LONG-TERM CARE INSURANCE (EX) TASK FORCE

- Long-Term Care Insurance (EX) Task Force and Long-Term Care Insurance Multistate Rate Review (EX) Subgroup Joint August 13, 2021, Summer National Meeting Minutes
  - Long-Term Care Insurance (EX) Task Force July 6, 2021, Meeting Minutes (Attachment One)
  - Long-Term Care Insurance Multistate Rate Review (EX) Subgroup June 22, 2021, Meeting Minutes (Attachment Two)
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Long-Term Care Insurance (EX) Task Force and the
Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
Columbus, Ohio
August 13, 2021

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

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

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

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

   a. Adopted its July 6 Minutes

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

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

   b. Heard an Update on Industry Trends

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

Commissioner Ridling asked if the Task Force should be monitoring for possible future solvency concerns and what should be looked at during insolvency. Commissioner White said that solvency analysis is ongoing. It is being conducted by the actuarial group through its annual review of insurers' AG 51 filings, and through having discussions with the company and its domestic

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state insurance regulator if reserves need to be strengthened. Mr. Andersen said the Valuation Analysis (E) Working Group has been performing targeted and broad-based reviews for three to four years and has been engaged with the companies and the NAIC on their work. He invited any of the state insurance regulators who would like to discuss these activities or any ideas for enhancements to this work to contact him or Commissioner White.

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

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

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

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

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

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

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

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

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

e. Released the LTCG Actuarial Consulting Group Report

Commissioner White said the NAIC engaged LTCG Actuarial Consulting Group to conduct a data call of certain insurers to assist the Task Force in evaluating the extent to which state rate review policies and practices have led to cross-state rate subsidization. The public LTCG report (Attachment Four) includes key points in the executive summary and data in different frames. The data call and analysis does show such cross-state rate subsidization does exist. The report took time to deliver as the original work product of LTCG was considered confidential because the information was gathered under Virginia

confidentiality statutes. Steps had to be taken to allow it to be shared publicly and to work through some contractual issues with LTCG regarding its scope of work and deliverables. This report is being released to the public for informational purposes only, and the Task Force does not expect further discussion on the matter.

f. Discussed the MSA Framework Timeline and Next Steps

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

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

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

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

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

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

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

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

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

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

Ms. Ahrens said an important change is the addition of what will be referred to as an "MSA Associate Program," which is aimed at addressing the concerns of state insurance regulators that more states need to be actively involved in participating in the actual MSA review rather than being limited or that the MSA team may be too small of a group of regulatory actuaries. While there would still be a core team, the proposed mentorship program recognizes that some state insurance departments

may lack LTCI actuarial expertise and need involvement in a process like this to help staff to gain LTCI experience. It also recognizes limitations on state insurance departments' resources but allows for meaningful participation with less time dedication, such as serving as a peer reviewer.

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

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

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

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

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

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

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

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

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

Ms. Graeber said the comments include a list of questions and issues. She said the MSA Framework should include transparency and consistency. The MSA Framework should include the rationale or criteria that determines the method the MSA team will apply. She said carriers need to understand the methodology to be used by the MSA team before the carriers prepare and make rate filings. She highlighted comments in the letter that note that certain provisions of the Texas method were not clearly included.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. Lee said summarized the Washington comment letter (Attachment Nine). She said a few key criteria need to be addressed to achieve the maximum value of the MSA process. If the MSA process is not binding, it may affect the goal of nationwide uniformity and defeat the purposes of the MSA process. To minimize the differences across states, more states need to participate in the MSA rate review, and the use of the results should be mandatory. She asked if the rate changes recommended by the MSA team can be implemented by all states and meet existing state laws and rules. If not, she asked if this invalidates the actuarial work of the MSA team. Some states have capped an LTCI rate increase regardless of actuarial justification. If the MSA team recommends a higher rate increase than a particular state's capped rate increase, the actuarial assumptions may no longer be valid. Also, those states without a rate cap will be continuing to subsidize the states with a rate cap. She said a key issue to address is if the MSA review can meet the proprietary or confidentiality requirements of the participating states. MSA rate reviews will be done by drawing on staff support from various state insurance departments. She asked if the MSA team can effectively maintain confidentiality and meet individual state's proprietary information law. She highlighted other comments in the letter regarding the actuarial considerations, specifically that the MSA report should not conflict with various states' laws, rules, and procedures, and that the NAIC should conduct a study to determine whether the Minnesota and Texas approaches are consistent with states' laws and rules. She said the methods in the MSA Framework are somewhat different from the review performed in Washington.

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

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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 Afable (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.

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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 it 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 (Attachment Two-A). 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 Two-B) 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 Two-C) 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.

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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 Three-A, Attachment Three-B, Attachment Three-C, Attachment Three-D) in response to an exposure of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist). She presented a version of the draft (Attachment Three-E) 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 Three-F) 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.

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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 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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Commissioner Jessica Altman
Chairman, NAIC LTCI Reduced Benefit Options (EX) Subgroup
Pennsylvania Insurance Department

July 21, 2021

Dear Commissioner Altman,

The American Council of Life Insurers (ACLI)[i] and the American Association of Health Insurance Plans (AHIP)[ii] appreciate the opportunity to comment on the draft Checklist for Premium Increase Communications (Checklist), exposed by the NAIC LTC (EX) Task Force on June 21, 2021. We believe the cooperative working relationship we share with the Task Force, and other stakeholders, in addition to our combined efforts, will result in a Checklist that helps to make RBO consumer communications consistent and clear.

ACLI/AHIP support the work of the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup in its charge to help consumers manage the impact of long-term care rate increases. By improving uniformity and clarity in consumer notices for reduced benefit options (RBO), consumers will better understand and objectively compare RBOs, and thereby choose the best options for their personal circumstances.

EXECUTIVE SUMMARY

Long-term care insurance mitigates the risk of catastrophic long-term care costs. How long-term care insurance accomplishes this important public good differs depending on the insurer, the policy terms, and the individual circumstances of the policyholder. When a long-term care rate increase becomes necessary, insurers need flexibility to determine what options make the most sense for their blocks of business and their policyholders. A Checklist that accommodates these varying factors will promote a robust and innovative RBO offering in the event of a premium increase.

As the Checklist's introduction states, the Checklist is meant as guidance and does not carry the weight of law or impose any legal liability. The RBO principles adopted by the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on November 30, 2020 should steer the Checklist queries. The Checklist should not create new requirements, but rather, standardize, clarify, and compile existing requirements and guidelines. Further, as the Checklist is only meant as guidance for insurers in drafting, and regulators in reviewing, RBO communications, the Checklist should explicitly state, that unless otherwise mandated by a particular state, an insurer is not required to include a completed Checklist with the filings.

In addition to this comment letter, we include specific, proposed edits to the Checklist. ACLI/AHIP request that this letter be considered in combination with our suggested amendments.

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SERFF FILING

Question 1 lists specific materials to include with the rate increase filing. Because some of those materials would not be applicable to all rate increase filings, readily available at the time of filing, and/or required by the state, we suggest a more general question, "Does the filing contain all materials required to be filed in connection with the rate increase request?"

Rephrasing question 3 to be more general would account for the different notification timing requirements amongst states, as well as the possibility notifications might be sent electronically.

On question 4 we recommend adding "new" before "innovation options" for additional clarification.

We recommend question 5 be amended to reference *state-required* samples of policyholder communications, so as not to imply a new requirement where one does not currently exist.

We find question 6 to be ambiguous and suggest removal, or clarification, without implying a new requirement regarding customer service operations.

Finally, we believe question 7 should reference *required* state-specific pre-rate increase filing notification procedures and that the example be removed because it could confuse insurers and regulators in instances where the scenarios given in the example do not apply.

READABILITY AND ACCESSIBILITY

We suggest the questions in this section be amended to remove specific requirements of readability and accessibility to give insurers maximum flexibility in creating communications that best serve their policyholders.

For instance, in question 8, instead of assigning the order of information in a communication, the question should indicate the end goal, "Does the communication clearly present the essential information and/or primary action?" The order of information is irrelevant so long as the communication is easy to follow, logical, and important information is clearly presented.

In question 11, removing the reference to 11-point type, but keeping the guidance that the communication be in "easily readable font" accounts for the additional impact formatting, layout, font, illustrations, bullet points, logos, etc. have on readability. Type size is just one element of many that make a communication easy to read and understand.

The Flesch reading ease score in question 15 implies a specific, new requirement. For this reason, and because the question is redundant with questions 8 through 14, which establish readability, we recommend question 15 be removed entirely.

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Amending question 16 to simply ask, "Are the RBOs clear and not misleading?" without implying a specific side-by-side format gives insurers greater flexibility in presenting information, unique to their business, as plainly as possible.

We believe questions 18 and 19 imply new, specific requirements for insurers in accommodating policyholders with disabilities or who do not speak English as a first language. All insurers must already meet the requirements of the Americans with Disabilities Act and other laws governing accessibility in all their policyholder communications. To avoid implying or creating new requirements, we suggest removing questions 18 and 19.

IDENTIFICATION

To both simplify and clarify questions 25 and 26, as well as the actual RBO communication, we recommend these questions read:

"25. Does the communication clearly explain how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice?
26. Does the communication clearly explain that the consumer is not being singled out for the increase?"

As written, question 26 suggests the communication attempt to explain class basis, a technical concept. The goal is to let policyholders know they are not being singled out for an increase and our edits would help to emphasize this.

COMMUNICATION TOUCH AND TONE

Question 27, which asks whether the communication reminds consumers to reflect on why they may have purchased the policy, is both subjective and prescriptive. Question 28, which asks whether the communication expresses empathy, is the same. Because all other items in the Checklist will help to ensure policyholders think through their decision by accounting for multiple factors—a statement directing a policyholder to reflect is unwarranted. Moreover, since the communication's very purpose is to *help* policyholders manage a rate increase, we believe the question about empathy is both needless and overly subjective. Whether or not a communication expresses empathy is open to interpretation. The goal is to help. The more helpful a communication is—the more empathetic is it likely to be perceived.

Since it is impossible to list all RBOs in one communication, we suggest question 30 simply read, "Are examples of the reduced benefit options represented fairly?" To avoid overwhelming or confusing policyholders, some options will likely not be in the communication, but accessible by contacting the insurer directly, or elsewhere, as the insurer directs. Insurers can discuss specific options available to a policyholder, while accounting for a policyholder's personal situation and current benefit levels. We want to ensure that regulators do not then conclude that the RBOs included in a communication are unfairly presented, while those RBOs that policyholders access outside the communication are unfairly de-emphasized.

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CONSULTATION AND CONTACT INFORMATION

We recommend question 35 be reworded to refer generally to any *required* government resources. Resources differ, depending on the state. Departments of insurance have varying policies about information or guidance they are willing to provide in the event of a rate increase.

UNDERSTANDING OPTIONS – PRESENTATION

Depending on the insurer, type of policy, and many other factors, it is possible policyholders could have dozens of RBOs. Including explanations for even 5 to 7 RBOs, as the Checklist suggests in question 39, is likely to be overwhelming and confusing to policyholders trying to decide amongst them. Consequently, we believe it is preferable to remove the reference to a specific number of RBOs and use "reasonable" as the guideline.

Question 40, referring to the right to reduce coverage at any time, ought to be removed entirely. Not all options are available at any time, some have time limits, and sometimes policyholders have the lowest level of benefits possible, based on a state's minimum benefit standards, with no option to reduce further. Also, RBOs might not be offered to policyholders currently on claim. Additionally, question 40 is redundant with questions 45 and 46, which already address deadlines.

UNDERSTANDING OPTIONS – PAST RATE ACTIONS

Question 43 pertains to including a 10-year nationwide rate increase history in the RBO communication. This information could be pertinent to the decision to purchase coverage and is provided in the outline of coverage upon purchase of a policy. In contrast, the RBO communication focuses on the current change in premium, the policyholder's options, and the potential for a future rate increase. Past rate increases vary widely due to prior state action and are not necessarily predictive of future increases. To avoid confusing policyholders, or inadvertently influencing them to decide against their best interests, we strongly recommend question 43 be removed entirely.

UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT

We tweaked the wording in question 45 to make it clearer.

We also amended question 47 to improve accuracy and account for differences in policies and state laws. We recommend the question read, "Does the communication indicate what happens if no payment is received? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?" Contingent benefit upon lapse (CBUL) is more accurate in this instance than "contingent non-forfeiture." Additionally, it's important to note that CBUL is not applicable for all forms in all states. In some states, CBUL is only effective for policies issued after a certain date or is not an option at all.

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UNDERSTANDING OPTIONS – CURRENT BENEFITS

We believe question 48 should be edited to allow insurers to either include, or direct the policyholder to, helpful information. An RBO communication that includes *all* benefit-related information could easily become unwieldy, lengthy, and confusing. Directing a policyholder to a website or some other resource would likely be the more manageable and effective option.

We think question 49, which references inflation option illustrations, should be removed from the Checklist for a few reasons. First, not all policies have a lifetime maximum benefit in dollars. Second, any future projection included in an RBO communication could be construed as a promise of future benefits. Third, including inflation option projections could confuse and overwhelm a policyholder already comparing multiple RBOs. And finally, a general illustration does not account for critical elements such as whether some benefits had previously been received, the policyholder's location at the time of receiving benefits, cost of care when benefits are received, additional policy terms, etc.

UNDERSTANDING OPTIONS – PERSONAL DECISION

We would like clarification on question 50. Will an insurer be able to refer to options that *may* be applicable to an individual policyholder?

Question 51, pertaining to descriptions of the policyholder's RBOs, is duplicative of questions 30 and 39 and should be removed.

We suggest a change of wording in question 52.

Finally, question 53, which refers to providing an unbiased resource to research cost of care, should be removed. An insurer cannot ensure an unbiased resource exists, nor can cost of care be predicted since it is heavily dependent on location and timing of benefits, both uncertain.

UNDERSTANDING OPTIONS – VALUE OF OPTIONS

We recommend question 54 be amended to remove the reference to value and to read, "Are the resulting benefits from each presented option clearly explained?" The question could be interpreted to mean general value or monetary value. The concept of value is too subjective to be a guideline. Perception of value differs depending on the personal circumstances of each individual policyholder, including their current age, health conditions, financial position, availability of caregivers, spouse/partner considerations, etc. Further, assessing value on behalf of policyholders could constitute steering. The communication should be objective, thereby aiding policyholders to make decisions in their best interest.

UNDERSTANDING OPTIONS – IMPACT OF DECISION

We recommend clarifying question 59 to read, "For phased-in increases: Is there a table with all phase-in dates and premium amounts <u>if no reduced benefit option is elected</u>?" It would be

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impossible to create a table with this information without knowing what the policyholder elected.

We also recommend question 60 be amended to accommodate a wider range of deadlines to send communications prior to a rate increase because states' time frames can differ quite a bit.

Lastly, the language in question 61, "Does the communication disclose that not all reduction options are equal in value?" is problematic. The same reasons we give for changing question 54 apply here. The concept of value is too subjective to be a guideline. Further, the entire communication, in addition to any supplemental information the insurer may direct the policyholder to consider, will demonstrate the differences between, and consequences of choosing, each RBO. For these reasons we advise deleting question 61.

CONCLUSION

Thank you for the opportunity to provide these comments. ACLI/AHIP welcome the opportunity to discuss our comments with you in the near future.

Sincerely,

Jan M. Graeber

Senior Actuary, ACLI

Ray Nelson

AHIP Consulting Actuary

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

[ii] AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public- private partnerships that improve affordability, value, access, and well-being for consumers.

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Checklist for Premium Increase Communications

AUTHORITY

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

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

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

INTRODUCTION

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

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

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

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

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

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase. The insurance company is not expected to include the Checklist with the filings.

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Checklist for Premium Increase Communications

Insurer name:	
Date of filing:	
Product form:	
Tracking number(s) SERFF *rate* filing:	
Tracking number(s) SERFF *form* filing:	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
☐	☐	☐	1. Does the filing contain all materials required to be filed in connection with the rate increase request? ~~to include: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?~~	
☐	☐	☐	2. Has actuarial review of the rate increase been completed?	
☐	☐	☐	3. Will the rate ~~action~~ increase notification be ~~mailed~~ sent pursuant to the notification timing requirements of the state?~~at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?~~	
☐	☐	☐	4. Have all new innovation options presented in the communication been mentioned prominently as part of the filing? Have they been vetted by policy and actuarial staff?	
☐	☐	☐	5. Are there sample policyholder communications included with the filing, if required by the state~~with a statement of variability~~?	

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☐	☐	☐	6. Are there insurer rules for customer service interactions regarding RBOs?	
☐	☐	☐	7. Were any required state-specific pre-rate increase filing notification procedures followed? ~~For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.~~	
Yes	**No**	**N/A**	**READABILITY AND ACCESSIBILITY**	**Page Reference and Filing Notes**
☐	☐	☐	8. Is the communication easy to follow? Does it flow logically? Does it ~~display~~ clearly present the essential information and/or the primary action? ~~first (followed by the nonessential information)?~~	
☐	☐	☐	9. Are all insurance technical terms clearly explained in the communication?	
☐	☐	☐	10. Are all technical terms used consistently throughout the communication?	
☐	☐	☐	11. Is the communication in an easily readable font ~~in at least [11-point] type~~?	
☐	☐	☐	12. Does the communication use headings to help the reader find information easily?	
☐	☐	☐	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
☐	☐	☐	14. Are tables, charts, and other graphics, easy to read and understand?	
☐	☐	☐	15. ~~Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease score [60] or higher)?~~	

Commented [A1]: What does this mean? Clarification needed.

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☐	☐	☐	16. ~~Are there side-by-side illustrations of options compared with current benefits?~~ Are the RBOs~~y~~ clear and not misleading?	
☐	☐	☐	17. If FAQs are included, are they succinct and easy to understand?	
☐	☐	☐	~~18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language?~~ ~~For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.~~	
☐	☐	☐	~~19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?~~	
Yes	**No**	**N/A**	**IDENTIFICATION**	**Page Reference and Filing Notes**
☐	☐	☐	~~20.~~18. Does the communication answer what is happening?	
☐	☐	☐	~~21.~~19. Does the communication answer why the consumer is receiving a rate increase?	
☐	☐	☐	~~22.~~20. Does the communication reflect negatively on the Department of Insurance?	
☐	☐	☐	~~23.~~21. Does the communication indicate when the rate increase will be effective?	
☐	☐	☐	~~24.~~22. Does the communication clearly indicate they have options?	

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☐	☐	☐	~~25.~~23. Does the communication clearly ~~indicate~~ explain how ~~to~~ the consumer may elect an option? Does the election documentation ~~clearly indicate the~~allow the consumer to clearly indicate his or her~~'s~~ choice?	
☐	☐	☐	~~26. Does the communication clearly explain that the consumer is not describe "class basis"?~~ 24. ~~Are consumers~~ Does the communication clearly explain that the consumer is not being singled out for the increase? ~~Suggested text: "Overall experience of all contracts in your class…"~~	
Yes	**No**	**N/A**	**COMMUNICATION TOUCH AND TONE**	**Page Reference and Filing Notes**
☐	☐	☐	~~27.~~25. ~~Does the communication remind consumers to reflect on why they may have purchased the policy?~~	
☐	☐	☐	~~28.~~26. ~~Does the communication express empathy?~~	
☐	☐	☐	~~29.~~27. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
☐	☐	☐	~~30.~~28. Are examples of ~~the o~~options represented fairly? ~~Is one option emphasized, mentioned multiple times or bolded where the others are not?~~	
☐	☐	☐	~~31.~~29. Are the words used that could influence a policyholder's decision, such as *must* or *avoid*? For instance, consider "now," instead of "must." Consider "mitigation options," "offset premium impact," or "manage an increase" instead of "avoid an increase."	
Yes	**No**	**N/A**	**CONSULTATION AND CONTACT INFORMATION**	**Page Reference and Filing Notes**

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☐	☐	☐	~~32.~~30. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open?	
☐	☐	☐	~~33.~~31. Are website links and phone numbers accurate and functional?	
☐	☐	☐	~~34.~~32. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, or trusted family member?	
☐	☐	☐	~~35.~~33. Does the communication include any required reference to SHIPP or other long-term care-related government resources? ~~Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments can only give general information?~~	
☐	☐	☐	~~36.~~34. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss Partnership status?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS - PRESENTATION**	**Page Reference and Filing Notes**
☐	☐	☐	~~37.~~35. Does the communication have a clearly worded, descriptive title or subject line? For example: **Your Long-Term Care Premiums Are Increasing**.	
☐	☐	☐	~~38.~~36. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
☐	☐	☐	~~39.~~37. Are the number of options presented reasonable ~~(5-7 options)~~?	

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☐	☐	☐	40.38. Is the Right to Reduce Coverage at Any Time clear? Does the communication explain that outside of a rate increase, the consumer may have the right to reduce benefits?	
☐	☐	☐	41.39. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on an option?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PAST RATE ACTIONS**	
☐	☐	☐	42.40. Does the communication include a statement that premiums may increase in the future?	
☐	☐	☐	43.41. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
☐	☐	☐	44.42. Does the communication disclose the policy is guaranteed renewable?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT**	**Page Reference and Filing Notes**
☐	☐	☐	45.43. Does the communication indicate what the reader must do to elect an option and provide the deadline to do it?	
☐	☐	☐	46.44. For options that are only available during the decision window, is it clear to consumers?	
☐	☐	☐	47.45. Does the communication answer what happens if no payment is receivedsent? For example, if no payment receivedthe policy lapses	

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			within 120 days, does it advise Contingent ~~Non-Forfeiture~~Benefit Upon Lapse will apply, if applicable?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – CURRENT BENEFITS**	**Page Reference and Filing Notes**
☐	☐	☐	~~48.~~46. Does the communication include or direct the policyholder to ~~all the following~~helpful information, such as~~? Current benefits (~~; daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status~~) in list form?~~?~~	
☐	☐	☐	~~49.~~47. ~~If current benefits have an inflation option include lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?~~	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PERSONAL DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	~~50.~~48. Are the options presented available to the policyholder?	
☐	☐	☐	~~51.~~49. ~~Does the communication contain descriptions of the consumer's options (including daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?~~	
☐	☐	☐	~~52.~~50. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need and cost of~~for institutionalized~~ care?	
☐	☐	☐	~~53.~~51. ~~Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?~~	

Commented [A2]: Clarification needed

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Yes	No	N/A	UNDERSTANDING OPTIONS – VALUE OF OPTIONS	Page Reference and Filing Notes
☐	☐	☐	~~54.~~52. ~~Do options clearly indicate value for consumers?~~ Are the resulting benefits from each presented option clearly explained? ~~Does Contingent Nonforfeiture (CNF)~~Benefit Upon Lapse ~~and other limited options clearly describe the reduction in value~~resulting benefits ~~(benefit period)?~~	
☐	☐	☐	~~55.~~53. Is there a statement telling consumers how to contact the insurer for more information, the full list of options, or help understand their options?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – IMPACT OF DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	~~56.~~54. Is there a statement telling policyholders they can maintain current benefits by paying the increased premium?	
☐	☐	☐	~~57.~~55. Do the options reflect the impact of the inflation option in terms of growth or reduction if the option is to remove or reduce inflation?	
☐	☐	☐	~~58.~~56. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?	
☐	☐	☐	~~59.~~57. For phased-in increases: Is there a table with all phase-in dates and premium amounts if no reduced benefit option is elected?	
☐	☐	☐	~~60.~~58. For phased-in increases, are ~~there~~ communications sent at least 45~~-60~~ days before each phase of the increase?	
☐	☐	☐	~~61.~~59. ~~Does the communication disclose that not all reduction options are equal in value?~~	

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Checklist for Premium Increase Communications

Comments from Bonnie Burns (identified as BB) and Brenda Cude (identified as BC)

AUTHORITY

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

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

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

INTRODUCTION

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

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

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and~~,~~ complaints, to improve the quality of consumer~~the~~ communications, and to ensure the information[A1] presented: The checklist seeks to ensure that consumer communications

- Read~~s~~ in a clear, logical, not overly complex manner.
- ~~Identifies if the~~Present options ~~are~~ presented fairly and without subtle coercion.

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- Include~~s~~ appropriate referrals to external resources, definitions, disclosures, and visualization tools.

The RBO (EX) Subgroup **RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and ~~adopt~~ use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

The RBO (EX) Subgroup **CALLS ON** all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.

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Checklist for Premium Increase Communications

Insurer name:	
Date of filing:	
Product form:	
Tracking number(s) SERFF *rate* filing:	
Tracking number(s) SERFF *form* filing:	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
☐	☐	☐	1. Does the filing contain all materials, ~~to~~ includinge: policyholder communication, supplemental FAQs, graphs, illustrations, website screenshots (expected ~~screenshots may be requested~~ if communication refers policyholder to website for more information)?	
☐	☐	☐	2. Has actuarial review of the rate increase been completed?	
☐	☐	☐	3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?	
☐	☐	☐	4. Have all innovation[A2] options presented in the communication been mentioned prominently as part of the filing? Have they been vetted by policy and actuarial staff?	
☐	☐	☐	5. Are there sample policyholder communications with a statement of variability?	

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☐	☐	☐	6. Are there insurer rules and training for customer service interactions regarding RBOs[A3]?	
☐	☐	☐	7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.	
Yes	**No**	**N/A**	**READABILITY AND ACCESSIBILITY**	**Page Reference and Filing Notes**
☐	☐	☐	8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?	
☐	☐	☐	9. Are all insurance technical terms clearly explained in the communication?	
☐	☐	☐	10. Are all technical terms used consistently throughout the communication?	
☐	☐	☐	11. Is the communication in an easily readable font (~~in~~ at least [[~~[~~11-point]]~~]~~ type)?	
☐	☐	☐	12. Does the communication use headings to help the reader find information easily?	
☐	☐	☐	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	

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☐	☐	☐	14. Are tables, charts, and other graphics, easy to read and understand[A4]?	
☐	☐	☐	15. Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease[A5] score [60] or higher)?[A6]	
☐	☐	☐	16. Are there side-by-side illustrations of options compared with current benefits? Are they clear and not misleading?	
☐	☐	☐	17. If FAQs are included, are they succinct and easy to understand?	
☐	☐	☐	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or low vision[A7], deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
☐	☐	☐	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?	
Yes	**No**	**N/A**	**IDENTIFICATION**	**Page Reference and Filing Notes**
☐	☐	☐	20. Does the communication answer what is happening?	
☐	☐	☐	21. Does the communication answer why the consumer is receiving a rate increase?	

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☐	☐	☐	22. Does the communication reflect negatively[A8] on the Department of Insurance?[A9]	
☐	☐	☐	23. Does the communication indicate when the rate increase will be effective?	
☐	☐	☐	24. Does the communication clearly indicate the policyholder~~y~~ has~~ve~~ options?	
☐	☐	☐	25. Does the communication clearly indicate how to elect an option? Does the election documentation clearly indicate the consumer's choice[A10]?	
☐	☐	☐	26. Does the communication clearly describe "class basis"? Are consumers being singled out for the increase? Suggested text: "Overall experience of all contracts[A11] in your class…"	
Yes	**No**	**N/A**	**COMMUNICATION TOUCH AND TONE**	**Page Reference and Filing Notes**
☐	☐	☐	27. Does the communication remind consumers to reflect on ~~why they may have purchased~~the original reason they bought the policy?	
☐	☐	☐	28. Does the communication express empathy and understanding of the difficulty of evaluating choices?	
☐	☐	☐	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	

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☐	☐	☐	30. Are the options represented fairly? Options are **not** presented fairly if~~s~~ one option is emphasized, mentioned multiple times or bolded when~~re the~~ other options~~s~~ are not?	
☐	☐	☐	31. Are ~~the~~ words used that could influence a policyholder's decision, such as *must* or *avoid*? For instance, consider "now," instead of "must[A12]." Consider "mitigation options[A13]," "offset premium impact[A14]," or "manage an increase" instead of "avoid an increase."	
Yes	**No**	**N/A**	**CONSULTATION AND CONTACT INFORMATION**	**Page Reference and Filing Notes**
☐	☐	☐	32. Is the insurer's consumer service number[A15] easy to find? Is it clear what hours and days consumer service is open[A16]?	
☐	☐	☐	33. Are website links and phone numbers accurate and functional?	
☐	☐	☐	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, state SHIP program [A17]with the state-specific name of the program, or trusted family member[A18]?	
☐	☐	☐	35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department~~s~~ can only give general information?	
☐	☐	☐	36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss Partnership status?	

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Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes
☐	☐	☐	37. Does the communication have a clearly worded, descriptive title or subject line? For example: **Your Long-Term Care Premiums Are Increasing**.	
☐	☐	☐	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
☐	☐	☐	39. Are the number of options presented reasonable (5-7 [A19]options)?	
☐	☐	☐	40. Is the Right to Reduce Coverage at Any Time at any time of a policyholder's choosing clear? Are the instructions about how to do that clear?	
☐	☐	☐	41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose~~decide on~~ an option?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PAST RATE ACTIONS**	
☐	☐	☐	42. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?	

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☐	☐	☐	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
☐	☐	☐	44. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT**	**Page Reference and Filing Notes**
☐	☐	☐	45. Does the communication indicate what the reader must do and the deadline to do it?	
☐	☐	☐	46. ~~For~~ If options ~~that~~ are only available during the decision window, is that limitation~~it~~ clear to consumers?	
☐	☐	☐	47. Does the communication ~~answer~~ address what happens if the policyholder does not send a~~no~~ payment ~~is sent~~? For example, if no payment is received within 120 days, does the communication explain~~it~~ that~~advise~~ Contingent Non-Forfeiture will apply and what that means?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – CURRENT BENEFITS**	**Page Reference and Filing Notes**
☐	☐	☐	48. Does the communication include all the following information? C~~C~~urrent policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?	

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☐	☐	☐	49. If current benefits have an inflation option, does the communication include the lifetime maximum benefit in dollars, illustrated both five and fifteen years into the future?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PERSONAL DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	50. Are the options presented [A20]available to the policyholder?	
☐	☐	☐	51. Does the communication contain descriptions of the consumer's options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	
☐	☐	☐	52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?	
☐	☐	☐	53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – VALUE OF OPTIONS**	**Page Reference and Filing Notes**
☐	☐	☐	54. Do options clearly indicate value for consumers? Does Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?[A21]	

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☐	☐	☐	55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options[A22], or help understand their options?	.
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – IMPACT OF DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	
☐	☐	☐	57. Do the options reflect the impact of removing or reducing the inflation option on the~~in terms of~~ growth or reduction ~~if the option is to remove or reduce inflation?~~of future benefits?	
☐	☐	☐	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?	
☐	☐	☐	59. For phased-in increases: [A23]Is there a table with all phase-in dates and premium amounts?	
☐	☐	☐	60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?	
☐	☐	☐	61. Does the communication disclose that ~~not~~ all reduction options ~~are~~ require careful consideration and are not of equal ~~in~~ value?	

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Checklist for Premium Increase Communications

AUTHORITY

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

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

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

INTRODUCTION

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

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

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

- Reads in a clear, logical, not overly complex manner.
- Identifies the options are fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

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

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

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Checklist for Premium Increase Communications

Insurer name:	
Date of filing:	
Product form:	
Tracking number(s) SERFF *rate* filing:	
Tracking number(s) SERFF *form* filing:	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
☐	☐	☐	1. Does the filing contain all materials to include: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?	
☐	☐	☐	2. Has actuarial review of the rate increase been completed?	
☐	☐	☐	3. Will the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?	
☐	☐	☐	4. Have all innovation options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff?	
☐	☐	☐	5. Are there sample policyholder communications with a statement of variability?	
☐	☐	☐	6. Are there insurer rules for customer service interactions regarding RBOs?	

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Commented [A1]: Could we add an example of a rule that a regulator should be looking for?

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☐	☐	☐	7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.	
Yes	**No**	**N/A**	**READABILITY AND ACCESSIBILITY**	**Page Reference and Filing Notes**
☐	☐	☐	8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)?	
☐	☐	☐	9. Are all technical insurance terms clearly explained in the communication?	
☐	☐	☐	10. Are all technical terms used consistently throughout the communication?	
☐	☐	☐	11. Is the communication in an easily readable font in at least [11-point] type?	
☐	☐	☐	12. Does the communication use headings to help the reader find information easily?	
☐	☐	☐	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
☐	☐	☐	14. Are tables, charts, and other graphics, easy to read and understand?	
☐	☐	☐	15. Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease score [60] or higher)?	
☐	☐	☐	16. Are there side-by-side illustrations of options compared with current benefits? Are they clear and not misleading?	

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☐	☐	☐	17. If FAQs are included, are they succinct and easy to understand?	
☐	☐	☐	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
☐	☐	☐	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?	
Yes	**No**	**N/A**	**IDENTIFICATION**	**Page Reference and Filing Notes**
☐	☐	☐	20. Does the communication answer what is happening?	
☐	☐	☐	21. Does the communication answer why the consumer is receiving a rate increase?	
☐	☐	☐	22. Does the communication reflect negatively on the Department of Insurance?	
☐	☐	☐	23. Does the communication indicate when the rate increase will be effective?	
☐	☐	☐	24. Does the communication clearly indicate they have options?	
☐	☐	☐	25. Does the communication clearly indicate how to elect an option? Does the election documentation clearly indicate the consumer's choice?	

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☐	☐	☐	26. Does the communication clearly describe "class basis"? Are consumers being singled out for the increase? Suggested text: "Overall experience of all contracts in your class…"	
Yes	**No**	**N/A**	**COMMUNICATION TOUCH AND TONE**	**Page Reference and Filing Notes**
☐	☐	☐	27. Does the communication remind consumers to reflect on why they may have purchased the policy?	
☐	☐	☐	28. Does the communication express empathy?	
☐	☐	☐	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
☐	☐	☐	30. Are the options represented fairly? Is one option emphasized, mentioned multiple times or bolded where the others are not?	
☐	☐	☐	31. Are words used that could influence a policyholder's decision, such as *must* or *avoid*? For instance, consider "now," instead of "must." Consider "mitigation options," "offset premium impact," or "manage an increase" instead of "avoid an increase."	
Yes	**No**	**N/A**	**CONSULTATION AND CONTACT INFORMATION**	**Page Reference and Filing Notes**
☐	☐	☐	32. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open?	
☐	☐	☐	33. Are website links and phone numbers accurate and functional?	
☐	☐	☐	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, or trusted family member?	

Commented [A2]: If the answer to the first is "yes," the answer to the second is likely to be "no," so this doesn't work well with the yes/no checklist.

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☐	☐	☐	35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments can only give general information?	
☐	☐	☐	36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS - PRESENTATION**	**Page Reference and Filing Notes**
☐	☐	☐	37. Does the communication have a clearly worded, descriptive title or subject line? For example: **Your Long-Term Care Premiums Are Increasing**.	
☐	☐	☐	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
☐	☐	☐	39. Are the number of options presented reasonable (5-7 options)?	
☐	☐	☐	40. Is the right to reduce coverage at any time clear?	
☐	☐	☐	41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on an option?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PAST RATE ACTIONS**	
☐	☐	☐	42. Does the communication include a statement that premiums may increase in the future?	

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☐	☐	☐	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
☐	☐	☐	44. Does the communication disclose the policy is guaranteed renewable?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT**	**Page Reference and Filing Notes**
☐	☐	☐	45. Does the communication indicate what the reader must do and the deadline to do it?	
☐	☐	☐	46. For options that are only available during the decision window, is it clear to consumers?	
☐	☐	☐	47. Does the communication answer what happens if no payment is sent? For example, if no payment is received within 120 days, does it advise Contingent Non-Forfeiture will apply?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – CURRENT BENEFITS**	**Page Reference and Filing Notes**
☐	☐	☐	48. Does the communication include all the following information? Current benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?	
☐	☐	☐	49. If current benefits have an inflation option, does the communication include lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PERSONAL DECISION**	**Page Reference and Filing Notes**

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☐	☐	☐	50. Are the options presented available to the policyholder?	
☐	☐	☐	51. Does the communication contain descriptions of the consumer's options (including daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	
☐	☐	☐	52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?	
☐	☐	☐	53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – VALUE OF OPTIONS**	**Page Reference and Filing Notes**
☐	☐	☐	54. Do options clearly indicate value for consumers? Do Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?	
☐	☐	☐	55. Is there a statement telling consumers how to contact the insurer for more information, the full list of options, or help understand their options?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – IMPACT OF DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	56. Is there a statement telling policyholders they can maintain current benefits by paying the increased premium?	

Commented [A3]: Is this question different than # 48?

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Commented [A4]: Does this question add anything to # 29 and 32?

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☐	☐	☐	57. Do the options reflect the impact of the inflation option in terms of growth or reduction if the option is to remove or reduce inflation?	
☐	☐	☐	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?	
☐	☐	☐	59. For phased-in increases: Is there a table with all phase-in dates and premium amounts?	
☐	☐	☐	60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?	
☐	☐	☐	61. Does the communication disclose that not all reduction options are equal in value?	

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Checklist for Premium Increase Communications

AUTHORITY

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

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

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

INTRODUCTION

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

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

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

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

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

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

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Checklist for Premium Increase Communications

Insurer name:	
Date of filing:	
Product form:	
Tracking number(s) SERFF *rate* filing:	
Tracking number(s) SERFF *form* filing:	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
☐	☐	☐	1. Does the filing contain all materials to include: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?	
☐	☐	☐	2. Has actuarial review of the rate increase been completed?	
☐	☐	☐	3. Will the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?	
☐	☐	☐	4. Have all innovation options presented in the communication been mentioned prominently as part of the filing? Have they been vetted by policy and actuarial staff?	
☐	☐	☐	5. Are there sample policyholder communications with a statement of variability?	
☐	☐	☐	6. Are there insurer rules for customer service interactions regarding RBOs?	

Commented [A1]: What is this looking for? Is the suggestion that DOIs should be getting the customer service script for RBO conversations? Possible deletion.

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☐	☐	☐	7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.	
Yes	**No**	**N/A**	**READABILITY AND ACCESSIBILITY**	**Page Reference and Filing Notes**
☐	☐	☐	8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)?	
☐	☐	☐	9. Are all insurance technical terms clearly explained in the communication?	
☐	☐	☐	10. Are all technical terms used consistently throughout the communication?	
☐	☐	☐	11. Is the communication in an easily readable font in at least [11-point] type?	
☐	☐	☐	12. Does the communication use headings to help the reader find information easily?	
☐	☐	☐	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
☐	☐	☐	14. Are tables, charts, and other graphics, easy to read and understand?	
☐	☐	☐	15. Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease score [60] or higher)?	
☐	☐	☐	16. Are there side-by-side illustrations of options compared with current benefits? Are they clear and not misleading?	

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☐	☐	☐	17. If FAQs are included, are they succinct and easy to understand?	
☐	☐	☐	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
☐	☐	☐	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?	
Yes	**No**	**N/A**	**IDENTIFICATION**	**Page Reference and Filing Notes**
☐	☐	☐	20. Does the communication answer what is happening?	
☐	☐	☐	21. Does the communication answer why the consumer is receiving a rate increase?	
☐	☐	☐	22. Does the communication reflect negatively on the Department of Insurance?	
☐	☐	☐	23. Does the communication indicate when the rate increase will be effective?	
☐	☐	☐	24. Does the communication clearly indicate they have options?	
☐	☐	☐	25. Does the communication clearly indicate how to elect an option? Does the election documentation clearly indicate the consumer's choice?	

Commented [A2]: This ends up being redundant of the prior question. I'd either pull language out of the prior question or delete this as a stand-alone question.

Commented [A3]: Redundant of question 16. Might be worth consolidating.

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☐	☐	☐	26. Does the communication clearly describe "class basis"? Are consumers being singled out for the increase? Suggested text: "Overall experience of all contracts in your class…"	
Yes	**No**	**N/A**	**COMMUNICATION TOUCH AND TONE**	**Page Reference and Filing Notes**
☐	☐	☐	27. Does the communication remind consumers to reflect on why they may have purchased the policy?	
☐	☐	☐	28. Does the communication express empathy?	
☐	☐	☐	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
☐	☐	☐	30. Are the options represented fairly? Is one option emphasized, mentioned multiple times or bolded where the others are not?	
☐	☐	☐	31. Are the words used that could influence a policyholder's decision, such as *must* or *avoid*? For instance, consider "now," instead of "must." Consider "mitigation options," "offset premium impact," or "manage an increase" instead of "avoid an increase."	
Yes	**No**	**N/A**	**CONSULTATION AND CONTACT INFORMATION**	**Page Reference and Filing Notes**
☐	☐	☐	32. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open?	
☐	☐	☐	33. Are website links and phone numbers accurate and functional?	
☐	☐	☐	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, or trusted family member?	

Commented [A4]: Might be worth consolidating with question 29.

Commented [A5]: I'd hope so…is this to suggest that the filing team should test the website addresses and phone numbers? Is that what we typically do with other filings?

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☐	☐	☐	35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments can only give general information?	
☐	☐	☐	36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss Partnership status?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS - PRESENTATION**	**Page Reference and Filing Notes**
☐	☐	☐	37. Does the communication have a clearly worded, descriptive title or subject line? For example: **Your Long-Term Care Premiums Are Increasing**.	
☐	☐	☐	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
☐	☐	☐	39. Are the number of options presented reasonable (5-7 options)?	
☐	☐	☐	40. Is the Right to Reduce Coverage at Any Time clear?	
☐	☐	☐	41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on an option?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PAST RATE ACTIONS**	
☐	☐	☐	42. Does the communication include a statement that premiums may increase in the future?	

Commented [A6]: I'd delete the second question. The first question suggests consumers should consult with the Department but the second suggests that such consultation might be a waste of time.

Commented [A7]: Might be worth consolidating with question 34.

Commented [A8]: Is 7 options "reasonable?" I think 5 or fewer is more appropriate.

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☐	☐	☐	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
☐	☐	☐	44. Does the communication disclose the policy is guaranteed renewal?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT**	**Page Reference and Filing Notes**
☐	☐	☐	45. Does the communication indicate what the reader must do and the deadline to do it?	
☐	☐	☐	46. For options that are only available during the decision window, is it clear to consumers?	
☐	☐	☐	47. Does the communication answer what happens if no payment is sent? For example, if no payment received within 120 days, does it advise Contingent Non-Forfeiture will apply?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – CURRENT BENEFITS**	**Page Reference and Filing Notes**
☐	☐	☐	48. Does the communication include all the following information? Current benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?	
☐	☐	☐	49. If current benefits have an inflation option include lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PERSONAL DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	50. Are the options presented available to the policyholder?	

Commented [A9]: Are insurers supposed to include the 10-year nationwide rate increase history? I'm not sure that is relevant for the consumer and may be more of a distraction.

Commented [A10]: I think this is missing a few words.

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☐	☐	☐	51. Does the communication contain descriptions of the consumer's options (including daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	
☐	☐	☐	52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?	
☐	☐	☐	53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – VALUE OF OPTIONS**	**Page Reference and Filing Notes**
☐	☐	☐	54. Do options clearly indicate value for consumers? Does Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?	
☐	☐	☐	55. Is there a statement telling consumers how to contact the insurer for more information, the full list of options, or help understand their options?	.
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – IMPACT OF DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	56. Is there a statement telling policyholders they can maintain current benefits by paying the increased premium?	
☐	☐	☐	57. Do the options reflect the impact of the inflation option in terms of growth or reduction if the option is to remove or reduce inflation?	

Commented [A11]: Questions 50 and 51 seem like they have been already addressed above in terms of the presentation and readibility of options. Worth considering some consolidation.

Commented [A12]: Redundant of one or more of the above questions.

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☐	☐	☐	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?	
☐	☐	☐	59. For phased-in increases: Is there a table with all phase-in dates and premium amounts?	
☐	☐	☐	60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?	
☐	☐	☐	61. Does the communication disclose that not all reduction options are equal in value?	

Commented [A13]: I don't think this is ever fair. Is that a consideration? You shouldn't lose inflation to date--it should be forward-looking.

DRAFT

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Comments as of 7-21-21 Noted

Checklist for Premium Increase Communications

AUTHORITY

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

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

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

INTRODUCTION

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

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

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

- Reads in a clear, logical, not overly complex manner.
- Identifies the options are fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

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

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Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and complaints, improve the quality of consumer communications, and to ensure the information presented. The checklist seeks to ensure that consumer communications

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

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

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

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Commented [A3]: BC: It seems a modifier is needed – to ensure that accurate information is presented? Or relevant? Or delete and add – The checklist seeks to ensure that consumer communications:

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Commented [A4]: CA

Commented [A5]: BB & BC

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DRAFT

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Checklist for Premium Increase Communications

Insurer name:	
Date of filing:	
Product form:	
Tracking number(s) SERFF *rate* filing:	
Tracking number(s) SERFF *form* filing:	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
☐	☐	☐	1. Does the filing contain all materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?	
☐	☐	☐	2. Has actuarial review of the rate increase been completed?	
☐	☐	☐	3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?	
☐	☐	☐	4. Have all innovation options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff?	
☐	☐	☐	5. Are there sample policyholder communications with a statement of variability?	
☐	☐	☐	6. Are there insurer rules and training for customer service interactions regarding RBOs?	

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Commented [A6]: ACLI: Question 1 lists specific materials to include with the rate increase filing. Because some of those materials would not be applicable to all rate increase filings, readily available at the time of filing, and/or required by the state, we suggest a more general question, "Does the filing contain all materials required to be filed in connection with the rate increase request?"

Commented [A7]: BB & BC

Commented [A8]: BB & BC

Commented [A9]: ACLI: Rephrasing question 3 to be more general would account for the different notification timing requirements amongst states, as well as the possibility notifications might be sent electronically.

Commented [A10]: BB: Should this be RBOs?

Commented [A11]: CA

Deleted: mentioned prominently as part of

Commented [A12]: ACLI: On question 4 we recommend adding "new" before "innovation options" for additional clarification.

Commented [A13]: ACLI: We recommend question 5 be amended to reference state-required samples of policyholder communications, so as not to imply a new requirement where one does not currently exist.

Commented [A14]: CA: Could we add an exampl... [1]

Commented [A15]: BB & BC

Commented [A16]: BB: I've had experience with ... [2]

Commented [A17]: MH: What is this looking for? ... [3]

Commented [A18]: ACLI: We find question 6 to b... [4]

3

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Yes	No	N/A		Page Reference and Filing Notes
☐	☐	☐	7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.	
			READABILITY AND ACCESSIBILITY	
☐	☐	☐	8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?	
☐	☐	☐	9. Are all technical insurance terms clearly explained in the communication?	
☐	☐	☐	10. Are all technical terms used consistently throughout the communication?	
☐	☐	☐	11. Is the communication in an easily readable font in at least [11-point] type?	
☐	☐	☐	12. Does the communication use headings to help the reader find information easily?	
☐	☐	☐	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
☐	☐	☐	14. Are tables, charts, and other graphics, easy to read and understand?	
☐	☐	☐	15. Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease score [60] or higher)?	
☐	☐	☐	16. Are there side-by-side illustrations of options compared with current benefits? Are they clear and not misleading?	

Commented [A19]: ACLI: Finally, we believe question 7 should reference required state-specific pre-rate increase filing notification procedures and that the example be removed because it could confuse insurers and regulators in instances where the scenarios given in the example do not apply.

Commented [A20]: ACLI: We suggest the questions in this section be amended to remove specific requirements of readability and accessibility to give insurers maximum flexibility in creating communications that best serve their policyholders.

Commented [A21]: ACLI: in question 8, instead of assigning the order of information in a communication, the question should indicate the end goal, "Does the communication clearly present the essential information and/or primary action?" The order of information is irrelevant so long as the communication is easy to follow, logical, and important information is clearly presented.

Commented [A22]: BB & BC

Commented [A23]: CA

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Commented [A24]: ACLI: In question 11, removing the reference to 11-point type, but keeping the guidance that the communication be in "easily readable font" accounts for the additional impact formatting, lay(... [5]

Commented [A25]: BB: Perhaps there should be some reference here to people with visual problems, size ... [6]

Commented [A26]: BC: Do the brackets indicate that a state that has different standards may change to r ... [7]

Commented [A27]: BC: If these are the standards you are expecting, then perhaps the checklist should b ... [8]

Commented [A28]: ACLI: The Flesch reading ease score in question 15 implies a specific, new ... [9]

Commented [A29]: ACLI: Amending question 16 to simply ask, "Are the RBOs clear and not misleadir ... [10]

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Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
☐	☐	☐	17. If FAQs are included, are they succinct and easy to understand?	
☐	☐	☐	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
☐	☐	☐	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?	
☐	☐	☐	20. Does the communication answer what is happening?	
☐	☐	☐	21. Does the communication answer why the consumer is receiving a rate increase?	
☐	☐	☐	22. Does the communication reflect negatively on the Department of Insurance?	
☐	☐	☐	23. Does the communication indicate when the rate increase will be effective?	
☐	☐	☐	24. Does the communication clearly indicate the policyholder has options?	
☐	☐	☐	25. Does the communication clearly indicate how to elect an option? Does the election documentation clearly indicate the consumer's choice?	

Commented [A30]: ACLI: We believe questions 18 and 19 imply new, specific requirements for insurers in accommodating policyholders with disabilities or who do not speak English as a first language. All insurers must already meet the requirements of the Americans with Disabilities Act and other laws governing accessibility in all their policyholder communications. To avoid implying or creating new requirements, we suggest removing questions 18 and 19.

Commented [A31]: BB: Macular degeneration and other visual conditions can make text and tables hard to read. Some people use various magnifying devices and can only see portions of a page or table at a time.

Commented [A32]: MH: This ends up being redundant of the prior question. I'd either pull language out of the prior question or delete this as a stand-alone question.

Commented [A33]: BC: Are examples needed to illustrate how the department might view a communication to reflect negatively on the department?

Commented [A34]: BB: Maybe this can be re-worded: Does the communication include information about how to contact the Department of Insurance?

Commented [A35]: BB & BC

Commented [A36]: MH: Redundant of question 16. Might be worth consolidating.

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Commented [A37]: BB: When check boxes are used to indicate a choice there should be some way to verify that choice on the form returned to the insurer to avoid mistakes.

Commented [A38]: ACLI: To both simplify and clarify questions 25 and 26, as well as the actual RBO communication, we recommend these questions ... [11]

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☐	☐	☐	26. Does the communication clearly describe "class basis"? Are consumers being singled out for the increase? Suggested text: "Overall experience of all contracts in your class…"	
Yes	**No**	**N/A**	**COMMUNICATION TOUCH AND TONE**	**Page Reference and Filing Notes**
☐	☐	☐	27. Does the communication remind consumers to reflect on the original reason they bought the policy?	
☐	☐	☐	28. Does the communication express empathy and understanding of the difficulty of evaluating choices ?	
☐	☐	☐	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
☐	☐	☐	30. Are the options represented fairly? Options are **not** presented fairly If one option is emphasized, mentioned multiple times or bolded when the other options are not?	
☐	☐	☐	31. Are words used that could influence a policyholder's decision, such as *must* or *avoid*? For instance, consider "now," instead of "must." Consider "mitigation options," "offset premium impact," or "manage an increase" instead of "avoid an increase."	
Yes	**No**	**N/A**	**CONSULTATION AND CONTACT INFORMATION**	**Page Reference and Filing Notes**
☐	☐	☐	32. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open?	
☐	☐	☐	33. Are website links and phone numbers accurate and functional?	

Commented [A39]: BC: Consumers don't think of their policies as contracts.

Commented [A40]: ACLI: Question 27, which asks whether the communication reminds consumers to reflect on why they may have purchased the policy, is both subjective and prescriptive. Question 28, which asks whether the communication expresses empathy, is the same. Because all other items in the Checklist will help to ensure policyholders think through their decision by accounting for multiple factors—a statement directing a policyholder to reflect is unwarranted. Moreover, since the communication's very purpose is to help policyholders manage a rate increase, we believe the question about empathy … [12]

Deleted: why they may have purchased

Commented [A41]: BB & BC

Commented [A42]: BB & BC

Commented [A43]: ACLI: Since it is impossible t … [13]

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Commented [A44]: CA: If the answer to the first … [14]

Commented [A45]: BB & BC

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Commented [A47]: BC: I don't understand how … [15]

Commented [A48]: BC: A term many consumers … [16]

Commented [A49]: BC: High reading level.

Commented [A50]: BB: Is the number direct to … [17]

Commented [A51]: BB: Are customer service … [18]

Commented [A52]: MH: Might be worth consoli … [19]

Commented [A53]: MH: I'd hope so…is this to s … [20]

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☐	☐	☐	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, state SHIP program with the state-specific name of the program, or trusted family member?	
☐	☐	☐	35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department can only give general information?	
☐	☐	☐	36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS - PRESENTATION**	**Page Reference and Filing Notes**
☐	☐	☐	37. Does the communication have a clearly worded, descriptive title or subject line? For example: **Your Long-Term Care Premiums Are Increasing**.	
☐	☐	☐	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
☐	☐	☐	39. Are the number of options presented reasonable (5-7 options)?	
☐	☐	☐	40. Is the right to reduce coverage at any time at any time of a policyholder's choosing clear? Are the instructions about how to do that clear?	
☐	☐	☐	41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?	

Commented [A54]: BB: The state SHIP program should be listed with the state specific name of the program.

Commented [A55]: BB: That information should be strategically located and clearly communicated.

Commented [A56]: BB & BC

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Commented [A57]: MH: I'd delete the second question. The first question suggests consumers should consult with the Department but the second suggests that such consultation might be a waste of time.

Commented [A58]: ACLI: We recommend question 35 be reworded to refer generally to any required government resources. Resources differ, depending on the state. Departments of insurance have varying ... [21]

Commented [A59]: CA

Commented [A60]: MH: Might be worth consoli ... [22]

Commented [A61]: MH: s 7 options "reasonable ... [23]

Commented [A62]: ACLI: Depending on the insu ... [24]

Commented [A63]: BB: Some insurers may offer ... [25]

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Commented [A64]: BB & BC

Commented [A65]: ACLI: Question 40, referring ... [26]

Commented [A66]: CA

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Commented [A68]: BB & BC

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Yes	No	N/A	UNDERSTANDING OPTIONS – PAST RATE ACTIONS	
☐	☐	☐	42. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?	
☐	☐	☐	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
☐	☐	☐	44. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT**	**Page Reference and Filing Notes**
☐	☐	☐	45. Does the communication indicate what the reader must do and the deadline to do it?	
☐	☐	☐	46. If options are only available during the decision window, is that limitation clear to consumers?	
☐	☐	☐	47. Does the communication address what happens if the policyholder does not send payment? For example, if no payment is received within 120 days, does the communication explain that Contingent Non-Forfeiture will apply and what that means?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – CURRENT BENEFITS**	**Page Reference and Filing Notes**
☐	☐	☐	48. Does the communication include all the following information? Current policy benefits (daily benefit, elimination period, current	

Commented [A69]: BB & BC

Commented [A70]: MH: Are insurers supposed to include the 10-year nationwide rate increase history? I'm not sure that is relevant for the consumer and may be more of a distraction.

Commented [A71]: ACLI: Question 43 pertains to including a 10-year nationwide rate increase history in the RBO communication. This information could be pertinent to the decision to purchase coverage and is provided in the outline of coverage upon purchase of a policy. In contrast, the RBO communication focuses on the current change in premium, the policyholder's options, and the potential for a future rate increase. Past rate increases vary widely due to prior state action and are not necessarily predictive of future increases. To avoid confusing policyholders, or inadvertently influencing them to decide against their best inte ... [27]

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Commented [A72]: BB & BC

Commented [A73]: CA

Commented [A74]: ACLI: We tweaked the wordi ... [28]

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Commented [A75]: BB & BC.

Commented [A76]: ACLI: We also amended que ... [29]

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Commented [A77]: BB & BC

Commented [A78]: ACLI: We believe question 4 ... [30]

Commented [A79]: BB & BC

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			lifetime maximum benefit in dollars, inflation option, partnership status) in list form?	
☐	☐	☐	49. If current benefits have an inflation option, does the communication include the lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – PERSONAL DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	50. Are the options presented available to the policyholder?	
☐	☐	☐	51. Does the communication contain descriptions of the consumer's options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	
☐	☐	☐	52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?	
☐	☐	☐	53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – VALUE OF OPTIONS**	**Page Reference and Filing Notes**
☐	☐	☐	54. Do options clearly indicate value for consumers? Do Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?	

Commented [A80]: ACLI: We think question 49, which references inflation option illustrations, should be removed from the Checklist for a few reasons. First, not all policies have a lifetime maximum benefit in dollars. Second, any future projection included in an RBO communication could be construed as a promise of future benefits. Third, including inflation option projections could confuse and overwhelm a policyholder already comparing multiple RBOs. A ... [31]

Commented [A81]: CA

Commented [A82]: BB & BC

Commented [A83]: MH: think this is missing a few words.

Commented [A84]: ACLI: We would like clarification on question 50. Will an insurer be able to refer to ... [32]

Commented [A85]: BB: I don't understand this question. Why would some options not be availa ... [33]

Commented [A86]: ACLI: Question 51, pertaining to descriptions of the policyholder's RBOs, is duplic ... [34]

Commented [A87]: BB & BC

Commented [A88]: CA: Is this question different than # 48?

Commented [A89]: MH: Questions 50 and 51 seem like they have been already addressed above in t ... [35]

Commented [A90]: ACLI: We suggest a change of wording in question 52.

Commented [A91]: ACLI: Finally, question 53, which refers to providing an unbiased resource to resea ... [36]

Commented [A92]: ACLI: We recommend question 54 be amended to remove the reference to value an ... [37]

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Commented [A93]: CA

Commented [A94]: BC: I don't understand what this means.

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☐	☐	☐	55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options, or help understand their options?	
Yes	**No**	**N/A**	**UNDERSTANDING OPTIONS – IMPACT OF DECISION**	**Page Reference and Filing Notes**
☐	☐	☐	56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	
☐	☐	☐	57. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?	
☐	☐	☐	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?	
☐	☐	☐	59. For phased-in increases: Is there a table with all phase-in dates and premium amounts?	
☐	☐	☐	60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?	
☐	☐	☐	61. Does the communication disclose that all reduction options require careful consideration and are not of equal value?	

Commented [A95]: BC: Why would they need to do this? Wouldn't the notice include that?

Commented [A96]: CA: Does this question add anything to # 29 and 32?

Commented [A97]: MH: Redundant of one or more of the above questions.

Commented [A98]: BB & BC

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Deleted: if the option is to remove or reduce inflation

Commented [A99]: BB & BC

Commented [A100]: MH: I don't think this is ever fair. Is that a consideration? You shouldn't lose inflation to date--it should be forward-looking.

Commented [A101]: BB: Are insurers required to offer RBO"s with each phase-in date? If so is that information included with the phase in information? Will policyholders know they will have options with each increase notice they receive?

Commented [A102]: ACLI: We recommend clarifying question 59 to read, "For phased-in increases: Is there a table with all phase-in dates and premium amounts if no reduced benefit option is elected?" It would be mpossible to create a table with this information without knowing what the policyholder elected.

Commented [A103]: ACLI: We also recommend question 60 be amended to accommodate a wider range of deadlines to send communications prio... [38]

Commented [A104]: ACLI: Lastly, the language in question 61, "Does the communication disclose t... [39]

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Commented [A105]: BB & BC

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Page 3: [1] Commented [A14] Author

CA: Could we add an example of a rule that a regulator should be looking for?

Page 3: [2] Commented [A16] Author

BB: I've had experience with customer service reps in foreign countries with strong accents and little knowledge of options.

Page 3: [3] Commented [A17] Author

MH: What is this looking for? Is the suggestion that DOIs should be getting the customer service script for RBO conversations? Possible deletion.

Page 3: [4] Commented [A18] Author

ACLI: We find question 6 to be ambiguous and suggest removal, or clarification, without implying a new requirement regarding customer service operations.

Page 4: [5] Commented [A24] Author

ACLI: In question 11, removing the reference to 11-point type, but keeping the guidance that the communication be in "easily readable font" accounts for the additional impact formatting, layout, font, illustrations, bullet points, logos, etc. have on readability. Type size is just one element of many that make a communication easy to read and understand.

Page 4: [6] Commented [A25] Author

BB: Perhaps there should be some reference here to people with visual problems, size of text, color, formatting?

Page 4: [7] Commented [A26] Author

BC: Do the brackets indicate that a state that has different standards may change to match their standards? If so, a drafting note if needed.

Page 4: [8] Commented [A27] Author

BC: If these are the standards you are expecting, then perhaps the checklist should be edited. The statistics for it currently are 12th grade and a Flesch Reading Ease Score of 32.

Page 4: [9] Commented [A28] Author

ACLI: The Flesch reading ease score in question 15 implies a specific, new requirement. For this reason, and because the question is redundant with questions 8 through 14, which establish readability, we recommend question 15 be removed entirely.

Page 4: [10] Commented [A29] Author

ACLI: Amending question 16 to simply ask, "Are the RBOs clear and not misleading?" without implying a specific side-by-side format gives insurers greater flexibility in presenting information, unique to their business, as plainly as possible.

Page 5: [11] Commented [A38] Author

ACLI: To both simplify and clarify questions 25 and 26, as well as the actual RBO communication, we recommend these questions read:

"25. Does the communication clearly explain how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? 26. Does the communication clearly explain that the consumer is not being singled out for the increase?"

As written, question 26 suggests the communication attempt to explain class basis, a technical concept. The goal is to let policyholders know they are not being singled out for an increase and our edits would help to emphasize this.

Page 6: [12] Commented [A40] Author

ACLI: Question 27, which asks whether the communication reminds consumers to reflect on why they may have purchased the policy, is both subjective and prescriptive. Question 28, which asks whether the communication expresses empathy, is the same. Because all other items in the Checklist will help to ensure policyholders think through their decision by accounting for multiple factors—a statement directing a policyholder to reflect is unwarranted. Moreover, since the communication's very purpose is to help policyholders manage a rate increase, we believe the question about empathy is both needless and overly subjective. Whether or not a communication expresses empathy is open to interpretation. The goal is to help. The more helpful a communication is—the more empathetic is it likely to be perceived.

Page 6: [13] Commented [A43] Author

ACLI: Since it is impossible to list all RBOs in one communication, we suggest question 30 simply read, "Are examples of the reduced benefit options represented fairly?" To avoid overwhelming or confusing policyholders, some options will likely not be in the communication, but accessible by contacting the insurer directly, or elsewhere, as the insurer directs. Insurers can discuss specific options available to a policyholder, while accounting for a policyholder's personal situation and current benefit levels. We want to ensure that regulators do not then conclude that the RBOs included in a communication are unfairly presented, while those RBOs that policyholders access outside the communication are unfairly de-emphasized.

Page 6: [14] Commented [A44] Author

CA: If the answer to the first is "yes," the answer to the second is likely to be "no," so this doesn't work well with the yes/no checklist.

Page 6: [15] Commented [A47] Author

BC: I don't understand how "now" is an alternative to "must."

Page 6: [16] Commented [A48] Author

BC: A term many consumers would not understand.

Page 6: [17] Commented [A50] Author

BB: Is the number direct to consumer service and individuals who can answer specific questions? The phone number should not consist of a lengthy phone tree that is difficult for consumers to navigate.

Page 6: [18] Commented [A51] Author

BB: Are customer service representatives located in other countries screened for their ability to clearly communicate with elderly policyholders who may have hearing difficulties, difficulty with heavy accents, unable to process fast speech?

Page 6: [19] Commented [A52] Author

MH: Might be worth consolidating with question 29.

Page 6: [20] Commented [A53] Author

MH: I'd hope so...is this to suggest that the filing team should test the website addresses and phone numbers? Is that what we typically do with other filings?

Page 7: [21] Commented [A58] Author

ACLI: We recommend question 35 be reworded to refer generally to any required government resources. Resources differ, depending on the state. Departments of insurance have varying policies about information or guidance they are willing to provide in the event of a rate increase.

Page 7: [22] Commented [A60] Author

MH: Might be worth consolidating with question 34.

Page 7: [23] Commented [A61] Author

MH: s 7 options "reasonable?" I think 5 or fewer is more appropriate.

Page 7: [24] Commented [A62] Author

ACLI: Depending on the insurer, type of policy, and many other factors, it is possible policyholders could have dozens of RBOs. Including explanations for even 5 to 7 RBOs, as the Checklist suggests in question 39, is likely to be overwhelming and confusing to policyholders trying to decide amongst them. Consequently, we believe it is preferable to remove the reference to a specific number of RBOs and use "reasonable" as the guideline.

Page 7: [25] Commented [A63] Author

BB: Some insurers may offer 2 or 3 options. Is 5 a required number of RBO"s to be offered? Seven seems an excessive number of options and would be hard to compare the value of each one. The highest number of RBO"s I've seen offered is 5 through a court ordered settlement.

Page 7: [26] Commented [A65] Author

ACLI: Question 40, referring to the right to reduce coverage at any time, ought to be removed entirely. Not all options are available at any time, some have time limits, and sometimes policyholders have the lowest level of benefits possible, based on a state's minimum benefit standards, with no option to reduce further. Also, RBOs might not be offered to policyholders currently on claim. Additionally, question 40 is redundant with questions 45 and 46, which already address deadlines.

Page 8: [27] Commented [A71] Author

ACLI: Question 43 pertains to including a 10-year nationwide rate increase history in the RBO communication. This information could be pertinent to the decision to purchase coverage and is provided in the outline of coverage upon purchase of a policy. In contrast, the RBO communication focuses on the current change in premium, the policyholder's options, and the potential for a future rate increase. Past rate increases vary widely due to prior state action and are not necessarily predictive of future increases. To avoid confusing policyholders, or inadvertently influencing them to decide against their best interests, we strongly recommend question 43 be removed entirely.

Page 8: [28] Commented [A74] Author

ACLI: We tweaked the wording in question 45 to make it clearer.

Note: I didn't see any amended language for this.

Page 8: [29] Commented [A76] Author

ACLI: We also amended question 47 to improve accuracy and account for differences in policies and state laws. We recommend the question read, "Does the communication indicate what happens if no payment is received? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?" Contingent benefit upon lapse (CBUL) is more accurate in this instance than "contingent non-forfeiture." Additionally, it's important to note that CBUL is not applicable for all forms in all states. In some states, CBUL is only effective for policies issued after a certain date or is not an option at all.

Page 8: [30] Commented [A78] Author

ACLI: We believe question 48 should be edited to allow insurers to either include, or direct the policyholder to, helpful information. An RBO communication that includes all benefit-related information could easily become unwieldy, lengthy, and confusing. Directing a policyholder to a website or some other resource would likely be the more manageable and effective option.

Page 9: [31] Commented [A80] Author

ACLI: We think question 49, which references inflation option illustrations, should be removed from the Checklist for a few reasons. First, not all policies have a lifetime maximum benefit in dollars. Second, any future projection included in an RBO communication could be construed as a promise of future benefits. Third, including inflation option projections could confuse and overwhelm a policyholder already comparing multiple RBOs. And finally, a general illustration does not account for critical elements such as whether some benefits had previously been received, the policyholder's location at the time of receiving benefits, cost of care when benefits are received, additional policy terms, etc.

Page 9: [32] Commented [A84] Author

ACLI: We would like clarification on question 50. Will an insurer be able to refer to options that may be applicable to an individual policyholder?

Page 9: [33] Commented [A85] Author

BB: I don't understand this question. Why would some options not be available to a policyholder? In some cases an insurer may offer various options connected to a policy form depending on the benefits of each insured, i.e., lifetime benefits or limited durations, various forms of inflation protection. Is t instruction trying to say that an insurer can't use one form with all the options connected to a policy form, some of which are not available to certain policyholders?

Page 9: [34] Commented [A86] Author

ACLI: Question 51, pertaining to descriptions of the policyholder's RBOs, is duplicative of questions 30 and 39 and should be removed.

Page 9: [35] Commented [A89] Author

MH: Questions 50 and 51 seem like they have been already addressed above in terms of the presentation and readibility of options. Worth considering some consolidation.

Page 9: [36] Commented [A91] Author

ACLI: Finally, question 53, which refers to providing an unbiased resource to research cost of care, should be removed. An insurer cannot ensure an unbiased resource exists, nor can cost of care be predicted since it is heavily dependent on location and timing of benefits, both uncertain.

Page 9: [37] Commented [A92] Author

ACLI: We recommend question 54 be amended to remove the reference to value and to read, "Are the resulting benefits from each presented option clearly explained?" The question could be interpreted to mean general value or monetary value. The concept of value is too subjective to be a guideline. Perception of value differs depending on the personal circumstances of each individual policyholder, including their current age, health conditions, financial position, availability of caregivers, spouse/partner considerations, etc. Further, assessing value on behalf of policyholders could constitute steering. The communication should be objective, thereby aiding policyholders to make decisions in their best interest.

Page 10: [38] Commented [A103] Author

ACLI: We also recommend question 60 be amended to accommodate a wider range of deadlines to send communications prior to a rate increase because states' time frames can differ quite a bit.

Page 10: [39] Commented [A104] Author

ACLI: Lastly, the language in question 61, "Does the communication disclose that not all reduction options are equal in value?" is problematic. The same reasons we give for changing question 54 apply here. The concept of value is too subjective to be a guideline. Further, the entire communication, in addition to any supplemental information the insurer may direct the policyholder to consider, will demonstrate the differences between, and consequences of choosing, each RBO. For these reasons we advise deleting question 61.

Issues related to LTC wellness benefits

First draft, work in progress – 7/22/2021

Background:

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

Technology firms are developing approaches that could be used by insurance companies to potentially prevent or lower the severity of LTC claims and improve health outcomes in a space called "LTC wellness". Examples of these early interventions include:

- Fall prevention programs;
- Home modification consultations, analysis and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis.

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

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

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Details:

1. Analysis of effectiveness

a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
   i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
      1. Expenses are typically upfront and significant.
      2. The financial impact on claims cost is typically unknown and down the road.
   ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
   iii. Some companies are concerned about regulatory reaction to these changes.

b. Current observations
   i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
   ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow and it is difficult to implement control trials.
      1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
   iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.

c. Addressing of Issues
   i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
   ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?

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iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.

d. Next steps
   i. Regulators engage with insurance companies to learn of recent developments.
   ii. Research public programs' data on effectiveness of LTC wellness programs to see if Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used.
   iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies are applying 3 to 4 pilot programs and finding success, it would be good news regarding broader, future efforts.
      1. Facilitate the sharing of general results (i.e., not individual policyholder data) among those insurance companies in a way that is within the legal and regulatory boundaries.
   iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios, including one where claims costs continue to increase.

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

a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete populations within the broader group of policyholders?
b. Current observations
   i. There may be state anti-discrimination and bias-related legal issues to address if certain policyholders are targeted, including through Big Data, to receive extra benefits.
      1. For instance, if older policyholders have less of an online footprint than younger policyholders, how would this impact the accuracy of the targeting of LTC wellness benefits or otherwise introduce bias?
      2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific conditions are based on age or the health of the policyholder, this seems like normal value-added products and services for loss prevention and not an example of unfair discrimination.
         a. Issues to address are likely related to creating a clear framework for compliance related to the use of data analytics and artificial intelligence.
c. Addressing of issues
   i. <u>Equality</u>: How policyholders are offered wellness initiatives could be unfairly discriminatory.
      1. Policyholders of "the same class and of essentially the same hazard" must be treated equally. *See* NAIC Model Unfair Trade Practices Act (#880) ("Model Law").

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2. How may an insurer "classify" policyholders post underwriting?
    a. What is fair? The insurers will need to provide justification.
        i. For example, under the Model Law the availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory.
    b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program's overarching goals?
    c. May classification be made by product form?

ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
    1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
        a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
    2. Would a random selection of policyholders be unfair?
    3. Should policyholders be given the option to participate in a wellness initiative?
        a. Must *all* policyholders be given the option to participate?
    4. How much time/data is needed to prove the initiative is valuable?
    5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.

iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
    1. Does it limit who can participate based on the medium? For example:
        a. Does it require access to a computer or internet for online participation?
        b. Does it require access to a smart phone, texting minutes, etc., to use an app?
        c. Does it require access to roads, pools, sidewalks?
    2. Does any such limitation require alternatives for those unable to participate in the initiative?

iv. Uniformity: If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?
    1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
    2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.

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a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for "all similarly situated individuals." *See* AK Stat § 21.36.110.

3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?

d. Dependencies
   i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
      1. Analyzing Effectiveness
      2. Actuarial Impacts
      3. Rebate Standards and Limitations
      4. Regulatory Evaluation

e. Next steps
   i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

3. Consumer confusion

a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.

b. Addressing of issues:
   i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.
      1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.

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ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.

iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont's sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.

iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html) . This builds trust through human contact with medical professionals.

    1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate

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increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.

vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

4. Rebating

a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes ("Wellness Initiative").

b. Addressing issues:

i. *NAIC Model Law.* The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) ("Model Law") explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from "the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost," even "when such products or services are not specified in the policy of insurance," if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be "primarily designed to satisfy" one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only

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enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law's anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state's rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:
    a. **Alaska**: Statutorily excludes "a reward under a wellness program established under a health care plan that favors an individual" from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. *See* AK Stat § 21.36.110.
    b. **Maine**: Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. *See* Me. Stat. tit. 24-A, § 2163-A.
2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction's rebating law and if there are any state specific requirements for offering such an initiative.

iii. Trends in State Law. Notwithstanding the variation in individual state's laws and if and how they have been amended or interpreted, there does appear to be a general trend that "services are not prohibited if they are directly related to the insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner." J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

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iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, and moreover where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer's share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.

v. Conclusion. Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either (a) adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or (b) take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

5. Tax considerations

a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
b. Current observations
    i. There may be tax consequences for consumers if benefits outside the federal definition of LTC benefits are provided, but this may depend on whether initial investment in programs is paid for out of general company expenses or from the benefit pool.
c. Addressing issues: *[section to be drafted]*
d. Next steps:
    i. Engage with the federal government and insurance industry tax experts to work out potential IRS/tax issues.

6. **Regulatory role in approving or evaluating LTC wellness approaches**

a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.

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b. Current observations:
    i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
c. Addressing issues *[section to be drafted]*
d. Next steps
    i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.
    ii. Because LTC insurance is in a desperate situation in some cases regarding solvency and rate increases, explore a regulatory sandbox approach regarding LTC wellness innovations.
    iii. Explore whether a company's commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase.

7. Actuarial considerations

a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?
b. Current observations
    i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.
    ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.
c. Addressing of Issues
    i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.
    ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
    iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States' LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.

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iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.

d. Next steps
   i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy

a. Issue: utilization of consumers' data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of data to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
   i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.

b. Current observations
   i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.
   ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.
   iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.

c. Addressing of issues
   i. <u>Data Use to Identify Wellness Initiatives:</u>
      1. Policyholders considerations:
         a. Confusion about why they are being solicited for the initiative.
         b. Suspicion about the motivation of the insurer.
         c. General lack of awareness that data is being collected, and what data is being collected.
         d. General lack the awareness or understanding on how data is collected and used.
         e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
         f. Will the policyholder know what data is going to be used prior to participation?

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g. Should the policyholder have the option to "opt in/out" of their data being used internally for other initiatives or for external sale or use?

2. Insurer considerations:
   a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
   b. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
   c. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
   d. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
   e. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
   f. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder's needs or preferences?
   g. When using third party data providers, what screening or data protection programs are in place?

ii. <u>Data Use During Wellness Initiative Development:</u>

1. Should insurers purchase policyholder specific information from third party data sources?
   a. Data collected during purchases, search history, television programming, etc.
   b. Should it always be headless, anonymized, or deidentified?
2. When considering big data, are there unacceptable "correlations"? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder's claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?

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6. Does the insurer have procedures in place to notify the policyholders of a potential breach?

iii. Wellness Results Data Use:

1. Should the results be sold? Aggregate vs specific demographic information?
2. Should insurers use the results internally for cross marketing other wellness initiatives?
3. Should the policyholder be notified and have the option to "opt in/out" of letting the insurer use the data?
4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
5. How should the data be shared, if at all, with other vendors or service providers?
6. How long will the data be retained? Will the data be destroyed or disposed?

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

9. **Other considerations**
   a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
   b. Current observations
      i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
         1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.

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ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.

iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.

c. Addressing issues *[section to be drafted]*

d. Next steps

i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?

ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.

iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.

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

DRAFT

LTC Data Call Agenda

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

LTCG

Executive Summary – Key Takeaways

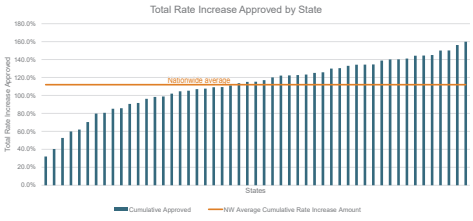
1. LTC rate increase approval disparities exist between states.
2. Premium inconsistencies exist among states as premium per policy varies greatly. Average premium ranges from $1,755 - $3,656, despite similar benefit distributions.
3. The cost of long-term care services does not appear to be the primary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

LTCG 3

Executive Summary – Key Takeaways

Question:

Are LTC rate approvals consistent by state?



See Cumulative Approved Rate Increase section for further detail

Outcome:

Evidence suggests inconsistent rate approval levels by state

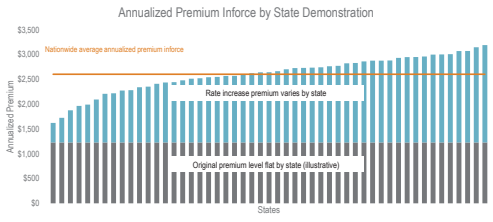
1. Data from 19 carriers and 50 states.
2. About 1/3 of industry.
3. 3,500+ approved rate increases.

LTCG 4

Executive Summary – Key Takeaways

Question:

How much premium is attributable to rate increases?



*For demonstration purposes only

Outcome:

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

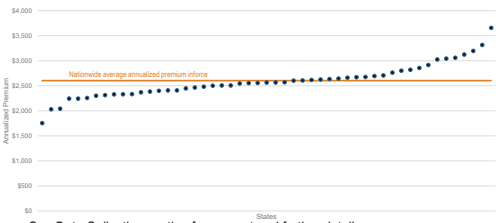
1. Impact of state specific cumulative approvals on annualized premium based on nationwide averages.
2. Nationwide average annualized premium inforce is $2,603.
3. Nationwide average cumulative approved rate increase is 112%.
4. Illustrative original premium levels.

LTCG 5

Executive Summary – Key Takeaways

Question:

Are premium levels for inforce policies consistent?



See Data Collection section for support and further detail

Outcome:

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

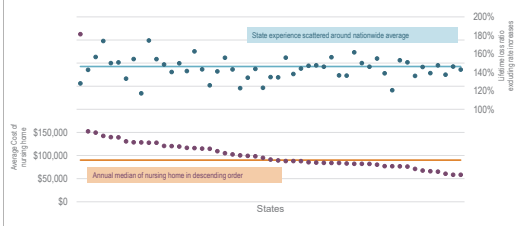
1. The average annualized premium by state ranges from $1,755 - $3,656.
2. Average nationwide annualized premium inforce is $2,603.
3. Benefit distribution mix is a partial contributor to differences by state.

LTCG 6

Executive Summary – Key Takeaways

Question:

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



See the Cost of Care section for further detail

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).

LTCG 7

LTC Data Call Agenda

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

LTCG

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.

LTCG 10

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

LTCG 11

LTC Data Call Agenda

Executive Summary Scope **Data Collection** Analysis Cumulative Approved Rate Increase Rate Increase Approvals Cost of Care	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.

LTCG

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.

LTCG 13

Inforce Statistics

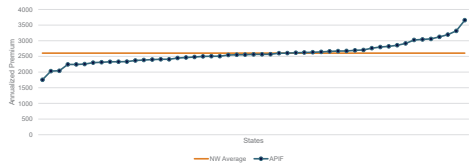
	Most Rate Increased Blocks	Largest Blocks
Average Attained Age	74.8 Range:72.7–76.8	70.8 Range:68.6–72.6
Average Inforce Policy Count	23.8k Range:1.5k–136.7k	37.2k Range:2.3k–67.3k
Average Inforce Annual Premium	$2,603 Range:$1,755-$3,656	$1,952 Range:$948-$3,174
Average Lifetime Loss Ratio w/o Rate 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

*Includes all approved rate increases

- 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.

LTCG 14

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 then 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.

LTCG 15

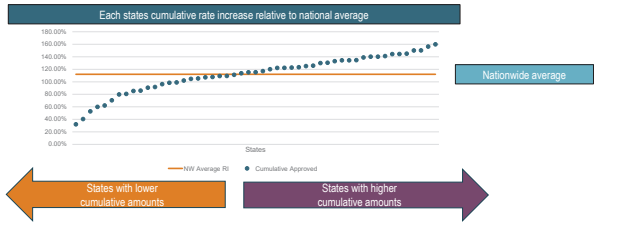
LTC Data Call Agenda

Executive Summary
Scope
Data Collection
Analysis
Cumulative Approved Rate Increase
Rate Increase Approvals
Cost of Care

Summary of state specific cumulative rate increase amounts as well as average approved number of rounds compared to nationwide averages.

LTCG

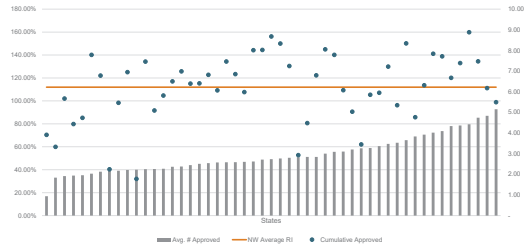
Analysis: Cumulative Approved Rate Increase



This does not consider timing of approvals

LTCG 17

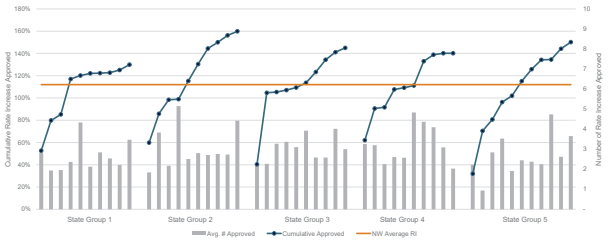
Analysis: Cumulative Approved Rate Increase



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

LTCG 18

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.

LTCG 19

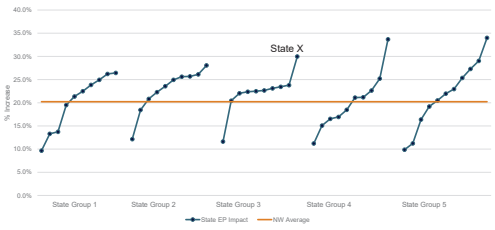
LTC Data Call Agenda

- Executive Summary
- Scope
- Data Collection
- Analysis
  - Cumulative Approved Rate Increase
  - **Rate Increase Approvals**
  - Cost of Care

Summary of state specific rate increase approvals and policy lifetime impact of rate increase approval amounts relative to original rates.

LTCG

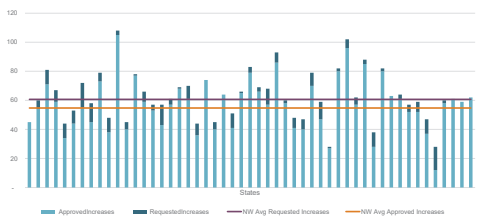
Lifetime Premium Impact



- 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.

LTCG 21

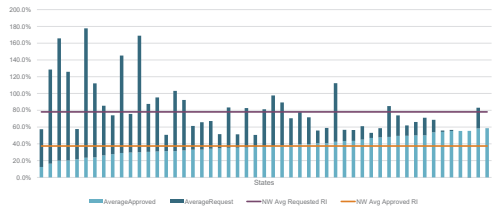
Average Number of Requested and Approved Rate Increases



- 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.

LTCG 22

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%.

LTCG 23

LTC Data Call Agenda

- Executive Summary
- Scope
- Data Collection
- Analysis
  - Cumulative Approved Rate Increase
  - Rate Increase Approvals
  - Cost of Care

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.

LTCG

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

LTCG 25

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.

LTCG 26

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.

LTCG 27

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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 Actuaries[1] 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.

1850 M Street NW Suite 300 Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948 www.actuary.org

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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.41[3] 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.

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- 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.

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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

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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.

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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

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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 Insurers[1] (ACLI) and the American Association of Health Insurance Plans[2] (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.

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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).

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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".

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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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FinancialMedic, LLC - MSA Framework Response

"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

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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 stakeholders[2] 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.

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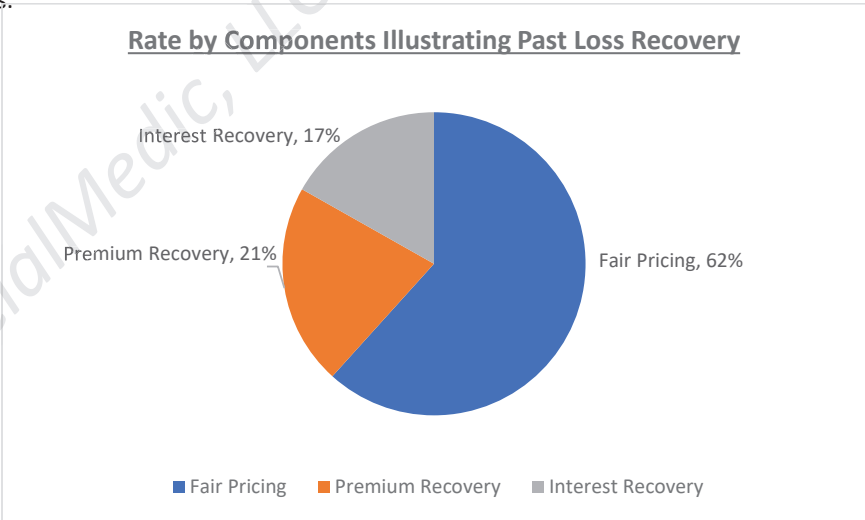
Loss Ratio Approach, the main culprit

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.

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The Texas Approach

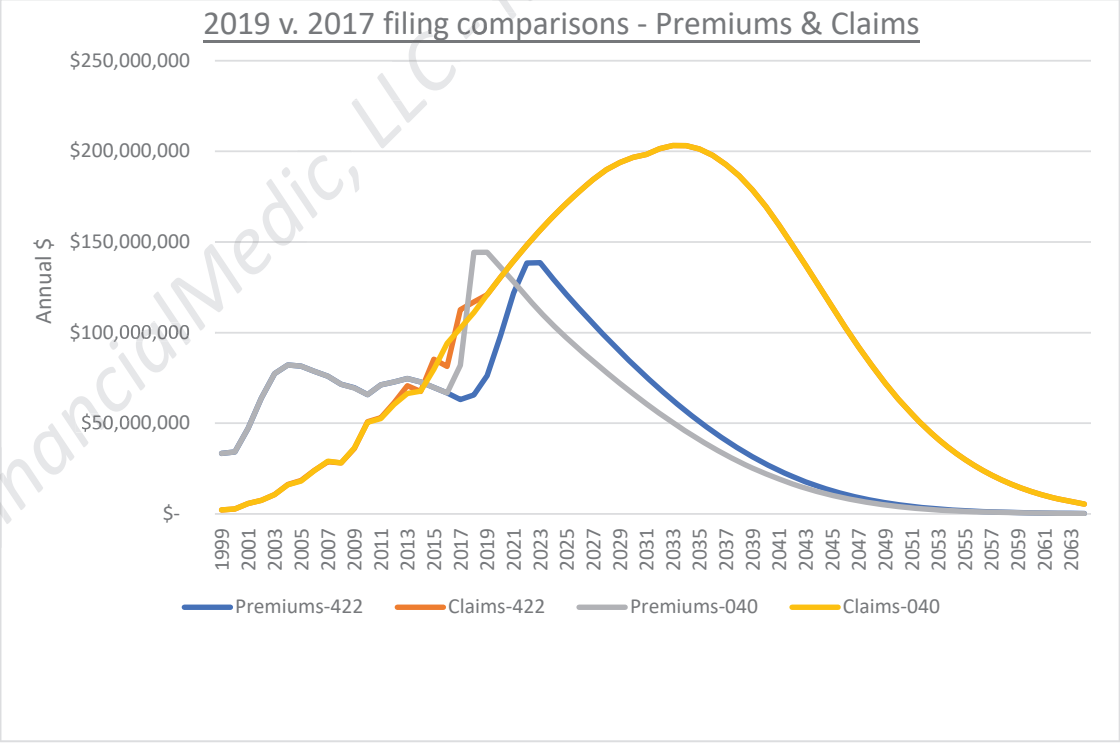
Our firm agrees with what the Texas Approach is designed to address, **Section D**, points 1 and 2, quoting:

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 noy 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.



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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
FinancialMedic, LLC (domiciled in CT)
Email: scuscovitch@financialmedic.com
(860) 942 0929
Samuel Cuscovitch | LinkedIn
Publications
ABA MEMBER ID: 05509363

Samuel T Cuscovitch Digitally signed by Samuel T Cuscovitch
Date: 2021.07.21 07:16:47 -04'00'

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VERMONT
DEPARTMENT OF FINANCIAL REGULATION
89 Main Street, Montpelier, VT 05620 - 3101
(p) 802-828-3301 | http://www.dfr.vermont.gov/

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.

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MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON
OFFICE OF
INSURANCE COMMISSIONER

Phone: 360-725-7000
www.insurance.wa.gov

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 (IIRPC) 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.

Mailing Address: PO Box 40255 Olympia, WA 98504-0255
Street Address: 5000 Capitol Blvd Tumwater WA 98501

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- **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

Mailing Address: PO Box 40255 Olympia, WA 98504-0255
Street Address: 5000 Capitol Blvd Tumwater WA 98501

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