that a premium reduction would be called for. The Texas approach provides a useful filtering mechanism. See example below. The claim “delta” was exactly zero, a *perfect* overlap, yet the regulatory agency granted a 40% increase. The stock language of the actuarial narrative based the increase on an expected deterioration of future claims. Accounting procedures refute the actuarial narrative but a simple picture tells the story even better absent professional formalities.



The Texas proposal acknowledges that the methodology would not work for a first time increase as no “deltas” exist. Moreover, we discovered the formula by itself is not a complete specification. For example, when measuring future “deltas” from one filing to the next, the specification does not clarify the source of PVs to be used for the baseline (old) filing. In our experience, many rate requests are not granted in full thus a baseline filing would not be a good source of information unless there were a recalculation of PV futures as *adjusted by the actual rate increase*.

A general concern is that the Texas Approach, being a mere draft or conceptualization, would have to be vetted to fit into the current environment. It is a dramatic change and one that would cause stakeholders to question why any methodological change is being proposed, much less implemented, after significant economic harm. Our firm has received questions from clients, who: (1) have lapsed, (2) paid more in premiums than they thought they should have, or (3) exercised an RBO – “have we been injured by the Loss Ratio Approach”? Answer is a resounding “yes”!

Summary

The views presented here have already been presented to parties who have a need to know. To date, our work has been well-distributed and has not been refuted.

We ask how the industry came about the LRA method and not Repriced in Accordance with Level Premium Precepts (Fair Pricing) as the product was originally intended and sold to clients.

The Actuarial Review raises fundamental questions as to the technical purity of rate adjudication methods yet the industry appears to be unduly focused on RBO. This is *cart before the horse* logic in our professional opinion.

Respectfully submitted,



Samuel T Cuscovitch, Research Scientist / Strategist

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Vermont Comments

LTC (EX) Multi-state Actuarial Rate Review Framework

On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads:

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.*

Rate increases for long-term care policies typically add thousands of dollars to the annual premium paid for the policy. These types of rate increases are significant and may be a hardship to elderly consumers on fixed incomes. Consumers may not be able to consider their own best interest in the face of a significant change to annual expenses. Any offer associated with a rate action, and which involves the collection of data through artificial intelligence should clearly explain how information will be collected and used to avoid profiting and potential discriminator actions on behalf of the insurer. Also, any offer to an insured tied to rate increases should be supported with data showing why and how the rate impact is directly correlated to the offer.

Consider this example:

- A consumer on a fixed income receives notice that long-term care premiums will increase by \$3,000 annually.
- That consumer now faces \$3,000 of new expenses.
- If the consumer checks a box, they will receive a smart device that will collect data from their home and computer.
- If they select this option, they will not have to pay any rate increase.

The consumer may not be in the position to act in their own best interest and may not be able to consider these options carefully for several reasons. First, the consumer may not fully understand the technology proposed, the data to be collected, and the privacy implications. Second, the consumer may not realize that there may be several other options to modify their policy and reduce premiums besides accepting the new technology option. The technology option may seem like the only choice available.

The MSA subgroup should consider keeping the wellness program offers separate from implementation of large rate increases (greater than 10%). Then, there would be no question that the consumer was coerced, rather than persuaded, to take part in any wellness program.



OFFICE OF
INSURANCE COMMISSIONER

July 21, 2021

Ms. Jane Koenigsman, Sr. Manager – L/H Financial Analysis
National Association of Insurance Commissioners
1100 Walnut St., Suite 1500
Kansas City, MO 64106-2197
Email: jkoenigsman@naic.org

RE: Exposure Draft: LTCI MSA Framework Comments

Dear Ms. Koenigsman,

Thank you for the opportunity to provide comments on the Long-Term Care Insurance (LTCI) Multi-State Actuarial (MSA) Rate Review Framework. We strongly support the goal of consistent rate review across all states for LTCI products.

We support a more consistent rate review approach to minimize the differences across states in their application of actuarial and nonactuarial considerations in rate review criteria for LTCI rate filings. While we think there are benefits for states to participate MSA rate review, a few key criteria and issues need to be addressed in order to achieve a maximum value from MSA rate review.

- **Is this binding? If not, limited participation might impact goal of nationwide uniformity and defeat the purposes of MSA rate review.**

Several states have made it clear that they are not willing to participate in or accept the results of the MSA rate review, thus hampering the ability of MSA rate review to achieve its stated goal of nationwide uniformity. In order to achieve a more consistent rate review approach and minimize the differences across states, most states (if not all) need to participate in the MSA rate review program and make use of the final results mandatory.

If the MSA rate review is not binding on participating states and is instead treated as a recommendation, state actuarial reviewers will use their own actuarial judgement to evaluate the MSA rate review and then apply state-specific laws and rules. The results will be different and therefore inconsistent. Enough state must bind themselves to the MSA rate review results in order for this approach to be effective.

The current status of LTCI rate review at the Interstate Insurance Product Regulation Compact (IIPRC) informs this concern. At least a half dozen of the IIPRC states have opted out of IIPRC LTC review standards. This lack of uniformity is exacerbated by the IIPRC only being allowed to consider rate increases for policies that the IIPRC originally approved, and only for increases up to 15%. These challenges for the IIPRC suggest similar challenges may exist for MSA rate review.

Ms. Jane Koenigsman
National Association of Insurance Commissioners
RE: Exposure Draft: LTCI MSA Framework Comments
July 21, 2021
Page 2

- **Can the rate changes recommended by the MSA team be implemented by all states and meet existing state laws and rules? If not, does this invalidate the actuarial work of the MSA team?**

Some states have capped an LTCI rate increase regardless of actuarial justification. If the 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.

- **Can the MSA Team review 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. Can the MSA Team effectively maintain confidentiality and meet individual state's proprietary information law?

Comments Specific to MSA Actuarial considerations:

- MSA (Advisory) Report: The actuarial requirements in the report should not conflict with various state's laws, rules, and procedures. The report's wording will also need to be edited carefully whether it is just a recommendation or if there are conflicts with state regulations. The report should also address that actuarial standards and expectations still apply, since the team members are expected to contribute their actuarial expertise.
- The NAIC should conduct a study to determine whether the "Minnesota" and "Texas" approaches mentioned in the MSA framework are consistent with the state laws and rules. Take our state as an example: we do not automatically calculate and discuss the "Minnesota" or "Texas" rate increase calculations. The proposed MSA rate review procedures are somewhat different from our current rate review, rules, and methodology. In our review, we also require carriers to clearly designate when policies were issued and whether the block is closed or still being sold. Carriers are also required to clearly demonstrate how the policies look in terms of rate stability requirements (e.g., the 58%/85% analysis) and the loss ratio requirements.

Sincerely,

Lichiou Lee

Lichiou Lee,
Chief Actuary, Rates, Forms, and Provider Networks

Sent electronically

CC: Molly Nollette, Deputy Commissioner, Rates, Forms, and Provider Networks
Amy Lopez, Senior Administrative Assistant, NAIC