

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 December 12, 2021, Fall National Meeting Minutes
- Long-Term Care Insurance Multistate Rate Review (EX) Subgroup November 15, 2021, Minutes (Attachment One)
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 - Draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Attachment Eleven-A)
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 - Draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Attachment Twelve-A)
- "Issues Related to LTC Wellness Benefits" Document (Attachment Thirteen)
- "Checklist for Premium Increase Communications" Document (Attachment Fourteen)

Draft Pending Adoption

Draft: 12/17/21

Long-Term Care Insurance (EX) Task Force and the
Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
San Diego, CA
December 12, 2021

The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met Dec. 12, 2021, immediately followed by a meeting of the Long-Term Care Insurance (EX) Task Force. The following Subgroup members participated: Michael Conway, Chair (CO); Alan McClain (AR); Andrew N. Mais represented by Paul Lombardo (CT); David Altmaier (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); James J. Donelon represented by Tom Travis (LA); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold and Fred Andersen (MN); Chlora Lindley-Myers (MO); Eric Dunning (NE); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented by Michael Wise (SC); Cassie Brown represented by Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler and Lichiou Lee (WA); and Allan L. McVey represented by Tonya Gillespie (WV).

The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Paul Lombardo (CT); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus represented by Susan Berry (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 and Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning and Justin Schrader (NE); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Judith L. French (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented by Michael Wise (SC); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Doug Slape (TX); Jonathan T. Pike (UT); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler and Lichiou Lee (WA); Mark Afable represented by Nathan Houdek (WI); and Allan L. McVey represented by Tonya Gillespie (WV).

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

a. Adopted its Nov. 15 and Sept. 28 Minutes

Commissioner Conway said the Subgroup met Sept. 10 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meeting. He said the Subgroup also met Nov. 15 and Sept. 28 and took the following action: 1) received and discussed interested state insurance regulator and interested party comments on the draft Long-Term Care Insurance Multi-State Rate Review Framework (MSA Framework); and 2) exposed the revised MSA Framework for a 21-day comment period ending Dec. 6.

Commissioner Altman made a motion, seconded by Commissioner Altmaier, to adopt the Subgroup's Nov. 15 (Attachment One) and Sept. 28 (Attachment Two) minutes. The motion passed unanimously.

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

Commissioner Conway said the MSA Framework was exposed for a public comment period ending Dec. 6. Comment letters were received from: 1) the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP); and 2) Risk & Regulatory Consulting LLC (RRC) (Attachment Three).

Jan Graeber (ACLI) thanked the Subgroup for its work on the MSA Framework. She said she recognizes that there are some issues that remain and this project will take time, and she looks forward to continuing the dialogue with the Subgroup. She said it will take the participation of both state insurance departments and insurance companies for the process to work.

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Mr. Andersen summarized the drafting group's response to comments received (Attachment Four). The drafting group agreed to make the recommended changes in items #3 and #9 from the letter. The drafting group did not recommended changes for the other items. Mr. Andersen discussed the rationale as follows:

- Item #2: The reasons for not utilizing the Interstate Insurance Product Regulation Commission (Compact) is because the rate proposals under the MSA Framework are outside the scope of the Compact.
- Item #4: The Subgroup recently decided that there is a benefit in sharing the MSA Advisory Report with the insurer. The MSA Team can answer questions from the insurer and provide clarifications rather than the insurer asking all jurisdictions.
- Item #5: The drafting group disagreed with the recommendation that at least one member of the MSA Team meet the qualification standards for actuaries issuing statement of opinion, as that is a high bar that is mostly for company actuaries that focus on valuation. No change was made.
- Item #6: As the process develops, the MSA Framework can be edited to address resources in the future.
- Item #7: The drafting group agreed that the MSA Team should have flexibility. The MSA Framework already includes this flexibility.
- Item #8: With each review, the MSA Team learns more about the time necessary for the review. Often, the timing is out of the MSA Team's control, as it is dependent on the quality and completeness of the rate proposal.
- Item #10: The Texas and Minnesota methodologies eliminate the subsidization of one policyholder by another.
- Item #11: The MSA Framework includes an information checklist. A template may be helpful, but it will need to be developed in the future after more experience is gained from the process.
- Item #12: Actuarial Standards of Practice (ASOPs) are required regardless of being listed in the MSA Framework.
- Item #13: Assessing adequacy of reserves is outside the scope of the MSA Framework, which is focused on rate review.
- Items #14 and #15: The drafting group recommends no change for now, but it may make changes in the future.

c. Adopted the MSA Framework

Commissioner Conway said the MSA Framework will continue to undergo improvements as the MSA Team learns more about the needs of the state insurance departments and the experience of the insurers. Mr. Lombardo made a motion, seconded by Mr. Trexler, to adopt the MSA Framework (Attachment Five). The motion passed with Louisiana abstaining.

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

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

a. Adopted the Long-Term Care Insurance (EX) Task Force's Oct. 29 and Summer National Meeting Minutes

The Task Force conducted an e-vote on Oct. 29 to adopt the 2022 proposed charges for the Task Force and its subgroups.

Commissioner Altmaier made a motion, seconded by Commissioner Altman, to adopt the Task Force's Oct. 29 (Attachment Six), and Aug. 13 (*see NAIC Proceedings – Summer 2021, Long-Term Care Insurance (EX) Task Force*) minutes. The motion passed unanimously.

b. Heard an Update on Industry Trends

Mr. Andersen said a group of state insurance regulators with long-term care insurance (LTCI) experience has reviewed insurers' *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) filings and coordinated and communicated with the domestic state insurance departments. This year, the group has focused on cost-of-care trends for policies with inflation protection. Often, the actual daily cost-of-care has been less than the inflation protected daily maximum benefits stated in the policy. If the cost-of-care increases, it could have a significant impact on the claims cost for inflation protected products, especially for companies with a lot of 5% inflation protected business. There has been a general trend of companies planning to increase the conservatism in the future cost-of-care assumptions. He said the group has seen some shift of care from more costly facilities to less costly home settings. This is likely temporary and an aspect that will continue. It will continue to be monitored as it affects reserves. Mr. Andersen said the group has also seen an increasing trend in the complexity of assets supporting reserves. The Life Actuarial (A) Task Force is currently asking for comments to determine if additional documentation or constraints are needed related to the modeling of these assets and reserve adequacy projections. Any changes by the Life Actuarial (A) Task Force could affect reserve standards as early as 2022. The impact of

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COVID-19 has also been studied. The increased mortality the last two years has generally resulted in shorter claims; however, due to the length of these policies, which may be in force for 30 years or more, any year-by-year loss ratio reductions will not have a material impact on the overall lifetime loss ratios. Generally, companies are not reducing reserves due to COVID-19 as they recognize the impact is short-term. Experience in this area continues to be monitored, including the emerging data on the Delta variant.

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

Commissioner Conway said the Subgroup met in regulator-to-regulator session Sept. 10 pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. He said the Subgroup also met Dec. 12, Nov. 15, and Sept. 28 and took the following action: 1) received and discussed interested state insurance regulator and interested party comments on the MSA Framework; 2) re-exposed the revised MSA Framework for a 21-day public comment period ending Dec. 6; and 3) adopted the MSA Framework.

Commissioner Conway described the due process that was undertaken to draft the MSA Framework. The drafting group was formed to draft and address comments on the MSA Framework. It began meeting in March of this year. The members of the group include six states—Connecticut, Minnesota, Nebraska, Texas, Virginia, and Washington—as well as the NAIC Legal team and support staff. The drafting group held 16 virtual working sessions between March and November, where it drafted and edited sections of the MSA Framework and reviewed comments. Three public exposures were held on each aspect of the draft, including two exposures for the operational section in April and September, two exposures for the actuarial section in June and September, and a third exposure of the combined draft in November. Commissioner Conway said the Subgroup has monitored the work of the drafting group and held eight meetings this year, including five public meetings to receive and address comments from state insurance regulators and interested parties and three regulator-to-regulator meetings to discuss confidential issues. All comments that were received have been reviewed and considered in the final draft.

Commissioner Conway said the MSA Framework has been a key goal of the Long-Term Care Insurance (EX) Task Force this year. He said a critical component for the future success of this MSA process is both state insurance department and insurer participation. He summarized the benefits of the MSA process to encourage both long-term care (LTC) insurers and state insurance departments to participate. The number one benefit of the MSA Framework is the expectation that through this coordinated review process, inequities in rate approvals between states can be reduced. The MSA process does not take away any authority of the state to make rate decisions, but it may reduce workloads for state insurance department staff, as it serves as another resource to help the rate review process. He said other benefits include: 1) the ability to leverage the collective expertise of the MSA Team working together to come to an advisory recommendation; 2) the ability to share questions and information between states on how the rate proposal promotes more consistency and increases one's own department's knowledge and expertise in this area; and 3) the ability to rely on the MSA Team, which will have the benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in one's state.

Commissioner Conway said positive feedback has been received on the Pilot Project, and it is anticipated that the process will only improve as the MSA Team reviews more and more rate requests. He said it is also anticipated that LTC insurers will benefit from the process with more consistent rate approvals between states and shortened timelines. Overall, it is aimed at achieving the goal of the Task Force.

Commissioner Conway said once adopted, the Subgroup will focus on implementation to make this process operational by late summer 2022, then focus on monitoring for issues that need to be adjusted as the process evolves, and ultimately monitor its success in achieving the Task Force's goals for reducing rate inequity. He said the MSA process will continue to undergo work and enhancements in the future. Feedback from both state insurance regulators and participating insurers on needs and ways to improve will be considered and likely result in revisions to the MSA Framework in the future.

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

d. Adopted the MSA Framework

Commissioner White thanked the drafting group, the Subgroup, NAIC staff, state insurance regulators, and interested parties that contributed and provided feedback throughout the process. Mr. Lombardo said the MSA Framework is a work-in-progress, and state insurance regulators will continue to work on the MSA Framework to make it better as more information is gathered.

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Commissioner White agreed that it is not a finished product and will be improved as the MSA Team completes its reviews. He asked everyone to remain engaged in the process going forward.

Commissioner Conway made a motion, seconded by Commissioner Pike, to adopt the MSA Framework (Attachment Five). The motion passed with Louisiana abstaining.

Commissioner Conway thanked Superintendent Cioppa for starting the process to find solutions for LTCI issues in 2019. Commissioner White thanked NAIC leadership for making LTCI a priority and giving the Task Force the necessary resources.

Commissioner White said the MSA Framework will be considered for adoption by the Executive (EX) Committee and Plenary at the 2022 Spring National Meeting. In 2022, the Subgroup will focus on implementation of the MSA Framework, which is expected to be fully operational by September 2022. Companies can continue to make rate proposals through the Pilot Project, which will inform future improvements to the MSA Framework.

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

Commissioner Altman said the Subgroup met Dec. 7 (Attachment Seven), Nov. 19 (Attachment Eight), Oct. 19 (Attachment Nine), Oct. 4 (Attachment Ten), Sept. 27 (Attachment Eleven), and Aug. 23 (Attachment Twelve). During these meetings, the Subgroup took the following action: 1) discussed comments received on a draft LTC wellness program issues document; and 2) discussed comments received on a draft reduced benefit options (RBOs) consumer notices checklist. Both documents were adopted through an open and collaborative process with state insurance regulators, industry, and consumer representatives. Both documents provide excellent guidance in two key areas aimed at protecting LTC consumers.

Commissioner Altman said on Nov. 19, the Subgroup adopted the “Checklist for Premium Increase Communications” document. This 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. It is a tool to try to gain more consistency across the states. This tool will be available to state insurance regulators to use; as reviews of consumer notices are performed, state insurance departments will need to consider states’ requirements.

Commissioner Altman said on Dec. 7, the Subgroup adopted a document titled “Issues Related to LTC Wellness Benefits Document.” She said the Subgroup first heard from industry about the types of benefits they were introducing and testing. This is an area of LTCI that is new, and there are a lot of innovative ideas out there. Therefore, it also requires state insurance regulators to consider the issues that may arise from these types of new benefits. The document outlines issues, observations, and next steps that the Subgroup identified for various topics, including:

- The effectiveness of LTC wellness programs.
- Preventions of unfair discrimination related to extra-contractual benefits and costs.
- Consumer confusion over wellness programs.
- Rebating; i.e., 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 document is intended to provide guidance to state insurance regulators. The area of wellness benefits is expected to evolve over time; therefore, this document may be revised and enhanced in the future as these benefits evolve and these conversations mature. She encouraged every state to review and utilize these documents.

Bonnie Burns (California Health Advocates) said RBOs are a serious decision for consumers when faced with the trade-offs they make to maintain some of their coverage. She related a story of an 88-year-old woman that had reduced benefits over the years instead of rate increases and was left with a policy with only two years of coverage and no inflation protection. That said, the RBOs given to consumers is decreasing the promise that the company made to the consumer when the policy was purchased. State insurance regulators need to understand how the RBOs work over time and how many decisions policyholders are being asked to make to keep some of their coverage. RBOs have serious consequences for consumers. Commissioner White said the work on RBOs is important. If policyholders are given options, they need to understand the consequences for accepting those RBOs. The checklist goes a long way in ensuring consumers have good options and understand those options.

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

f. Adopted the “Issues Related to LTC Wellness Benefits” Document

Commissioner Altman made a motion, seconded by Mr. Gaffney, to adopt the “Issues Related to LTC Wellness Benefits” document (Attachment Thirteen). The motion passed unanimously.

Ms. Burns said wellness benefits are new and are operating in an unregulated and unstructured environment. It is important for the NAIC to have some oversight over these benefits. Ms. Burns asked that state insurance regulators monitor these products as they emerge.

g. Adopted the “Checklist for Premium Increase Communications” Document

Commissioner Altman made a motion, seconded by Commissioner Altmaier, to adopt the “Checklist for Premium Increase Communications” document (Attachment Fourteen). The motion passed unanimously.

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

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Draft: 11/22/21

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

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

1. Discussed and Exposed Comments on an MSA Framework Draft

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

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

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

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

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

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TO: Commissioner Michael Conway, Chair
Long-Term Care Insurance Multistate Rate Review (EX) Subgroup
Sent via email

FROM: Commissioner Jessica K. Altman, Chair
Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

DATE: October 6, 2021

SUBJECT: MSRRSG Referral to RBOSG

The Vermont Department of Financial Regulation submitted the following comment to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (MSRRSG) in response to the Subgroup's exposure of operational sections of the Long-Term Care Insurance (LTCI) Multistate Rate Review Framework (MSA Framework) for public comment:

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

- 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.

Vermont suggests keeping the bullet above as is, and adding another bullet:

- In the case that an offering is tied to a rate increase, and involves the collection of consumer data, regulators should ensure that data collection and use is clearly disclosed and easily understood, that the consumer is made aware of any other available options, that the offer is not discriminatory, and that the rate impact is correlated to the offering. Consumer data should not be collected to be monetized for profit or for advertising.

The MSRRSG referred the comment to the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (RBOSG) during its Sept. 28, 2021 meeting for evaluation.

The RBOSG discussed the referral during its Oct. 4, 2021 meeting. It recommends the following:

The RBOSG recommends that the proposed language not be added to the MSA Framework at this time. However, if the Multistate Actuarial LTCI Rate Review Team (MSA Team) is presented with a rate increase filing that includes the issue addressed in the comment, the RBOSG requests that the MSRRSG make a referral that includes details of the offering's connection to the rate increase request.

Cc: Commissioner Scott A. White, Shannen Logue, Anna Van Fleet, Jeff Johnston, Jane Koenigsman

Arizona Comments
Greetings,

The following comments are submitted from the Arizona Department of Insurance and Financial Institutions on the LTC Multistate Rate Review Framework (MSA). Thank you for accepting our late submission.

We appreciate the potential benefit of the uniformity of the MSA LTC rate review and standardized format of the corresponding reports, particularly if the MSA process becomes used by many state insurance departments. We also appreciate that there are multiple points in the process where participating/impacted states will be able to ask questions about and comment on the MSA review. However, we may not always be able to participate in, or become aware of, an MSA review until an insurer references an MSA report in its subsequent AZ rate filing. Thus, in order for Arizona to be able to maximize its use of the MSA reports to augment, or even potentially replace, some of its review of a LTC rate filing, we believe the MSA report should contain a certain level of detail about the actuarial rate review analysis. Currently, the framework document indicates the report will contain a “summary” of the analysis, rather than the actual analysis. Here are our suggestions for actuarial review details that we believe should be made available to participating/impacted states:

- A more detailed description about how the MSA reached its conclusions regarding the application of the different methodologies it used (Texas method, Minnesota method, other), including the calculated values (at a high level). Given that the methodologies used by the MSA to analyze the filing might differ from state-specific statutory or regulatory requirements, this analysis could be important for subsequent state reviewers to understand.
- A clear indication of whether the recommended increase in the report is based on:
 - a total allowed increase in the pending request, or
 - a recommended cumulative inception-to-date increase?
- A clear indication about whether the rate increase submitted for review to the MSA involved:
 - different increases for different coverages based on lifetime vs limited coverages,
 - different increase with or without inflation coverage
 - different increases based on issue age groupings
- In order to determine when we can and cannot use the MSA analysis, we must be able to discern whether the filing contains Pre Stabilization and/or Post Stabilization business in accordance with when our Rate Stabilization rules became effective. Currently, it appears that the MSA combines its results into a single Recommended rate increase, with no distinction between the policy issuance periods. Because states may have different standards for Pre Stabilization business than for Post Stabilization business, and because states adopted the Pre and Post rules at different times, there is a potential for the resulting recommended rate increase found in the MSA report to be either higher or lower than a rate more accurately based only on whether policies were issued in a Pre or Post period.
- A clear indication about whether the MSA independently projects lifetime premiums and claims and a comparison of the MSA projections to the filer's projections.

Arizona Comments

- A clear indication about any analysis the MSA made regarding the "fairness" or equity of landing spots or benefit reduction options.
- A clear indication about any analysis the MSA made regarding the filer's actuarial assumptions and margins, discount interest rate, and other pertinent factors.

Regards,

Erin H. Klug

Assistant Director, Product Filing & Compliance Division
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North Carolina Comments on Operational Section of the MSA Framework – 9/14/21

I had a few insignificant observations on the Long-Term Care Insurance Multi-State Rate Review Framework.

1. The Table of Contents needs to be updated with the addition of Section II. D.
2. In section VI. B. Appendix, I think the first sentence should read: "... LTCI rate increase review inquiries *from all ~~of~~ states*"
3. Section VI. A. 2. Disclaimers does not seem to be in the Section VII. A. Exhibit – Sample MSA Advisory Report.

Some additional questions:

1. How will Reduced Benefit Options like "landing spots" or new endorsements for reduced inflation benefits be handled? Especially when the MSA Team is recommending different rate increases for different states due to historical approvals.
2. Section II. F. states "the MSA Team ... may communicate with the insurer outside of SERFF." Will this be documented?
3. Section IV. B. – Will the insurer get a chance to respond to the MSA Team's recommendation before the Advisory Report is released to the states?

Thank you for the opportunity to comment.

David Yetter
NCDOI



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October 8, 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: Long-term Care Insurance (LTCI) Multistate Rate Review Framework Operational and Actuarial Sections, September 2021 Exposures

Dear Commissioners White and Conway:

On behalf of the American Academy of Actuaries¹ LTC Reform Subcommittee, I appreciate the opportunity to offer comments on the exposure drafts of the [operational](#) and [actuarial](#) sections of the *Long-Term Care Insurance Multi-State Rate Review Framework* (“Framework”) released September 10, 2021, and September 15, 2021, respectively. This letter provides our comments on both the operational and actuarial aspects of the exposed Framework.

We previously provided comments on the operational aspects of the prior version of the Framework in our [letter](#) dated May 24, 2021, and comments on the actuarial aspects in our [letter](#) dated July 26, 2021. We appreciate the NAIC Long-Term Care Insurance (EX) Task Force’s consideration of our previous comments and the opportunity to discuss them with the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.

Actuarial Qualifications and Professional Judgment

We appreciate the revisions and additions to the Framework reflecting our previous comments on actuarial qualifications and professional judgment.

Future Updates

Section IV.E. of the Framework calls for regulatory feedback on the Multi-State Actuarial (MSA) Review process. We recommend that interested parties continue to be invited to review and comment on future changes to the Framework. In particular, if any formalized actuarial and/or policy approaches beyond the Minnesota and Texas approaches are considered for

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.

frequent use by the MSA Team in evaluating rate proposals (as contemplated in Section V.A.), we suggest that those new approaches should be similarly vetted through the NAIC's Multistate Rate Review (EX) Subgroup or the Long-Term Care Pricing (B) Subgroup, with opportunity for feedback from the Academy and others.

Future Non-Actuarial Considerations

Section V.F.2. of the Framework discusses the potential for additional non-actuarial considerations to be incorporated into the MSA Review process. This introduces—or continues—a potentially open-ended and inconsistent decision-making process with respect to future rate increase proposals. Insurers and their pricing actuaries should be able to anticipate a stable regulatory framework when introducing new long-term care (LTC) policies into the market. We recognize that individual states' use of non-actuarial considerations may be outside the scope of the MSA Framework.

Loss Ratio Approach

Section V.A. of the Framework specifies that the MSA Team will “apply both the Minnesota and Texas approaches for each rate proposal submitted.” This implies that the rate stabilization methodology is not sufficient. The rate stabilization approach is used by many state insurance departments. To not include this baseline approach would be contrary to the intent of the MSA Team proposal, which seeks uniformity across states and reduces the implied subsidization that currently exists. The MSA Team should also apply the appropriate loss ratio approach and provide an opinion on the assumptions underlying the calculation if it seeks to have greater state participation.

Section V.B.4. states that

“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.”

We suggest that the opinion in the preceding sentence be properly attributed to either the members of the MSA Team and/or a decision of an appropriate committee.

Section V.B.5. discusses an application of the 58% / 85% standard to rate-stabilized business. Not all states have adopted rate stability regulations, and effective dates vary across states that have adopted regulations based on policy issue date. Therefore, it is not entirely clear when a rate proposal will be considered to cover a “relevant block” of rate-stabilized business. Given that this test would impose, by regulation, a restriction on rate increases for policies initially issued under rate stability regulation, the MSA Framework's statement that “if this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase,” may not be justified in all jurisdictions. If the 58% / 85% standard is analyzed by the MSA team, we suggest that the resulting rate increase be reported in comparison with the Minnesota and Texas results. This will allow individual Participating States to consider whether the 58/85 limit applies under their own regulations. Otherwise, the MSA Team's use of the 58/85

standard may have the effect of layering on a limit that was never applicable to some of the policies in a nationwide block.

Minnesota and Texas Approaches

In sections V.D. and VII.A, the Minnesota and Texas approaches are described as actuarially justified approaches. As mentioned in our July 26 letter, these approaches include decisions based on non-actuarial considerations. Two examples of non-actuarial considerations in these approaches are cost-sharing provisions and disallowing interest rate deviations as a reason for a rate increase. We suggest recognizing that these approaches include both actuarial and non-actuarial considerations.

We believe that the Minnesota approach embeds implied policy decisions that are not actuarial in nature. While the calculations themselves may require actuarial methods, as stated in Section V.C., the approach embeds non-actuarial considerations that seek a “fair and reasonableness consideration,” the level of which is not clearly defined. Also, as the approaches labeled “if-knew / makeup approach” and “cost-sharing formula” are public policy decisions that are not specified in adopted model law, *defining* them as “actuarially justified” seems inappropriate.

Appendix 3 of the sample MSA Advisory Report in Section VII.A. includes a reference to cost sharing and the Texas approach. This reference should be clarified or corrected, as cost sharing does not appear throughout the rest of the Framework in the description of the Texas approach. To our knowledge, cost sharing has never been included in prior documentation of the Texas approach.

Goals of MSA Review Process

The sample MSA Advisory Report in Section VII.A. mentions a goal of the MSA Team to attain the same resulting rate tables in each state for a given product. When products have had varied historical rate increase approvals, both in magnitude and timing across states, this goal conflicts, at least in part, with another stated goal of the MSA Review of eliminating cross-state subsidization. A goal of having the same resulting rate tables in each state has a potential adverse impact of creating less incentive for more appropriate rate increase approvals in states that were slow to approve (or did not approve at all) prior rate increase requests, before participating in an MSA review. Said another way, this could have the unintended effect of encouraging states to delay approving rate increases.

Additional Items

Insurers may want to file rate increase requests in non-participating states concurrently with the MSA Review filing so that the insurer does not needlessly delay the filing and review process in non-participating states. It is unclear if and how insurers will know which states are Participating States in the MSA Review, and whether states will decide on participation in the MSA review each time any rate increase request is submitted.

Average premiums may vary significantly based on policy characteristics and issue age distribution differences across jurisdictions, in addition to past rate increase approvals. Also, Section V.A. acknowledges that premium rates may be lower in lower-cost states based on coverage differences elected by insureds. In the sample MSA Advisory Report in Section VII.A., the reference to average annual premium rate variation by state should be clarified. We suggest that any comparison of average premium rates be carefully considered as it may be misleading.

Thank you for the opportunity to provide input on the development of the operational and actuarial aspects of the Long-Term Care Insurance Multi-State Rate Review Framework. We 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 do 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



October 11, 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 (ACLI)ⁱ and the American Association of Health Insurance Plans (AHIP)ⁱⁱ appreciate the opportunity to comment on the second draft of the Operational Section of the Long-Term Care Insurance (LTC) Multi-State Rate Review Framework, exposed by the NAIC LTC (EX) Task Force on September 13, 2021. Our members recognize the hard work that has gone into developing the Framework thus far and hope that our input can further the progress already made.

GENERAL

The purpose of the Framework is to develop a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner that eliminates cross-state rate subsidization. We provide our comments in full support of this charge from the NAIC to the LTCI Multi-State Rate Review (EX) Subgroup.

Consistent, actuarially appropriate, timely rate increases that eliminate cross-state rate subsidization are achieved when the governance, policies, procedures, and actuarial methodologies utilized by the MSA Review Team are openly communicated and reliably followed. We are encouraged by the Subgroup's edits to the first draft of the Operational Section to give insurers access to the MSA Advisory Report. Access to the final Report will help insurers to understand the thought process the MSA Team worked through to make their recommendation, thereby giving insurers greater predictability in how their business will be regulated.

This letter's headings correspond with the various sections and subsections of the Framework for which we have comments. In addition to these comments, we respectfully submit our suggested edits (highlighted in yellow) to the Operational Section in the attached redlined document.

I. INTRODUCTION

PURPOSE

We urge the Subgroup to incorporate its entire charge into the Framework. Currently, the portion of the charge directing the Subgroup to develop an approach to the MSA Review that eliminates cross-state rate subsidization is not included. Eliminating cross-state rate subsidization should be a key component of, and explicitly stated in, the Framework. The original charge of the LTC (EX) Task Force emphasized the importance of addressing cross-state inequities. It recognized, "... the gravity of the threat posed by the current long-term care



insurance environment both to consumers and our state-based system of insurance regulation” and the need to take action to address the threat.

Many of the recommendations that ACLI/AHIP made in our comments on the first draft of the Operational Section, and are making again in this comment letter, would mitigate cross-state rate inequities. If adopted, these recommendations will help to keep rate increase decisions on blocks of business both consistent and actuarially sound.

STATE PARTICIPATION IN THE MSA REVIEW

ACLI/AHIP acknowledges the careful balance the Framework must achieve “to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon.” A voluntary, yet dependable, MSA Review requires an expectation that Participating States will rely on the MSA Advisory Report in their rate approval decisions. If this expectation is not communicated to, and followed by, the states, rate recommendations will not be consistent, nor will regulators or insurers depend on them in their decision-making. We recommend that the Framework emphasize the expectation that participating in the MSA Review means a commitment to the results of the Review, barring any contradictory state law requirements.

Understanding that the Review process will be refined over time, we suggest that wording in the Operational Section be changed to say, “state participation is expected to increase (as opposed to evolve) in the future.” Emphasizing state reliance on the MSA Review will help to promote the consistency and efficiency the review process is meant to achieve.

In order for “[i]nsurance companies . . . to understand how . . . the MSA Advisory Report may impact the insurer’s in-force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators” the MSA Review process must be transparent about how it applies the actuarial methodologies. ACLI/AHIP will address this matter in more detail in our comments on the second draft of the Actuarial Section of the Framework.

GENERAL DESCRIPTION OF THE MSA REVIEW

In our redline document, we suggest amendments to the language in this section to clarify that the MSA Team will keep insurers updated throughout the Review process and inform the insurer if the recommendation differs from the proposal. We also recommend language that strongly encourages states to rely on the MSA Advisory Report to achieve the charge and purpose of the MSA Review process.

BENEFITS OF PARTICIPATING IN THE MSA REVIEW

This Section lists the benefits state regulators will attain if they participate in the MSA process. However, unless the MSA Team, does, in fact, use the *same* dedicated approach to evaluate in force LTCI rate increase reviews, the states will *not* obtain the stated “benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.” The MSA process will also not realize the “increased efficiency and reduced timelines for nationwide premium rate increase



requests” listed as a benefit for insurers. For these reasons, and as asserted in other sections of this letter, the Operational Section should encourage the states to not only accept the Advisory Report, but to also accept the rate filing submitted to the MSA Team, without additional state-specific filing requirements, unless mandated by state law.

DISCLAIMERS AND LIMITATIONS

While we appreciate the additional clarification that Participating States will provide MSA Advisory Reports the same protection from disclosure as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings, we remain concerned that insurers’ proprietary information could be revealed in the MSA Review process. Section I. E. 2. refers to the Master Information Sharing and Confidentiality Agreement between states that governs the sharing of information among state insurance regulators. We respectfully request that this document be shared with insurers so that we may understand the privacy protocols in place throughout the MSA review process. We recommend that the Subgroup clarify which privacy rules govern each part of the MSA Review process in the Framework. The safeguards used to keep insurers’ information confidential will influence whether an insurer decides to participate in the MSA Review process. Development of the MSA recommendation, including the Advisory Report, should be held confidential, subject to the Master agreement. Once the insurer filed the Advisory Report with the state it should be provided the confidentiality protections afforded by the state’s law.

II. MULTI-STATE ACTUARIAL LTCI RATE REVIEW TEAM (MSA TEAM) MSA ASSOICATE PROGRAM

We applaud the addition of the MSA Associate Program to the Framework to develop and expand LTCI actuarial expertise amongst state insurance department regulators. ACLI/AHIP members offer their support of the program and their help answering questions, if desired.

III. REQUESTING AN MSA REVIEW PROCESS FOR REQUESTING AN MSA REVIEW

ACLI/AHIP requests clarification on the confidentiality of information in SERFF. The draft Framework states that “Participating States will have access to view the insurer’s rate proposal and review correspondence in SERFF.” Is the request for a rate proposal in SERFF, as well as accompanying information and correspondence, protected by Compact confidentiality procedures, state law, the Master Agreement, or something else?

CERTIFICATION

The certification provision references Participating States that “affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or . . . consents in writing to use the MSA Review and/or the MSA Advisory Report.” Under what circumstances does the Subgroup believe that a state would do either? We suggest that all Participating States disclose whether they affirmatively relied on the MSA Review/Advisory Report in making their rate recommendations.

IV. REVIEW OF THE RATE PROPOSAL



RECEIPT OF A RATE PROPOSAL

In the referenced SERFF or email notifications, how much of the rate proposal submission, correspondence between the MSA Team and insurers, and other activities be visible to Participating States? Will Participating States be able to read all submitted information in its entirety? How will this information be kept confidential among the MSA Team and Participating States?

COMPLETION OF THE MSA REVIEW

We would appreciate clarity regarding the timeline once the MSA Team completes its review. The Framework states that the insurer will receive sufficient information regarding the MSA Team's recommendation to allow "the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with MSA Team in order to ask questions, understand the MSA Team's reasoning, and provide additional information in support of its proposal [sic] will address questions from the insurer about the result of the review." Does this mean an insurer will see the recommendation before it is communicated to state insurance departments? If so, ACLI/AHIP are in support.

At what point will the MSA Team decide to abort the insurer's efforts to refute a MSA recommendation differing from its proposal? We suggest that the Framework clearly state that an insurer can see and appeal the MSA recommendation prior to its communication to Participating States. A minimum two-week appeal period would give the insurer time to compile and submit additional information in support of its proposal.

PREPARATION AND DISTRIBUTION OF THE MSA ADVISORY REPORT

Furthermore, whether the recommendation differs from the proposal or not, our members would like to participate in MSA Team presentations of the draft MSA Advisory Report with regulators from Participating States. We believe an insurer's ability to answer questions and respond to concerns from Participating States, if needed, would be helpful to all involved and increase MSA review efficiency.

TIMELINE OF REVIEW AND DISTRIBUTION OF THE MSA ADVISORY REPORT

Please see our suggested changes to the timeline in the redline document.

FEEDBACK TO THE MSA TEAM

The MSA Review process will be refined over time. With this in mind, we strongly recommend that the draft Framework be edited to specify a formal, annual assessment of the MSA Review process. Further, in addition to a survey gathering feedback from Participating States, insurers should also be surveyed for feedback on the process. Obtaining a clear and complete picture of the process from all participants will give NAIC leadership a more accurate picture of how well the process is working and what areas need improvement. Moreover, the anonymous results of the annual assessment should be shared with both Participating States and insurers to aid both groups in their business-planning and decision-making.



VII. EXHIBITS

EXHIBIT A. SAMPLE MSA ADVISORY REPORT

In Appendix 1, the note regarding the Minnesota approach refers to downward adjustments to morbidity assumptions. We suggest the Advisory Report include more explicit information about the adjustments made so that they may be re-evaluated, if appropriate.

The cost-sharing formula included in Appendix 3 of Exhibit A. assumes a company should have had more information about the possibility of rate increases than the consumer had. Whether or not this is true in any given circumstance, inclusion of the cost-sharing formula here is inappropriate. The assumption is a policy consideration that should not be incorporated into the actuarial approach. Further, Appendix 3 appears to apply the prospective cost-sharing formula within the Texas methodology, which differs from the provided Texas methodology explanation. See our red-lined document for additional suggested edits to this portion of the draft Framework.

CONCLUSION

ACLI/AHIP remains committed to working with the Subgroup to address the challenges in developing an MSA Review Framework. We look forward to addressing questions on our comments at our next LTCI Multi-State Rate Review (EX) Subgroup meeting.

Sincerely,

Jan M. Graeber
ACLI Senior Actuary

Ray Nelson
AHIP Consulting Actuary

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

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

Draft: 9/10/21

LONG-TERM CARE INSURANCE MULTI-STATE RATE REVIEW FRAMEWORK

*Drafted by the
Ad Hoc Drafting Group¹ of the
NAIC Long-Term Care Insurance (EX) Task Force*

¹ The Ad Hoc Drafting Group consists of representatives from state insurance departments in Minnesota, Nebraska, Texas, Virginia, and Washington

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LTCI MSA Framework

VII. Exhibits
A. Exhibit A – Sample MSA Advisory Report.....

I. INTRODUCTION

A. Purpose

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

This framework is based upon the extensive efforts of the LTCI Multi-State Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (“Pilot Team”). As part of that pilot program, the Pilot Team reviewed ~~seven~~ LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals (“rate proposal”)² and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decreases can be contemplated within the MSA Review process. The same concepts of this MSA Framework would be applied, if such a decrease request is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so that they will voluntarily ~~rely upon~~ utilize that process’s recommendations when conducting their own state level reviews of in force LTCI rate increase filings³. Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a ~~user’s manual~~ framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This ~~user’s manual~~ MSA framework is intended to communicate the governance, policies,

² “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review process.

³ The term “filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance for a regulatory decision.

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LTCI MSA Framework

procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the multi-state actuarial LTCI rate review team's ("MSA Team") MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how the MSA Advisory Report may impact the insurer's in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the LTCI (EX) Task Force and be revised as directed by the Task Force [or an appointed Subgroup](#). This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

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

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer's in force LTCI premium rate increase proposal is or has been issued.
- "Participating State" is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section I.E.1 below. Participation may include activities such as, but not limited to, receiving notifications of rate proposals in SERFF, participation in communication/Webinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to [evolve/increase in the future as the MSA Review process continues to be developed and refined](#).

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an [MSA Advisory Report](#) which state insurance departments [may choose to rely on/utilize/will consider when deciding to make decisions](#) on an insurer's rate increase filing or to supplement the state's own review process.

The MSA Review is conducted by a team of state's regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff, the Interstate Insurance Product Regulation Commission ("Compact") staff, who will [administratively](#) assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD⁴] States. The NAIC's electronic infrastructure, the System for Electronic Rates and Forms ("SERFF") will be used to streamline the rate proposal and review process. Although the administrative services of the Compact staff and SERFF's Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and [MSA](#)

⁴ Certain processes for Impacted vs. Participating States are yet to-be-determined (TBD).

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~~Advisory Reports~~ are prepared by the MSA Team. ~~MSA rate proposals are not Compact filings and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.~~

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

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

~~Throughout the MSA Review process the MSA team will provide updates to the insurer. The MSA team will deliver the final MSA advisory Report to the insurer and address any questions the insurer has about the results of the Review. Through the MSA Review the MSA Team will communicate MSA information to the insurer, including the final MSA Advisory Report, and the MSA Team will address any questions from the insurer about the results of the review.~~

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

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States ~~and insurers~~ that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. ~~The MSA Advisory Report will also indicate whether the recommendation differs from the insurer's proposal. Participating States can be encouraged to utilize either rely on the information filed with the MSA Team in addition to the Advisory Report's recommendation unless, or required by state law, supplement their own state's rate review with it~~ as described in the following Subsection I.D.

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

D. Benefits of Participating in the MSA Review

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

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For state insurance regulators:

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

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

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

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

E. Disclaimers and Limitations

1. State Authority over Rate Increase Approvals

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The MSA Advisory Report is ~~only~~ a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state's laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state's regulatory authority, responsibility and/or decision-making. Each state remains ultimately responsible for approving, partially approving or disapproving any rate increase in accordance with applicable state law. To satisfy the LTC EX 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" it is expected that states will generally follow the MSA Advisory Report's recommendations and not impose state-specific caps on actuarially appropriate increases unless specifically mandated by state law.

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

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

2. Information Sharing Between State Insurance Departments

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

3. Confidentiality of the Rate Proposal

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Members of the MSA Team affirm and represent that [they will provide](#) any in-force LTCI rate proposal as discussed herein [with the same protection from disclosure, if any, as provided](#) ~~is protected from disclosure~~ by the confidentiality provisions contained within their state's laws and regulations.

4. Confidentiality of the MSA Reports

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

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

The NAIC LTCI (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force [or any successor](#) will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed.

The LTCI (EX) Task Force may create one or more subgroups to carry out its oversight responsibilities.

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

II. Multi-State Actuarial LTCI Rate Review Team (MSA Team)

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

Membership must follow the requirements below and be approved by the Chair of the LTCI (EX) Task Force or the Chair of an appointed Subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

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

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or long-term care insurance
- Be recommended by the Insurance Commissioner of the state in which the actuary serves
- Have over five years of relevant LTCI insurance experience
- Hold an Associate of the Society of Actuaries (ASA) designation
- Currently participates as a member of the LTCI Multistate Rate Review (EX) Subgroup (or equivalent Subgroup appointed by the LTCI (EX) Task Force) and the LTC Pricing (B) Subgroup
- [At least one member of the MSA Team must be a member of the American Academy of Actuaries](#)

Additionally, the following qualifications are preferred:

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

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

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

[Consultants engaged by the state insurance department would not be considered for MSA Team membership.](#)

B. Duties of an MSA Team Member

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

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Confidentiality Agreement. [MSA Team Members should communicate any request for public disclosure of MSA information or any obligation to disclose.](#)

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

C. Participation of an MSA Team Member

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

D. [MSA Associate Program](#)

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

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

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

1. [Authority of the MSA Team](#)

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

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2. Disclosures and Confidentiality Obligations, as Applicable

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

3. Conflict of Interest Avoidance Procedures and Certifications

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

E.F. Required NAIC and Compact Resources

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

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA Filings at the direction of the MSA Team and as described in this Framework.

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III. REQUESTING AN MSA REVIEW

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

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

- Must be an in force long-term care insurance product ([individual or group](#))
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders [nationwide](#)
- Includes any stand-alone LTCI product approved by states, not by the Interstate Insurance Product Regulation Commission (Compact)
- For Compact-approved products meeting certain criteria, the Compact Office will provide the first-level advisory review subject to the input and quality review of the MSA

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

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

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

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

B. Process for Requesting an MSA Review

As noted in Section I.C. above, the MSA Review will utilize the Compact's multi-state review platform within the NAIC's SERFF application and its format for in-force LTCI rate increase requests. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance department regulators.

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless request.

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- Instructions containing a checklist for information required to be included in the rate proposal, as reflected in Appendix B, will be available to insurers through the Compact’s webpage or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase request is or has been issued. Participating States will have access to view the insurer’s rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [To Be Determined].
- Rate proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the Impacted States upon receipt of the request with the SERFF Tracking No.
- The MSA Team may utilize a “queue” process for managing workload and resources for incoming requests through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team’s review of objections and insurer responses are completed through SERFF.

C. Certification

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

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

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

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication

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Form, which will be available through the Compact webpage. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate proposal in SERFF. The MSA Team will be notified, via SERFF, when the proposal is available for review.

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

B. Completion of the MSA Review

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

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

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

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

C. Preparation and Distribution of the MSA Advisory Report

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

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

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States, on a [regulatory-only](#) WebEx call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States. [Insurers may participate in the call, or a portion of call, to directly address state regulator questions.](#)

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

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

The content and format of the MSA Advisory Report may be modified in the future under the direction of the LTCI (EX) Task Force, or appointed Subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback through this process. [A formal, annual review will ensure Participating States and insurers have a forum to provide feedback.](#)

D. Timeline for Review and Distribution of the MSA Report

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

- [Share the draft Report with the insurer. If the recommendation in the Report differs from the insurer's proposal, allow the insurer a two-week comment period to ask questions and provide additional information.](#)
- Day 1 – Distribution of a draft MSA Advisory Report to all Participating States

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

E. Feedback to the MSA Team

At the direction of the LTCI (EX) Task Force, or appointed Subgroup, state insurance departments will be requested to ~~periodically~~ annually provide data and feedback on their state rate increase approval amounts and feedback on their state’s use of and reliance on the MSA Advisory Reports. Among other things, the annual review/survey will collect and share information about:

1. The number of filings made with the MSA Review Team
2. The number of rate requests approved by the MSA Review Team
3. The number of states that approved MSA recommendations
4. The number of states that required additional information from the insurer before making an approval or disapproval decision
5. Feedback regarding how the Review process and methodology could be improved

State responses will be confidential pursuant to the Master Agreement and aggregated results of feedback surveys will not specifically identify state responses. Insurers will also be anonymously surveyed on their experience using the MSA Review process. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review process in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process, improve future reports to better meet participants’ needs and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated survey results will be shared with Participating States and insurers. –

VII.A. APPENDIX A—MSA ADVISORY REPORT FORMAT FOR REGULATORS

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate

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increase and complexity of the rate proposal and the insurer's financial condition. [See also the sample MSA Advisory Report in Exhibit A.](#)

1. Executive Summary
 - a. Overall recommended rate increase, before consideration of different states' history of approvals
 - b. [Explanation of whether or not the recommended rate approval is in line with the insurer's proposal](#)
2. Disclaimers
 - a. Purpose and intent of how states should use the MSA Advisory Report
 - b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer
 - c. [Statement that the in-force rate increase request filed with the respective states shall be subject to the approval of each state, and each state's applicable state laws and regulations shall apply to the entire rate schedule increase filing](#)
 - d. [Statement that states are encouraged to work directly with insurers to address lifetime rate equity](#)
3. Background on the MSA Rate Review process
4. Explanation of the Insurer's Request
5. Summary of the MSA Team's rate review analysis, including these aspects:
 - a. Actuarial review
 - b. Summary of consideration of differences in the history of state's rate increase approvals
 - c. Non-actuarial considerations and findings
 - d. Financial solvency-related aspects and adjustments
 - e. Review for reasonableness and clarity of reduced-benefit options
 - f. Summary information about the mix of business
6. Appendices
 - a. Summary of the drivers of the rate increase request
 - b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal
 - c. Summary of rate proposal correspondence
 - d. Tables of recommended rate increases by state, after consideration of different state's history of approvals
 - e. Frequently Asked Questions (FAQ)

VI.B. APPENDIX B— INFORMATION CHECKLIST

At the request of the former Long-Term Care Insurance (B/E) Task Force, the LTC Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all

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of states. In this context, “checklist” means the list or template of inquiries, that states typically send at the beginning of reviews of state-specific rate increase filings.

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

A. Information Required for an MSA Review of a Rate Proposal

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

1. Identify all states for which the product associated with the rate increase request is or has been issued.
2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
 - a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
 - b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios
3. Rate increase history that reflects the filed increase.
 - a. Provide the month, year, and percentage amount of all previous rate revisions.
 - b. Provide the SERFF MSA numbers associated with all previous rate revisions.
4. Actuarial Memorandum justifying the new rate schedule, which includes:
 - a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
 - i. The projection should be by year.
 - ii. Provide the count of covered lives and count of claims incurred by year.

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

⁶ https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx

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- iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies should be provided.
 - iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and impact on requested rate increase.
5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
 - a. Attribution analysis - present the portion of the rate increase allocated to and impact on the lifetime loss ratio from each change in assumption.
 - b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.
 - c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
 - d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate increase request.
6. Statement that policy design, underwriting, and claims handling practices were considered.
 - a. Show how benefit features, e.g., inflation and length of benefit period, and premium features, e.g., limited pay and lifetime pay, impact requested increases.
 - b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
 - c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.
7. A demonstration that actual and projected costs exceed anticipated costs and the margin.
8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
 - a. Provide applicable actual-to-expected ratios regarding key assumptions.
 - b. Provide justification for any change in assumptions.

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9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
 - a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
 - b. A comparison of the population or industry study to the in-force related to the rate proposal should be performed, if applicable.
 - c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
 - d. Provide the year of the most recent morbidity experience study.

10. Information from the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation Q&A: Morbidity, Lapse, Mortality, Interest*.
 - a. Comparison with asset adequacy testing reserve assumptions.
 - i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
 - ii. Additional reserves that the insurer is holding above NAIC Model Regulation 10 formula reserves should be provided, (such as premium deficiency reserves and Actuarial Guideline 51 reserves).
 - b. Assumptions Template in Appendix 6 of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation* (for policies issued after 2017, where applicable).
 - c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate*:
 - a. Present value of future benefits (PVFB) under current assumptions
 - b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
 - c. Present value of future premiums (PVFP) under current assumptions.
 - d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

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

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

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12. *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation* checklist items: summaries (including past rate adjustments); average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; reserve description.
13. Assert that analysis complies with actuarial standards of practice, including 18 & 41.
14. Numerical exhibits should be provided in Excel spreadsheets with active formulas maintained, where possible.
15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
16. Policyholder notification letter – should be clear and accurate.
 - a. Provide a description of options for policyholders in lieu of or to reduce the increase.
 - b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
 - c. Explain the comparison of value between the rate increase and policyholder options.
 - d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
 - e. How are partnership policies addressed?
17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

B. Supplemental Information

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

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

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LTCI MSA Framework

- a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, other.
 - b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
 - c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.
3. Reduced benefit options (RBOs)
 - a. Provide the history of RBOs offered and accepted for the block.
 - b. Provide a reasonability analysis of the value of each significant type of offered RBO.
4. Investment returns:
 - a. Provide original and updated / average investment return assumptions underlying the pricing.
 - b. Explain how the updated assumption reflects experience.
5. Expected loss ratio:
 - a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
 - b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.
6. Shock lapse history: Provide shock lapse data related to prior rate increases on this block.
7. Waiver of premium handling:
 - a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
 - b. Explain how counting is appropriate (as opposed to double counting or undercounting).
8. Actual-to-expected differences: Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.
9. Assumption consistency with the most recent asset adequacy testing: Explain the consistency or any significant differences between assumptions underlying the rate increase request and those included in Actuarial Guideline 51 testing.

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LTCI MSA Framework

VII.A. EXHIBIT – SAMPLE MSA ADVISORY REPORT⁷

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

Executive Summary

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

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

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

Background

[The MSA Team was formed to assist the Task Force in developing 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.](#)

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

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

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

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As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

Insurer's Request

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

In addition, ABC is requesting higher rate increases for states that did not grant full approval of prior rate increase requests, consistent with the MSA Team's goal of attaining the same resulting rate tables in each state for a given product.

Workstream-related Review Aspects

Actuarial Review

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

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

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

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

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

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

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

[Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.](#)

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

[Consideration of Differences in Histories of States' Rate Increase Approvals](#)

[According to the *Historical Rate Level Summary*, Appendix D in the insurer filing, past rate increase approvals by state have varied and can be categorized as follows:](#)

- [25 states have granted full or near-full approval of ABC's past requests \(at or near 55% cumulative\).](#)
- [18 states have granted cumulative approvals averaging 45%.](#)
- [5 states have granted cumulative approvals averaging 27%.](#)
- [2 states have granted cumulative approvals averaging 15%.](#)

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

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

[A table of examples of recommended rate increases, based on past cumulative approval history is provided in Appendix 2.](#)

[Non-actuarial & Valuation/Solvency Considerations](#)

[Non-actuarial considerations, including, flexibility regarding phase-in of rate increases, waiting periods between rate increases should be coordinated with phase-in periods, and other issues are being discussed at the LTCI \(EX\) Task Force and LTCI Multistate Rate Review \(EX\) Subgroup.](#)

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

[Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase request are consistent with assumptions underlying the reserve adequacy testing.](#)

[Reduced Benefit Options – Review for Reasonableness](#)

[Unless a rider was purchased, ABC policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:](#)

- [1\) extending the elimination period;](#)
- [2\) decrease the benefit period;](#)
- [3\) Reduce future inflation accumulation.](#)

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

[Financial Impact for Insurer](#)

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

[Mix of Business](#)

[From the insurer's actuarial memorandum:](#)

[Enrollees:](#)

- [• Total enrollees as of date of filing: 15,000](#)
- [• Inflation protection: 9,000 \(inflation protection\), 6,000 \(no inflation\)](#)
- [• Benefit period: 8,500 \(lifetime benefits\), 6,500 \(limited benefits\)](#)

[Product type: Expense reimbursement](#)

[Average issue age: 58](#)

[Average attained age: 75](#)

[Annualized premium: \\$30 million; \\$2,000 average per policyholder](#)

[Appendix 1](#)

[Drivers of Rate Increase Request - Summary](#)

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

Details Regarding Minnesota Approach

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

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

Note that the Minnesota approach includes reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward due to lack of credible support at extremely high ages.

Commented [CB1]: See ACLI/AHIP comment letter

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[and general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.](#)

[Details regarding Texas approach](#)

- [Insurer Calculation \(aggregate\): 52%](#)

[PPV calculations](#)

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

[LHAO Comments](#)

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

[Texas rate stabilized PPV Formula:](#)

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

[Reconciliation of Minnesota and Texas approaches](#)

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

[Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.](#)

[Filing Correspondence Summary](#)

- [Template information request for multi-state rate increase filings, based on the list adopted by the NAIC Health Actuarial Task Force on March 23, 2018.](#)
- [New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.](#)
- [Rate increase history that reflects the filed increase.](#)
- [Actuarial Memorandum justifying the new rate schedule, which includes:](#)

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- [Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.](#)
 - [Reasons for the rate increase, including which pricing assumptions were not realized & why.](#)
 - [Statement that policy design, underwriting, and claims handling practices were considered.](#)
 - [A demonstration that actual and projected costs exceed anticipated costs and the margin.](#)
 - [The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.](#)
 - [Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.](#)
 - [Information \(from NAIC *Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*, “Guidance Manual” Q&A\): Morbidity, Lapse, Mortality, Interest
 - \[Comparison with asset adequacy testing reserve assumptions\]\(#\)
 - \[Provide actuarial assumptions from original pricing and most recent rate increase filing, and have the original actuarial memorandum available upon request.\]\(#\)](#)
 - [Guidance Manual Checklist items: summaries \(including past rate adjustments\); average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; reserve description](#)
 - [Assert that analysis complies with Actuarial Standards of Practice, including No. 18 & No. 41.](#)
 - [Numerical exhibits should be provided in Excel spreadsheets with active formulas maintained, where possible.](#)
- [Rate Comparison Statement of renewal premiums with new business premiums, if applicable.](#)
 - [Policyholder notification letter – should be clear and accurate.](#)
 - [Provide a description of options for policyholders in lieu of or to reduce the increase.](#)
 - [If inflation protection is removed or reduced, is accumulated inflation protection vested?](#)
 - [Explain the comparison of value between the rate increase and policyholder options.](#)
 - [Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?](#)
 - [How are partnership policies addressed?](#)
 - [Supplementary information, based on a list developed by the MSA Team following review of initial pilot program filings:](#)
 - [Information on benefit utilization](#)
 - [Attribution of rate increase by factor](#)

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- [Reduced benefit option history and reasonability analysis](#)
- [Investment returns](#)
- [Expected loss ratio](#)
- [Shock lapse history](#)
- [Waiver of premium handling](#)
- [Actual-to-expected differences](#)
- [Assumption consistency with Actuarial Guideline 51 asset adequacy testing](#)

• [Following initial review of the filing, additional information was requested by the MSA Team related to:](#)

- [Original pricing assumptions.](#)
- [Lapse assumption by duration.](#)
- [Premiums & incurred claims by calendar year based on original assumptions.](#)
- [Distribution of inforce by inflation protection.](#)
- [Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.](#)
- [Description of waiver of premium handling in premium & claim projections.](#)
- [Commentary on COVID-19 short-term and long-term LTC impact](#)

Appendix 2

Examples of Rate Increases if a Reduced Benefit Option is not Selected

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

Commented [CB2]: Change to "state with full past approvals"
 Re "state with average past approvals"—is this the average or is this the maximum rate approved by a state?

Appendix 3

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LTCI MSA Framework

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

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

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

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

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

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

Commented [CB3]: See ACLI/AHIP comment letter

Commented [CB4]: Is there a legal ruling regarding this justification?



October 28, 2021

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

Dear Commissioner Conway and Subgroup Members,

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 second draft of the Actuarial Section of the Long-Term Care Insurance (LTC) Multi-State Rate Review Framework, exposed by the NAIC LTC (EX) Task Force on September 15, 2021. Our members recognize the hard work that has gone into developing the Framework and hope that our input can further the progress already made.

PRIMARY COMMENT

The purpose of the Framework is to develop a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner that eliminates cross-state rate inequities. We provide our comments in full support of this charge from the NAIC to the LTCI Multi-State Rate Review (EX) Subgroup.

As we mentioned in our July 26, 2021 comment letter, insurers best protect their policyholders when they can fulfill the obligations they made to these policyholders. This is accomplished when insurers have some level of predictability in their ability to effectively manage their 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 with respect to the methodology used to calculate the increase recommended by the MSA Team.

While some fundamental questions outlined in our prior comment letter remain, we recognize that for a new process of this magnitude, many questions will need to be addressed over time as both regulatory and industry experience evolves. Our hope is that regulators will continue to have an open dialogue with industry to address outstanding issues.

As mentioned in Section V. A of the Framework document, the *“MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the method most appropriate.”*

Our primary request at this time is that the Framework document include a commitment that after review of a certain number of filings, the MSA Team will provide insight into the general rationale or criteria utilized when determining which method applied to each filing. We understand that this is a dynamic review and that flexibility is key. We acknowledge that different characteristics of the block might influence the method used in the future. For example, general category trends, such as those in the chart below, would be helpful to



industry in managing their blocks of business going forward as well as in understanding how business being sold today will be regulated.

We suggest that the following language be added to Section V. A - MSA Team’s Actuarial Review Considerations

After review of “X” filings, the MSA Team will provide the method generally applied to the filings based on the following general characteristics:

Primary Characteristic of the Block	Method Used (Texas, Minnesota, Loss Ratio)
Small Remaining Block (i.e. percentage of policyholders remaining is less than X percent)	
Older Legacy Block or Newer Block (i.e. blocks with policies first issued before or after MM/DD/YYYY)	
Cumulative Past Rate Increase Percentage Greater Than “X” Percent	

The above characteristic are examples and may differ from those the MSA Team identified as the primary characteristics of the blocks actually.

ADDITIONAL COMMENT

We appreciate the subgroup’s change to heading of Section V. C. 5. with respect to the term “bait and switch” under the Minnesota method. We believe the name itself draws a legal conclusion and believe that all references to this type of adjustment should be categorized as an “original assumption adjustment”. The term “bait and switch” remains in Sections V.C.5.a.iii and VI.A.3.a.i.3.c. We believe this is an oversight and respectfully request that the term “bait and switch” be removed from these sections.



CONCLUSION

ACLI/AHIP remains committed to working with the Subgroup to address the challenges in developing an MSA Review Framework. We look forward to addressing questions on our comments at our next LTCI Multi-State Rate Review (EX) Subgroup meeting.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jan M. Graeber', written over a light blue rectangular background.

Jan M. Graeber
ACLI Senior Actuary

A handwritten signature in black ink, appearing to read 'Ray Nelson', written over a light blue rectangular background.

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.

Draft: 11/5/21

- **Green**—commentor recommendations from 2nd exposure accepted.
- **Yellow**—drafting group edits since 2nd exposure.
- Substantive unhighlighted edits were included in the 2nd exposure.
- Non-substantive grammatical edits are not highlighted.

LONG-TERM CARE INSURANCE MULTI-STATE RATE REVIEW FRAMEWORK

*Drafted by the
Ad Hoc Drafting Group¹ of the
NAIC Long-Term Care Insurance (EX) Task Force*

¹ The Ad Hoc Drafting Group consists of representatives from state insurance departments in [Connecticut](#), Minnesota, Nebraska, Texas, Virginia, and Washington.

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I. INTRODUCTION

A. Purpose

The ~~National Association of Insurance Commissioners (“NAIC”)~~ charged the Long-Term Care Insurance (EX) Task Force (~~“LTCI (EX) Task Force”~~) with developing a consistent national approach for reviewing current long-term care insurance (“LTCI”) rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization^{[Staff1][DG2]}. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the ~~LTCI (EX)~~ Task Force developed this framework for a multi-state actuarial (“MSA”) LTCI rate review process (~~“MSA Review”~~).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multi-State Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (~~“Pilot Team”~~). As part of that pilot program, the Pilot Team reviewed ~~seven~~ LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or (“rate^{[Staff3][DG4]} proposal²)² and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal request is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so ~~that~~ they will voluntarily rely upon utilize that process the Multistate Actuarial LTCI Rate Review Team’s (MSA Team’s) recommendations when conducting their own state level reviews of in force LTCI rate increase filings.³ Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a user’s manual framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This ~~user’s manual~~ MSA framework is intended to communicate the governance, policies, procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the ~~multi-state actuarial LTCI rate review team’s (“MSA Team’s”)~~ MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how

² “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review ~~process~~.

³ The term “rate increase filing” or “rate filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.

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the MSA Advisory Report may ~~impact~~ affect the insurer's in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

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

B. State Participation in the MSA Review

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

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer's in force LTCI premium rate increase proposal is or has been issued.
- "Participating State" is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section I.E.(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/~~W~~webinars with the MSA Team, and access to the MSA Advisory Report.

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

C. General Description of the MSA Review

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

The MSA Review is conducted by a team of state's regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff ~~and, the~~ Interstate Insurance Product Regulation Commission ("Compact") staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD⁴] States. The NAIC's electronic infrastructure, the System for Electronic Rates and Forms ("SERFF") will be used to streamline the rate proposal and review process. Although the administrative services of ~~the~~ Compact staff and SERFF's Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA a Advisory ~~Reports~~ are prepared by the MSA Team. MSA rate proposals are not Compact filings, and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

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

⁴ Certain processes for Impacted vs. Participating States are yet to ~~be~~ determined (TBD).

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

Throughout the MSA Review, the MSA team will provide updates to the insurer. The MSA team will deliver the final MSA advisory Report to the insurer and address any questions the insurer has about the results of the Review. Through the MSA Review the MSA Team will communicate MSA information to the insurer, including the final MSA Advisory Report, and the MSA Team will address any questions from the insurer about the results of the review. (Staff9)(DG10)

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

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States and insurers that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. The MSA Advisory Report will also indicate whether the recommendation differs from the insurer's proposal. Participating States can utilize either rely on the MSA Advisory Report or supplement their own state's rate review with it as described in the following Subsection (Staff11)(DG12) I-D. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

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

D. Benefits of Participating in the MSA Review

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

For state insurance regulators:

- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCI rate increases filings to their state. It is recognized that multiple states may not have significant actuarial expertise with LTCI, so participation in the MSA Review will allow those states to build on the specific, dedicated LTCI actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize rely on the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states, and among actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCI rate increase reviews, states who utilize rely on the MSA Team will have the benefit

of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.

- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries, which affords them an opportunity to establish LTCI-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a “Qualified Actuary” include years of experience under the supervision of another already qualified actuary in that subject matter.
- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state’s knowledge base in this area and promoting a more consistent national approach to in force LTCI rate review.

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

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

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

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is ~~only~~^{[Staff13][DG14]} a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state’s laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state’s regulatory authority, responsibility, and/or decision-making. Each state remains ultimately responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law. To satisfy 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”^{[Staff15][DG16]}

A Participating State’s ~~use~~^{adoption} of the MSA Advisory Report’s recommendations with respect to one filing does not require that state to consider or ~~use~~^{adopt} any MSA Advisory Report recommendations

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with respect to any other filing. The MSA Review in no way: ~~(a)1~~ eliminates the insurer's obligation to file for a rate increase in each Participating State; or, ~~(b)2~~ modifies the substantive or procedural requirements for making such a filing. While encouraged^{[Staff17][DG18]} to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

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

Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence ~~with insurers~~ on insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if certain information and documents related to specific companies that are confidential under the state law of an MSA Team member or a Participating State need to ~~Participating States' laws but will~~ be shared with other state insurance regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement (~~Master Agreement~~^{[Staff19][DG20]}) between states that governs the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

Confidentiality of the Rate Proposal

Members of the MSA Team and Participating States^{[Staff21][DG22]} affirm and represent that they will provide any in-force LTCI rate proposal, as discussed herein with the same protection from disclosure, if any, as provided is protected from disclosure by the confidentiality provisions contained within their state's laws and regulations.

Confidentiality of the MSA Reports

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

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

The ~~NAIC~~ Long Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously

evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed.

The ~~LTCI (EX)~~-Task Force may create one or more subgroups to carry out its oversight responsibilities.

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

~~II. Multi-State Actuarial LTCI Rate Review Team (MSA Team)~~

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

Membership must follow the requirements below and be approved by the ~~C~~hair of the ~~LTCI (EX)~~-Task Force or the ~~C~~hair of an appointed ~~S~~ubgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

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

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

Additionally, the following qualifications are preferred:

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

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

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

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

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master ~~Information Sharing and Confidentiality~~ Agreement. MSA Team Members should communicate any request for public disclosure of MSA information or any obligation to disclose.
- Active involvement within NAIC LTCI actuarial groups.
- Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

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

D. MSA Associate Program^{[Staff23][DG24]}

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries

that wish to gain expertise in LTCI. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

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

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

Authority of the MSA Team

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

Disclosures and Confidentiality Obligations, as Applicable

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

Conflict of Interest Avoidance Procedures and Certifications

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

E.F. Required NAIC and Compact Resources

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

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate increase proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF^[Staff25]^[DG26]. The material substance of such communication can be documented within SERFF. -NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. -Compact staff will perform administrative work related to MSA rate increase proposals Filings at the direction of the MSA Team and as described in this Framework.

III. REQUESTING AN MSA REVIEW

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

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

- Must be an in force long-term care insurance^{LTCI} product (individual or group).
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide.
- Includes any stand-alone LTCI product approved by states, not by the Interstate Insurance Product Regulation Commission ~~(Compact)~~.
- For Compact-approved products meeting certain criteria, the Compact Office will provide the first-level advisory review subject to the input and quality review of the MSA.

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

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

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

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

B. Process for Requesting an MSA Review

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

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

C. Certification

The insurer shall provide certifications signed by an Officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state's decision to approve, partially approve, or disapprove a rate increase filing except when: 1) [Staff 27] [DG 28]) the individual state is a (Participating/Impacted State [TBD])

State that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

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

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

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

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

The supporting NAIC and Compact staff ~~via SERFF or e-mail~~ will notify ~~{(Participating/Impacted sStates [TBD])}~~ ~~via SERFF or e-mail~~ ^{[Staff29][DG30]} when rate **increase** proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of ^{[Staff31][DG32]} the MSA Review

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

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

The timeframe for completing ~~ng~~ ~~on~~ ~~of~~ the MSA Team's review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a "queue" process for managing workload and resources for incoming **rate increase proposals** ~~requests~~ through SERFF. The timeliness of any

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necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will ~~impact~~affect the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review, and ~~that~~ a final MSA Advisory Report with recommendations will be drafted and communicated to state insurance departments within the next month, which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and, 2) the insurer will receive MSA Review information for the insurer and the MSA Team will address questions from the insurer about the result of the review. 2) the insurer will receive sufficient information regarding the MSA Team's recommendation to allow the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with the MSA Team in order to ask questions, and understand the MSA Team's reasoning[Staff33][DG34].

C. Preparation and Distribution of the MSA Advisory Report

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

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

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only ~~WebEx~~ call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States[Staff35][DG36].

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

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

The content and format of the MSA Advisory Report may be modified in the future under the direction of the ~~LTCI (EX)~~ Task Force, or an appointed Subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback from Participating states and the insurer, through this process[Staff37][DG38].

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

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

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

E. Feedback to the MSA Team

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

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

State responses will be confidential pursuant to the Master Agreement, and aggregated results of feedback surveys will not specifically identify state responses. The MSA Team and state insurance regulators welcome feedback from insurers on their experience using the MSA Review Process. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review process in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review

process, improve future reports to better meet participants' needs, and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated feedback results will be shared with Participating States and insurers as determined appropriate.

V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

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

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

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

- Review company/insurer experience, company/insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
 - Validate that the patterns of claims and premium projections over time match/reasonably align those reflected in the assumptions.
 - Adjust or request new projections of claims and premium to the extent that any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between the MSA Team and the insurer via SERFF.
 - After verifying loss ratio compliance, apply both the Minnesota and Texas approaches for each rate proposal submitted [Staff49][DG50].

~~which ensure remaining policyholders do not make up for losses associated with past policyholders.~~

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the most appropriate method. The MSA Team's recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches: or using professional judgement, the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In developing a recommendation, the MSA Team will In applying regulatory actuarial

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professional judgement, for instance (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience-), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high. As^[Staff51][DG52] the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.

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

- The MSA Team's recommendation results in the same rate per unit in each state following the current rate increase round, ~~(leading to higher percentage rate increases in states that approved lower rate increases in the past).~~
- Analysis will continue on state cost differences ~~impact~~affecting justifiable rate increases. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in ~~lower-cost states~~^[Staff53][DG54] should receive lower percentage rate increases. Part of the reason is that there was a tendency for people in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.
- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

Consideration of Solvency Concerns

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

Follow-Up ~~Proposals~~Filings on the Same Block

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

B. Loss Ratio Approach

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

1. At policy issuance, pricing based on a lifetime loss₂-ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the Long-Term Care Insurance Model Regulation (#641), Section 19 for more details on compliance with loss ratio standards.
2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.
3. The loss ratio approach increases future premiums to a level₂ (referred to as make-up premium₂) such that the original loss ratio target is once again attained.
4. The loss ratio approach^{[Staff55][DG56]}, 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 standards₂ 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 high₂-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~~insurer is allowed to always ~~to~~ return to the 60% loss ratio, there ~~is~~ may be a lower incentive for more ~~responsible~~appropriate initial-pricing.
5. For rate-stabilized business^{[Staff57][DG58]}, lifetime loss ratios are broken out, such as in a 58%₂-/85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA ~~Team~~. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. Minnesota Approach^{[Staff59][DG60]}

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

1. Blended if-knew / makeup approach to address the shrinking block issue.
 - a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.

- b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
 - c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care Pricing (B) Subgroup calls from 2015 to 2019⁵ are incorporated, including the concept that rates will not substantially rise as the block shrinks, ~~(as policyholder persistency falls over time).~~
2. Cost-sharing formula that increases the companyinsurer's burden as cumulative rate increases rise.
 - a. This addition to ~~company~~ the insurer's burden moves rates away from a direction that could potentially be seen as misleading. The companyinsurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.
 3. Assumption review.
 - a. Verification that the companyinsurer's original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the companyinsurer.
 - b. Verification of appropriateness of current assumptions.
 - i. A combination of credible companyinsurer experience, relevant industry experience, and regulatory professional judgement is applied.
 - ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the companyinsurer-provided assumptions. This conservatism can be released as credible experience develops.
 4. Interest rate / investment return component
 - a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
 - i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
 - ii. In the Minnesota approach, all factors impacting the business are considered.
 1. If interest rates rise, this would tend to lead to lower rate increase approvals. -Note, in this scenario, if interest rate changes were not considered, it is possible an companyinsurer would get approval for rate increases even when profits on the block were higher than expected.
 2. If interest rates fall, this would tend to lead to higher rate increase approvals.
 - iii. To prevent shifting of "good assets" and "bad assets" to supporting LTC rates, and ~~to~~ prevent an companyinsurer from increasing rates based on risky investments ~~that~~ turned into losses, an index of average corporate bond yields (e.g., Moody's) is relied on to reflect experience and current expectations.
 - iv. Original pricing typically includes an assumption on investment returns, ~~(for which premiums and other positive cash flows are assumed to accumulate).~~- This forms the interest component of the original assumption.

⁵ NAIC Proceedings including meeting minutes are available from the NAIC Library, <https://naic.soutrnglobal.net/portal/Public/en-US/Search/SimpleSearch>.

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- v. The original pricing investment return in [Section VC\(4\)iv](#) is compared to the average corporate bond yields in [Section VC\(4\)iii](#) to determine the adversity associated with the interest rate factor.
- 5. ~~Anti-bait and switch adjustment~~[Original Assumption Adjustment](#)
 - a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium.”
 - i. This results in a lower rate increase.
 - ii. This adjustment wears off over 20 years from policy issue.
 - 1. The rationale for the wearing off of this adjustment is the assumption that no ~~companyinsurer~~ would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
 - iii. This adjustment is intended to prevent ~~bait & switch~~[\[Staff61\]\[DG62\]](#), where, e.g., for example, an ~~companyinsurer would~~ underprice a product, gaining market share, and then immediately requesting a rate increase).

D. Texas [Approach](#)[\[Staff63\]\[DG64\]](#)

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

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

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

1. ~~{Note that for all **four** projections above, the projection period is typically 40--50 years; although, some companies project for 60 or more years.}~~

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

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

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

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

E. Reduced Benefit Options (RBOs)~~(RBOs_[Staff65]_[DG66])~~

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

RBOs in the MSA Advisory Report

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

Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA ~~R~~review ~~process~~ will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review ~~process~~ evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the ~~LTCI (EX)~~ Task Force will encourage its appointed Subgroup and/or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise. This process will provide for input and technical

advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.

F. Non-Actuarial Considerations

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

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

Considerations in the MSA Advisory Report

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

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

Future Non-Actuarial Considerations [Staff67] [DG68]

The MSA review process will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTCI (EX) Task Force will encourage

its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations, as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

VI. APPENDICES—MSA ADVISORY REPORT FORMAT FOR REGULATORS

A. Appendix A. – MSA Advisory Report Format

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

1. Executive Summary
 - a. Overall recommended rate increase, before consideration of different states' history of approvals.
2. Disclaimers
 - a. Purpose and intent of how states should use the MSA Advisory Report.
 - b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer.
 - c. Statement that the in-force rate increase request filing submitted ed withto the respective states shall be subject to the approval of each state, and each state's applicable state laws and regulations shall apply to the entire rate schedule increase filing.
3. Background on the MSA Rate-Review-process.
4. Explanation of the insurer's Proposal Request
 - a. The explanation will be based on the aspects of the insurer's rate proposal, which may include details as to whether the rate increase submitted for review involved different types of coverages or groupings.
5. Summary of the MSA Team's rate review analysis, including these aspects:
 - a. Actuarial review
 - i. The summary of the review and the MSA Team's recommendation will be based on the aspects of the insurer's rate proposal, and may include specific details of the review, for example analysis of projections, assumptions, margins or other aspects.
 - a-b. Summary of consideration of differences in the history of state's rate increase approvals.
 - b-c. Non-actuarial considerations and findings.
 - c-d. Financial solvency-related aspects and adjustments.
 - d-e. Review for reasonableness and clarity of reduced benefit option RBOs.
 - e-f. Summary information about the mix of business.
6. Appendices.

- a. Summary of the drivers of the rate proposal ~~increase request~~.
- b. ~~Details~~^[Staff81]~~[DG82]~~ regarding the Minnesota and Texas approaches as applied to the rate proposal.
- c. Summary of rate proposal correspondence.
- d. Examples of rate increases if an RBO is not selected.
- e. Potential cost-sharing formula for typical circumstances.
- ~~e. Tables of recommended rate increases by state, after consideration of different state's history of approvals~~
- d. Frequently Asked Questions (FAQ)

A.B. Appendix B – Information ~~e~~ Checklist

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

This document contains aspects of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*⁶ (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to ~~have a~~ more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90-~~to 100% percent~~ of the information necessary to decide on approvable rate increases. State and block specifics will generate the other ~~0-10% zero to ten percent~~ of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the *Guidance Manual* ~~for Rating Aspect of the Long-Term Care Insurance Model Regulation~~.

A. Information Required for an MSA Review of a Rate Proposal

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews”⁷ as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. Identify all states for which the product associated with the rate increase request ~~proposal~~ is or has been issued.
2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.

⁶ https://www.naic.org/documents/committees_b_senior_issues_160609_ltc_guidance_manual.pdf

⁷ https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx

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

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

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

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- b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.
12. ~~NAIC~~*The* Guidance Manual *for Rating Aspect of the Long-Term Care Insurance Model Regulation* checklist items: 1) summaries (including past rate adjustments); 2) average premium; 3) distribution of business, including rate increases by state; 4) underwriting; 5) policy design and margins; 6) actuarial assumptions; 7) experience data; 8) loss ratios; 9) rationale for increase; and 10) reserve description.
13. Assert that analysis complies with ~~a~~Actuarial ~~s~~Standards of ~~p~~Practice (ASOPs), including 18 ~~&~~and 41.
14. Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.
15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
16. Policyholder notification letter— should be clear and accurate.
- Provide a description of options for policyholders in lieu of or to reduce the increase.
 - If inflation protection is removed or reduced, is accumulated inflation protection vested?
 - Explain the comparison of value between the rate increase and policyholder options.
 - Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
 - How are partnership policies addressed?
17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

Supplemental Information

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

- Benefit utilization:
 - Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
 - Explain how benefit utilization assumptions vary by maximum daily benefit.
 - Provide the cost of care inflation assumption implied in the benefit utilization assumption.
- Attribution of rate increase
 - Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other.
 - For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.

- c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.
3. ~~Reduced benefit options (RBOs)~~
 - a. Provide the history of RBOs offered and accepted for the block.
 - b. Provide a reasonability analysis of the value of each significant type of offered RBO.
4. Investment returns:
 - a. Provide original and updated / average investment return assumptions underlying the pricing.
 - b. Explain how the updated assumption reflects experience.
5. Expected loss ratio:
 - a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
 - b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.
6. ~~6.~~ Shock lapse history:
 - a. Provide shock lapse data related to prior rate increases on this block.
7. Waiver of premium handling:
 - a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
 - b. Explain how counting is appropriate (as opposed to double counting or undercounting).
8. Actual-to-expected differences:
 - a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.
9. Assumption consistency with the most recent asset adequacy testing:
 - a. Explain the consistency or any significant differences between assumptions underlying the rate increase ~~request proposal~~ and those included in Actuarial Guideline 51 testing.

~~B.C.~~ Appendix C—Actuarial Approach Detail

~~A.~~ Minnesota Approach

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

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
 - a. A combination of credible ~~company insurer~~ experience, relevant industry experience, and ~~regulatory professional~~ judgement is applied.
2. If-knew premium and makeup premium aspects – aggregate application.
 - a. Makeup percentage:
 - i. $\{[PV(\text{claims}) / \text{original LLR}] - PV(\text{past premium})\} / PV(\text{future premium}) - 1$.

- ii. Premiums in the formula reflect the actual rate level.
- b. If-knew percentage:
 - i. $[PV(\text{claims}) / PV(\text{premiums})] / \text{original LLR} - 1$.
 - ii. Premiums in the formula are at the original rate level.
 - iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
- c. Definitions and explanations:
 - i. PV means present value.
 - ii. LLR means lifetime loss ratio.
 - iii. Interest rates underlying PVs and LLRs are based on:
 - 1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
 - 2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over 5 years of the current rate to a target rate (currently 4%) is assumed.
 - iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
 - v. ~~Company/Insurer~~-provide premium and claim cash flows may be adjusted based on assumption review.
 - vi. Makeup percentage is similar to that attained by the loss ratio approach.
- 3. If-knew premium and makeup premium aspects – sample policy-level verification.
 - a. Over a range of issues 5 years, issue ages, benefit periods, and inflation protection:
 - i. Calculate an estimate of the original premium.
 - 1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
 - 2. Apply first principles.
 - a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
 - b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
 - c. Divide by the sum of the PV of an annuity of 1 per year.
 - d. Multiply {b / c} times (1 + originally assumed profit percentage) to attain the original premium.
 - e. This premium provides the basis for comparison against the makeup and if-knew premium.
 - 3. Replace the original premium with a benchmark premium.
 - a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) ~~was~~ere out of line with industry-average assumptions at the time of original pricing.
 - b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.

- c. The benchmark aspect is intended to prevent ~~bait & switch~~^{[Staff83][DG84]} example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.
- ii. Calculate an estimate of the makeup premium.
 - 1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
 - 2. Calculate an updated dollar PV of profits for the sample policy using:
 - a. Actual history of premiums and claims.
 - b. Expectations of future claims.
 - c. “Backed into” makeup premium.
 - 3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
 - a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.
- iii. Calculate an estimate of the if-knew premium.
 - 1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
 - b. Verifying the impact on expectation changes on rates
 - i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
 - ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
 - 1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
 - 2. Experience
 - 3. Impact on LLR of changes in expectations of morbidity.
 - 4. Industry information and trends (for reasonableness checks).
 - c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
 - i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the ~~company~~insurer’s aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
 - ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
 - 1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).

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

Texas PPV Formula

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

For rate stabilized policies:

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

Where:

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

The *current* subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the $\Delta PV(\text{future incurred claims})$ term in the above formula could be multiplied by $(1 + \text{margin})$).

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

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

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

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

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

A. Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
 - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
 - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.
2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:

- The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.
- 3. Clarity of communication with policyholders eligible for an RBO:
 - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
 - Companies should present RBOs in clear and simple language, format and content, with clear instructions on how to proceed and whom to contact for assistance.
- 4. Consideration of encouragement or requirement for an ~~company insurer~~ to offer certain RBOs:
 - State insurance ~~R~~egulators should evaluate legal constraints, the impact on remaining policyholders and ~~company insurer~~ finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.
- 5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
 - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, (e.g., providing hand railings for fall prevention in high-risk homes), and identifying the pros and cons of such an approach.

~~B.~~ Widely Established RBOs in Lieu of Rate Increases

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

~~C.~~ Less Common RBOs for Potential Discussion

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

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

~~D-E.~~ Appendix E—Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials

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LTCI MSA Framework

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

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

This document is intended to establish consistent high-level guiding principles for ~~long-term care insurance reduced benefit options~~~~LTCI RBOs~~ presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

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

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

Filing Rate Action Letters

Insurers should consider:

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

Readability and Accessibility

Insurers should consider:

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

Identification

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

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

Communication Touch and Tone

Insurers should consider:

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

Consultation and Contact Information

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

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

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

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

Understanding Policy Options

Insurers should consider the presentation of the communication by:

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

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

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

Insurers should consider including disclosures regarding rate increase history by:

- Disclosing that future rate actions could occur.
- Advising if prior rate actions have or have not occurred to include:

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- Policy form(s) impacted.
- Calendar year(s) the policy form(s) was available for purchase.
- Percentage of increase approved to include the minimum and maximum, if they vary by benefit type.
- Reminding policyholders that their policy is guaranteed renewable.

Insurers should consider advising policyholders of their current benefits:

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

Insurers should consider personal needs decision-making by:

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

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
 - Daily/monthly benefit.

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- Benefit period.
 - Inflation option.
 - Maximum lifetime amount.
 - Premium increase percentage and/or new premium.
 - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
 - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
 - Current premium.
- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
 - What will happen if they take no action?
 - What will happen if they make no payment before the policy anniversary date?
 - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
 - If they elect the cash buyout, there could be tax implications.
 - If they elect a paid-up ~~nonforfeiture option~~NFO, how long will the reduced benefit last if they had a claim?
 - If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
 - Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

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

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

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT⁸

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

Executive Summary

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

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

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

Background

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

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

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

The [Staff85][DG86] MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer. As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal

⁸ Information contained in this sample report is an example only and is not derived from any actual rate filing.

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of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

Insurer's Request Proposal

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

In addition, ABC Company is requesting higher rate increases for states that did not grant full approval of prior rate increase requests, consistent with the MSA Team's goal of attaining the same resulting rate tables in each state for a given product. [Staff87][DG88]

Workstream-Related Review Aspects

Actuarial Review

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

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

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

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

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

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

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

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

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent

correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

Consideration of Differences in Histories of States' Rate Increase Approvals

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

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

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

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

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

Non-actuarial & Valuation/Solvency Considerations

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

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

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

RBOs – Review for Reasonableness

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

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

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

Financial Impact for Insurer

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

Mix of Business

From the insurer's actuarial memorandum:

Enrollees:

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

Product type: Expense reimbursement

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

Appendix 1

Drivers of Rate Increase **Request/Proposal** – Summary

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

Details Regarding Minnesota Approach

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

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

- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
 - Minimum of: calculated approval rate of 35% and insurer requestproposal of 60%
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the Minnesota approach includes the reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward [Staff89][DG90] due to a lack of credible support at extremely high ages, and a general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

Details Regarding Texas Approach

- Insurer Calculation (aggregate): 52%

PPV calculations

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

LHAO Comments

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

Texas rate stabilized PPV Formula:

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

Reconciliation of Minnesota and Texas Approaches

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

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

Filing Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.

- Actuarial Memorandum justifying the new rate schedule, which includes:
 - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
 - Reasons for the rate increase, including which pricing assumptions were not realized and why.
 - Statement that policy design, underwriting, and claims handling practices were considered.
 - A demonstration that actual and projected costs exceed anticipated costs and the margin.
 - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
 - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
 - Information (from NAIC *Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*, “Guidance Manual” Q&A): Morbidity, Lapse, Mortality, Interest.
 - Comparison with asset adequacy testing reserve assumptions.
 - Provide actuarial assumptions from original pricing and most recent rate increase filing, and have the original actuarial memorandum available upon request.
 - Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
 - Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
 - Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.
- Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
- Policyholder notification letter – should be clear and accurate.
 - Provide a description of options for policyholders in lieu of or to reduce the increase.
 - If inflation protection is removed or reduced, is accumulated inflation protection vested?
 - Explain the comparison of value between the rate increase and policyholder options.
 - Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
 - How are partnership policies addressed?
- Supplementary information, based on a list developed by the MSA Team following the review of initial pilot program filings/proposals:
 - Information on benefit utilization.
 - Attribution of rate increase by factor.
 - RBO history and reasonability analysis.
 - Investment returns.
 - Expected loss ratio.
 - Shock lapse history.
 - Waiver of premium handling.
 - Actual-to-expected differences.
 - Assumption consistency with Actuarial Guideline 51 asset adequacy testing.

- Following initial review of the filing proposal, additional information was requested by the MSA Team related to:
 - Original pricing assumptions.
 - Lapse assumption by duration.
 - Premiums and incurred claims by calendar year based on original assumptions.
 - Distribution of in force by inflation protection.
 - Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
 - Description of waiver of premium handling in premium and claim projections.
 - Commentary on COVID-19 short-term and long-term LTC impact

Appendix 2_{[Staff91][DG92]}

Examples of Rate Increases If an RBO is Not Selected

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

Appendix 3_{[Staff93][DG94]}

Potential Cost-Sharing Formula for Typical Circumstance_{[Staff95][DG96]}

Cumulative rate increase since issue date is haircut by:

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

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

- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%

DRAFT: 11/5/21

LTCI MSA Framework

- Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%
- = 15% + 32% + 38% + 33% + 30%
- = 147%

Legal Justification [Staff97][DG98] for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

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

Draft: 10/26/21

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

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

1. Discussed Comments on an MSA Framework Draft

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

Mr. Andersen gave a summary of the changes to the Actuarial sections of the draft MSA Framework, using a marked-up version of the draft (Attachment Two-A) and a summary of received comments (Attachment Two-B) as references. He said comments (see *NAIC Proceedings – Summer 2021, Long-Term Care Insurance (EX) Task Force*) were received from the Washington State Office of the Insurance Commissioner, the Vermont Department of Financial Regulation (DFR), the American Academy of Actuaries (Academy), the American Council of Life Insurers (ACLI) and the America's Health Insurance Plans (AHIP), and FinancialMedic LLC.

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

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

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

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

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

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

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

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

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

[02 09-28-21 LTCI MSRR min.docx](#)

Draft: 9/15/21

LONG-TERM CARE INSURANCE MULTI-STATE RATE REVIEW FRAMEWORK

*Drafted by the
Ad Hoc Drafting Group¹ of the
NAIC Long-Term Care Insurance (EX) Task Force*

¹ The Ad Hoc Drafting Group consists of representatives from state insurance departments in Minnesota, Nebraska, Texas, Virginia, and Washington

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V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

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

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

The MSA Team will consider the following in performing their review, applying their expertise and [professional](#) judgement to the review as well as reviewing the actuarial formulas and results.

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

~~which ensure remaining policyholders do not make up for losses associated with past policyholders.~~

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

DRAFT: 9/15/21

LTCI MSA Framework

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

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

[Consideration of Solvency Concerns:](#)

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

[Follow-Up Filings on the Same Block:](#)

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

B. Loss Ratio Approach

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

1. At policy issuance, pricing based on a lifetime loss-ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. [In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%.](#) The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. [Refer to state law or regulation modeled from the Long-term Care Insurance Model Regulation \(#641\), Section 19 for more details on compliance with loss ratio standards.](#)

2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.
3. The loss ratio approach increases future premiums to a level (referred to as make-up premium) such that the original loss ratio target is once again attained.
4. The loss ratio approach, one of the minimum standards in many states' statutes, is evaluated by the MSA ~~Team~~. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards such as fair and reasonable rates.
 - a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.
 - b. The loss ratio approach shifts all the risk to the policyholders. If the ~~company~~insurer is allowed always to return to the 60% loss ratio, there ~~is~~ may be a lower incentive for more ~~responsible~~appropriate initial- pricing.
5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58% / 85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA ~~Team~~. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. Minnesota Approach

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

1. Blended if-knew / makeup approach to address the shrinking block issue.
 - a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
 - b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
 - c. The blending method helps ensure concepts discussed in public NAIC LTC ~~P~~Pricing (B) ~~S~~Subgroup calls from 2015 to 2019² are incorporated, including the concept that rates will not substantially rise as the block shrinks (as policyholder persistency falls over time).

² NAIC Proceedings including meeting minutes are available from the NAIC Library, <https://naic.soutrnglobal.net/portal/Public/en-US/Search/SimpleSearch>.

2. Cost-sharing formula that increases the ~~company~~insurer's burden as cumulative rate increases rise.
 - a. This addition to ~~company~~the insurer's burden moves rates away from a direction that could potentially be seen as misleading. The ~~company~~insurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.
3. Assumption review
 - a. Verification that the ~~company~~insurer's original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the ~~company~~insurer.
 - b. Verification of appropriateness of current assumptions.
 - i. A combination of credible ~~company~~insurer experience, relevant industry experience, and ~~regulatory~~professional judgement is applied.
 - ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the ~~company~~insurer-provided assumptions. This conservatism can be released as credible experience develops.
4. Interest rate / investment return component
 - a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
 - i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
 - ii. In the Minnesota approach, all factors impacting the business are considered.
 1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an ~~an~~ ~~company~~insurer would get approval for rate increases even when profits on the block were higher than expected.
 2. If interest rates fall, this would tend to lead to higher rate increase approvals.
 - iii. To prevent shifting of "good assets" and "bad assets" to supporting LTC rates, and to prevent an ~~an~~ ~~company~~insurer from increasing rates based on risky investments that turned into losses, an index of average corporate bond yields (e.g., Moody's) is relied on to reflect experience and current expectations.
 - iv. Original pricing typically includes an assumption on investment returns (for which premiums and other positive cash flows are assumed to accumulate). This forms the interest component of the original assumption.
 - v. The original pricing investment return in iv is compared to the average corporate bond yields in iii to determine the adversity associated with the interest rate factor.
5. ~~Anti-bait and switch adjustment~~Original Assumption Adjustment

- a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium”.
 - i. This results in a lower rate increase.
 - ii. This adjustment wears off over 20 years from policy issue.
 1. The rationale for the wearing off of this adjustment is the assumption that no ~~company~~insurer would intentionally underprice a product knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
 - iii. This adjustment is intended to prevent bait & switch, where, e.g., a ~~an~~ ~~company~~insurer would underprice a product, gain market share, and then immediately request a rate increase.

D. Texas Approach

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

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

1. Past losses are assumed by the ~~company~~insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits to some extent, the recoupment of past losses.
2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.
3. Data Requirements for Calculation:
 - a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
 - i. Present Value of Future Benefits (PVFB) under current assumptions.
 - ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
 - iii. Present Value of Future Premiums (PVFP) under current assumptions.
 - iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
 - (Note that for all 4 projections above, the projection period is typically 40-50 years, although some companies project for 60 or more years.)

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

Also, the [company/insurer](#) should identify and explain any estimates or adjustments to the data, as applicable.

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

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

E. Reduced Benefit Options (RBO)

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

1. RBOs in MSA Advisory Report

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

2. Future RBOs

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

F. Non-Actuarial Considerations

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

- Caps or limits on approved rate changes
- Phase-in of approved rate changes over a period of years
- Waiting periods between rate change requests
- Considerations of prior rate change approvals and disapprovals
- Limits or disapproval on rate changes based solely or predominately on number of policyholders in a particular state
- Limits or disapproval on rate changes based on attained age of the policyholder
- Fair and reasonableness considerations [for policyholders](#)
- Impact of the rate change on the financial solvency of the insurer

1. Considerations in MSA Advisory Report

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

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

2. Future Non-Actuarial Considerations

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

VI.C. APPENDIX C—ACTUARIAL APPROACH DETAIL

A. Minnesota Approach

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

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
 - a. A combination of credible ~~company~~insurer experience, relevant industry experience, and ~~regulatory~~professional judgement is applied.
2. If-knew premium and makeup premium aspects – aggregate application
 - a. Makeup percentage
 - i. $\{[PV(\text{claims}) / \text{original LLR}] - PV(\text{past premium})\} / PV(\text{future premium}) - 1$
 - ii. Premiums in the formula reflect the actual rate level.
 - b. If-knew percentage
 - i. $[PV(\text{claims}) / PV(\text{premiums})] / \text{original LLR} - 1$
 - ii. Premiums in the formula are at the original rate level.
 - iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
 - c. Definitions and explanations
 - i. PV means present value
 - ii. LLR means lifetime loss ratio
 - iii. Interest rates underlying PVs and LLRs are based on:
 1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
 2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over 5 years of the current rate to a target rate (currently 4%) is assumed.
 - iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate
 - v. ~~Company~~Insurer-provide premium and claim cash flows may be adjusted based on assumption review.
 - vi. Makeup percentage is similar to that attained by the loss ratio approach
3. If-knew premium and makeup premium aspects – sample policy-level verification
 - a. Over a range of issues years, issue ages, benefit periods, and inflation protection:
 - i. Calculate an estimate of the original premium
 1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.

2. Apply first principles
 - a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
 - b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
 - c. Divide by the sum of the PV of an annuity of 1 per year
 - d. Multiply {b / c} times (1 + originally assumed profit percentage) to attain the original premium.
 - e. This premium provides the basis for comparison against the makeup and if-knew premium.
3. Replace the original premium with a benchmark premium
 - a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) were out of line with industry-average assumptions at the time of original pricing.
 - b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
 - c. The benchmark aspect is intended to prevent bait & switch.
- ii. Calculate an estimate of the makeup premium.
 1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
 2. Calculate an updated dollar PV of profits for the sample policy using:
 - a. Actual history of premiums and claims.
 - b. Expectations of future claims.
 - c. "Backed into" makeup premium.
 3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
 - a. The reason for target the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.
- iii. Calculate an estimate of the if-knew premium.
 1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
- b. Verifying the impact on expectation changes on rates
 - i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
 - ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
 1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
 2. Experience

3. Impact on LLR of changes in expectations of morbidity.
4. Industry information and trends (for reasonableness checks).
- c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
 - i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the [companyinsurer](#)'s aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
 - ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations result in similar rate increase approval amounts.
 1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
 2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
 - iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the [companyinsurer](#) (after initial attempts to resolve significant differences or gaps).
4. Reconciliation of aggregate and sample policy applications
 - a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
 - b. In other cases, some steps are taken to understand the difference, including additional requests for information.
 - c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
 - d. When reconciliation does not occur after rounds of communication, decisions will be made based on the information provided.
5. Blending – same for aggregate and sample policy applications
 - a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
 - b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
 - c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
 - d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.

6. Cost-sharing formula that increases the ~~company~~insurer burden as cumulative rate increases rise.
 - a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
 - i. No haircut for the first 15%;
 - ii. 10% for the portion of cumulative rate increase between 15% and 50%;
 - iii. 25% for the portion of cumulative rate increase between 50% and 100%;
 - iv. 35% for the portion of cumulative rate increase between 100% and 150%;
 - v. 50% for the portion of cumulative rate increase in excess of 150%.

7. Reduction for past rate increase:
 - a. Take one plus the cost-sharing-adjusted blend amount and divide by one plus the previous, cumulative rate increases. Then subtract one. This is the approvable rate increase.

8. Summary
 - a. Review current assumptions
 - b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
 - c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
 - d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
 - e. Apply the cost-sharing formula to the blended amount.
 - f. Deduct past rate increases.
 - g. Example – if:
 - i. the original premium is \$1,000
 - ii. makeup premium is \$3,000;
 - iii. if-knew premium is \$1,500;
 - iv. 60% of policyholders remain;
 - v. Past rate increases are 50%:
 - vi. Blended amount is:
 1. $\$3,000 / \$1,000 * .60 +$
 2. $\$1,500 / \$1,000 * .40$
 3. $- 1 =$
 4. $180\% + 60\% - 1 = 240\% - 1 = 140\%$.
 - vii. Cost sharing is:
 1. $100\% * .15 +$
 2. $90\% * .35 +$
 3. $75\% * .5 +$
 4. $65\% * .4 =$

5. 110%
- viii. Deduction for past rate increases results in:
 1. $(1 + 1.1) / (1 + .50) - 1 =$
 2. 40%.

B. Texas PPV Formula

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

For rate stabilized policies:

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

Where:

- Δ indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.
- C is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then C = .5.

The *current* subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (Regulators may wish to consider the addition of margin to the rate increase. For example, the ΔPV(future incurred claims) term in the above formula could be multiplied by (1 + margin)).

For pre-rate stabilized policies, we use .6 in place of .58 and .8 in place of .85:

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

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

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

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

A. Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
 - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
 - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.
2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
 - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.
3. Clarity of communication with policyholders eligible for an RBO:
 - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
 - Companies should present RBOs in clear and simple language, format and content, with clear instructions on how to proceed and whom to contact for assistance.
4. Consideration of encouragement or requirement for an [company insurer](#) to offer certain RBOs:
 - Regulators should evaluate legal constraints, the impact on remaining policyholders and [company insurer](#) finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.
5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
 - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach.

B. Widely Established RBOs in Lieu of Rate Increases

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

C. Less Common RBOs for Potential Discussion

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

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

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

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

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

This document is intended to establish consistent high-level guiding principles for long-term care insurance reduced benefit options presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

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

- **RECOMMENDS** that insurance companies recognize these fundamental principles.

- **CALLS ON** all insurance companies to consider the following principles in communicating reduced benefit options available to consumers in the event of a rate increase.
- **UNDERLINES** that the following principles are complementary and should be considered as a whole.

A. Filing Rate Action Letters

Insurers should consider:

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

B. Readability and Accessibility

Insurers should consider:

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

C. Identification

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

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

D. Communication Touch and Tone

Insurers should consider:

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

E. Consultation and Contact Information

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

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

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

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

F. Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
 - For example, the header could say, "Your Long-Term Care Premiums Are Increasing."
- Including the reduced benefit options with the rate action letter.

- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which reduced benefit option(s) have limited time frames.
- Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.
- Providing enough information in the communication to make a decision.
 - If supplemental materials (e.g., insurer's website) are provided, they would enhance the policyholder's understanding, but not be necessary to use when making a decision.

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

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

Insurers should consider including disclosures regarding rate increase history:

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

Insurers should consider advising policyholders of their current benefits:

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

Insurers should consider personal needs decision-making by:

- Only listing reduced benefit options that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact long-term care costs, such as:
 - The average cost of care for in-home care, assisted living, and nursing home care in their area.
 - The inflation rate of the cost of care for in-home and nursing home care in their area.
 - The average age and duration of a long-term care claim for in-home and nursing home care.
 - Factors that influence the age, duration and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
 - Buyout or cash-out disclosures.

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- The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
 - Daily/monthly benefit.
 - Benefit period.
 - Inflation option.
 - Maximum lifetime amount.
 - Premium increase percentage and/or new premium.
 - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
 - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
 - Current premium.
- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
 - What will happen if they take no action?
 - What will happen if they make no payment before the policy anniversary date?
 - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
 - If they elect the cash buyout, there could be tax implications.
 - If they elect a paid-up nonforfeiture option, how long will the reduced benefit last if they had a claim?
 - If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
 - Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

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

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

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Summary of Comments on MSA Actuarial Framework Exposure – July 26, 2021

- See comment letters for full text.

General Comments on Actuarial Approaches			Where/How Addressed in Framework
1	Washington	<p>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.</p>	<p>Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions.</p> <p>No further edits to framework.</p>
2	American Academy of Actuaries (May comment letter)	<p>We would first like to emphasize the importance of actuarial input from the beginning of any process involving the consideration, design, and evaluation of a potential long-term care (LTC) policy approach. Actuaries are uniquely qualified according to their professional standards and play a crucial role in the financing and design of LTC financing systems—from private long-term care insurance (LTCI) to public programs that provide LTC benefits. Actuaries have specialized expertise in managing the risk of adverse selection in insurance coverages, the ability to recognize and incorporate uncertainty into cost projections and premiums, and experience in evaluating the long-term solvency and sustainability of public and private insurance programs.</p> <p>An actuarial perspective can provide a basis for exploration of new and innovative review frameworks. We would refer the task force to two specific publications for examples of such perspective. One is an October 2018 Academy issue brief on considerations for treatment of past losses in rate increase requests for long-term care insurance. The second is a June 2016 Academy issue brief to enhance understanding of what is leading to significant rate increases, examine how the need for a rate increase is determined, discuss the effects of increases on various stakeholders, and explore alternatives to premium rate increases.</p>	<p>Actuarial considerations are important; however, other considerations factor into a state’s decision.</p> <p>Actuaries vetted the MN & TX approaches for several years in public LTC pricing SG sessions.</p> <p>See subsequent comment letter.</p> <p>No further edits to the Framework.</p>
3	American Academy of Actuaries (May Comment Letter)	<p>The Long-Term Care Reform Subcommittee appreciates 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.”</p> <p>The multi-state actuarial LTCI rate review (“MSA Review”) proposed in the Framework has the potential to create a robust actuarial review, independent of state-specific considerations, to advance the stated objective. However, it will be critical to consider detailed proposals for Actuarial Review, Reduced Benefit Options, and Non-Actuarial</p>	<p>See subsequent comment letter. MN and TX approaches are included in the Framework.</p> <p>No further edits to the Framework.</p>

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		<p>Considerations, which appear only as “placeholders” in the draft Framework. The subcommittee is reserving comment on Appendix B of the draft until its information requirements can be considered in context with exposure drafts of the placeholder sections.</p> <p>We suggest that the Framework include a description of the Minnesota and Texas approaches applied by the MSA Review team, or a citation to specific documents.</p>	
4	ACLI/AHIP (May Comment Letter)	<p><u>Methodology Used in the MSA Team Recommendation</u></p> <p>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”, to calculate recommended, approvable rate increases. We suggest that the Actuarial Section of the final Framework document outline specific reasons for use of one method over another.</p> <p>In addition, the methodology used by the MSA Team in determining its recommendation must be actuarially sound and acknowledge an insurer’s ability to achieve and preserve equity among policyholders in all states over the lifetime of the policy. Transparency in this piece of the process will result in greater consistency and confidence in outcomes, which is key to the Task Force achieving its charge.</p>	<p>Not intended to limit the MSA to only the MN or TX methods.</p> <p>Edits to V.A refer to either a blend of the two or other recommendation.</p>
5	Academy	<p>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: (Actuarial Standards Board; Actuarial Standard of Practice No. 1, Introductory Actuarial Standard of Practice; March 2013.)</p> <p>2.9 PROFESSIONAL JUDGMENT</p> <p>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.</p> <p>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</p>	<p>Edited to “professional judgement” throughout the Framework.</p>

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		Team may be guided by ASOP No.413 regarding appropriate communications and disclosures when issuing an actuarial opinion in an MSA Advisory Report. Specifically, disclosures may be necessary where material assumptions or methods are specified by applicable law (statutes, regulations, and other legally binding authority) or selected by another party.	
Decision Making Process / Transparency / Which Method Applies			
6	Academy	<p><u>Decision-making Process of the Multi-State Actuarial (MSA) Team:</u></p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	See edits to Section V.A.
7	Academy	<ul style="list-style-type: none"> • 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? 	<p>Catch up and transition are concepts applied after the TX PPV is calculated.</p> <p>See edits to Section V.A.</p>
8	Academy	<ul style="list-style-type: none"> • 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. • 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 	<p>MN approach allows a rate increase to be considered solely due to morbidity experience being more credible.</p> <p>Beyond the MSA, a company can work with a state to attempt to resolve the time value of money issue.</p> <p>See edits to Section V.A.</p>

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		<p>when submitting or reviewing a follow-up filing to achieve the recommended rate level?</p> <ul style="list-style-type: none"> ○ 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? 	
9	ACLI/AHIP	<p>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.</p> <p>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.</p> <p>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.</p> <p>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?</p> <ul style="list-style-type: none"> • If all methods will be used, will the MSA Team recommend a blend of the results? • Or will they recommend the lowest percentage? 	<p>Both the TX and MN methods are run for each MSA rate increase submitted. The MSA team will not recommend the lowest percentage method just because it's the lowest percentage or the highest percentage method just because it's the highest percentage. Professional judgement will be applied for each rate submission based on the characteristics of the block to determine if one method is more appropriate than the other or if it will be a blend of the two methods. Prior rate increases, morbidity, blends of demographics are just a few of the factors considered.</p> <p>See these edits in Section V.A.</p>
10	ACLI/AHIP	<p>2. What public policy issue is each methodology designed to address (e.g. certain issues with aging or shrinking blocks)?</p>	<p>There is a balance of professional judgment that addresses some of the agreed upon policy issues, this includes a reduction in rate increase at later policy durations to address the shrinking block issue and elimination of rate increases related to inappropriate recovery of past losses. The Minnesota approach also considers adverse investment expectations related to the decline in market</p>

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			interest rates and a cost-sharing formula is commonly applied. The TX approach makes rate changes prospective. See edits to Section V.A.
11	ACLI/AHIP	3.How will each methodology address the inequity between policyholders in states that have routinely capped or delayed increases and those that have not?	Non-actuarial considerations are a topic for further discussion. No edits to the Framework.
12	ACLI/AHIP	4. 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.	See edit to Section V.A. to point out that the catch-up increase only achieves current rate equity and not lifetime equity.
13	ACLI/AHIP	5.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?	At this time the MSA recommendation, for the filed rate increase, could be what the Texas or Minnesota method generates, a blend of the two methods or using professional actuarial judgement the MSA Team may recommend a rate increase outside of these two methods. Other methods may evolve over time that the MSA Team may want to incorporate into the future process that may generate similar or unique results. See this edit to Section V.A.
14	ACLI/AHIP	6. In the example proposed (where there’s less-than-credible older-age morbidity) what actions would the MSA Team take?	Use a balance approach if less than fully credible morbidity data. See edit to Section V.A.
Section V.A – MSA Team’s Actuarial Review Considerations			
15	Academy	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	See added sentence to this bullet in Section V.A.

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		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.	
Section V.B. Loss Ratio Approach			
16	Academy	<p>The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance:</p> <p>Section V.B.4(b) states that the loss ratio method results in “low incentive for responsible pricing.” Practicing LTC pricing actuaries are responsible for compliance with all relevant actuarial standards of practice, and a company has incentives to price appropriately. Most companies would prefer to receive premium sooner rather than later. Additionally, there are the costs associated with filing and implementing a rate increase and the impact on policyholders of premium adjustments.</p>	See edit to this bullet in Section V.B.4.b.
17	Financial Medic LLC	<p>Addressing Actuarial Review, Loss Ratio Approach, Section B, point 4:</p> <p>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 principle 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 LTCL contract involved a hidden lending arrangements.</p> <p>Typical example (2021): A recent rate increase for a large carrier expands SNOP premium to 4.02x original premium though the book remains considerably underpriced 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 LTCL actuaries in carrier filings or regulatory final dispositions. This non-disclosure misleads all LTCL 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.</p> <p>We ask how the industry came about the LRA method and not <u>Repriced in Accordance with Level Premium Precepts</u> (Fair Pricing) as the product was originally intended and sold to clients.</p> <p>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 <i>cart before the horse logic</i> in our professional opinion.</p>	<p>MN & TX deal with the past loss issue, but in different ways.</p> <p>No edits to the Framework.</p>

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18	Academy	<p>(Framework V.B.5)</p> <p>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?</p>	<p>Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions.</p> <p>No further edits to framework.</p>
Sections V.C. Minnesota Approach and V.D. Texas Approach			
19	Academy	<p>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.</p>	<p>Added footnote in Section V.D. to NAIC Library for past proceedings.</p>
20	Academy	<p>The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance:</p> <ul style="list-style-type: none"> • 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. 	<p>Edited paragraph title.</p> <p>Topic under consideration for future discussion among actuary groups.</p> <p>No other specific changes to the Framework.</p>
21	Academy	<p>Section V.C.5(a) refers to “industry-average assumptions at the time of original pricing” for LTC products.</p> <ul style="list-style-type: none"> • 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. 	<p>There was enough demand to eliminate incentive for bait & switch that a broad-brush approach was developed – not perfect but generally effective. Mortality, lapse, and investment returns are focus – able to look at average assumptions for each year of issue.</p> <p>Topic under consideration for future discussion among actuary groups.</p> <p>No edits to the Framework as these topics are more detailed than intended for the Framework.</p>
22	ACLI/AHIP	<p>7. The description of the Minnesota methodology includes a focus on underlying assumptions and indicates that the reviews are benchmarking to industry-average assumptions.</p>	<p>See response to Academy comment #21.</p> <p>Added “e.g., Moody’s”</p>

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		<ul style="list-style-type: none"> • 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? 	<p>Remaining topics under consideration for future discussion among actuaries.</p> <p>No edits to the Framework as these topics are more detailed than intended for the Framework.</p>
23	ACLI/AHIP	<p>8. The “anti-bait and switch adjustment” under the Minnesota method appears to suggest the insurers intentionally underpriced LTC products.</p> <ul style="list-style-type: none"> • 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? 	<p>Edited title of the subsection.</p> <p>Topic under consideration for future discussion among actuary groups.</p> <p>No edits to the Framework as these topics are more detailed than intended for the Framework.</p>
24	ACLI/AHIP	<p>9. The Minnesota Approach accounts for changes in interest rates; the Texas Approach explicitly does not.</p> <ul style="list-style-type: none"> • How do these conflicting approaches achieve similar results? <p>The same is true in cases of solvency concern – the document states that the cost-sharing formula in the Minnesota Approach can be adjusted.</p> <ul style="list-style-type: none"> • How will the cost-sharing formula be adjusted? • How is solvency accounted for in the Texas Approach? 	<p>Solvency considerations are outside the calculation and are a consideration of individual states.</p> <p>See added subparagraph to Section V.A.</p>
25	ACLI/AHIP	<p>13. 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:</p>	<p>Framework allows for flexibility when applying the MN, TX or any other approach to deal with unforeseen circumstances, data limitations, etc. Circumstances will be addressed on a case-by-case basis.</p> <p>Catch up and transition are concepts applied after the TX PPV is calculated. The base TX PPV amount applies to a typical case (across states).</p> <p>No edits to the Framework.</p>

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		<p>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.</p>	
26	ACLI/AHIP	<p>13.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”.</p>	Edited title of the subsection.
27	Financial Medic LLC	<p>Our firm agrees with what the Texas Approach is designed to address, Section D points 1 and 2.</p> <p>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 allows our firm to back test with a small code snippet to our LTCL processing subsystem that already had a forensic analysis capability.</p> <p>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. (refer to the full comment letter for example). 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.</p> <p>The Texas proposal acknowledges that the methodology would not work for a first time increase as not “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 the baseline filing would not be a good source of information unless there were a recalculation of PV futures as <i>adjusted by the actual rate increase</i>.</p> <p>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</p>	<p>MN & TX approaches address issue with past losses.</p> <p>No edits to the Framework.</p>

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		that would cause stakeholders to question why any methodological changes in being proposed, much less implemented, after significant economic harm. Our firm has received questions from clients, who (1) have lapsed, (2) paid more premium than they thought they should have, or (3) exercised an RBO – “have we been injured by the Loss Ratio Approach”? answering a resounding “yes”!	
Section V.F. Non-Actuarial Considerations			
28	Academy	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.”</p>	<p>Non-actuarial considerations are topics for future discussion.</p> <p>No edits to the Framework.</p>
29	Academy	<p>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.</p>	<p>Fair and reasonableness refers to impact on policyholders. See edit to V.F.</p> <p>Non-actuarial considerations are topics for future discussion.</p>

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30	ACLI/AHIP	<p>9. Will the MSA Team recommendation reflect any non-actuarial considerations or is the document simply acknowledging their existence?</p> <p>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).</p> <p>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.”</p>	<p>#9 – acknowledging their existence. Non-actuarial considerations are outside the MSA team’s review.</p> <p>#10 - Solvency considerations are outside the calculation and are a consideration of individual states. See added subparagraph to Section V.A.</p> <p>#11 - States retain authority for final rate decisions.</p> <p>Non-actuarial considerations (caps, phasing, etc.) are topics for future discussion.</p>
31	Washington	<p>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.</p>	<p>Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions.</p> <p>Non-actuarial considerations are topics for future discussion.</p> <p>No edits to framework.</p>
Appendix D. Principles for RBOs associated with LTCI rate increases			
32	Vermont	<p>On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads:</p> <p style="padding-left: 40px;"><i>Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:</i></p> <ul style="list-style-type: none"> • <i>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.</i> 	<p>VT provided an additional sentence. <i>“In the case that an offering is tied to a rate increase, and involves the collection of consumer data, regulators should ensure that data collection and use is clearly disclosed and easily understood, that the consumer is made aware of any other available options, that the offer is not discriminatory, and that the rate impact is correlated to the offering. Consumer data should</i></p>

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		<p>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.</p> <p>Consider this example:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p>	<p><i>not be collected to be monetized for profit or for advertising.”</i></p> <p>Referred VT comment letter to RBO Subgroup for input as the Subgroup is currently discussing wellness initiatives.</p>
Appendix E. Guiding Principles for LTCI RBOs Options Presented in Policyholder Notification Materials			
33	Academy	<p>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.</p> <ul style="list-style-type: none"> • 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? 	<p>Goal is for MSA recommendation to be the final rate review unless the block’s expectations deteriorate, or adverse morbidity experience becomes more credible.</p>

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		<ul style="list-style-type: none"> How would any such disclosure apply to Participating and/or non-Participating states? 	<p>Disclosing all associated future planned rate increases approved by a state is already being applied in state's rate reviews.</p> <p>No edits to Framework.</p>
34	ACLI/AHIP	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.	No edits to Framework.
Comments on the Operational Section of the Framework			
35	ACLI/AHIP	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.	<p>Process is expected to continually evolve and be evaluated.</p> <p>Responsibility for the Framework updates is addressed in section I.A and feedback from states in section III.E.</p> <p>No edits to the Framework.</p>
36	Washington	<p>Is this binding? If not, limited participation might impact goal of nationwide uniformity and defeat the purposes of MSA rate review.</p> <p>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.</p> <p>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.</p> <p>The current status of LTCI rate review at the Interstate Insurance Product Regulation Compact (IIPRC) informs this concern. At least a half dozen of the IIPRC states have opted out of IIPRC LTC review standards. This lack of uniformity is exacerbated by the IIPRC only being allowed to consider rate increases for policies that the IIPRC originally approved, and only for increases up to 15%. These challenges for the IIPRC suggest similar challenges may exist for MSA rate review.</p>	<p>Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions.</p> <p>Regarding benefits of MSA results, see edit to I.B & I.D of the Operational section second exposure draft.</p>

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37	Washington	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?	Edited throughout that confidentiality is based on each state's law. See edits to paragraphs I.E.3 & 4 of the Operational section second exposure draft.
38	Washington	Appendix A: 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.	Section I.E.1 states that the MSA Review is not specific to any state's law and that individual states retain ultimate authority for rate decisions. No edits to the Framework.
39	Academy	Appendix B: Information Checklist <ul style="list-style-type: none"> • 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. 	The list of information was previously vetted at Health Actuarial (B) Task Force. Topic under consideration for future discussion among actuary groups. No edits to the Framework.



December 6, 2021

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

Dear Commissioner Conway and Subgroup Members,

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

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

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

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

Sincerely,

Jan M. Graeber
ACLI Senior Actuary

Ray Nelson
AHIP Consulting Actuary

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

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



Memo

To: Commissioner Conway, Chair, Long Term Care Insurance Multistate Rate Review Subgroup
From: Tricia Matson, Partner
Date: December 6, 2021
Subject: RRC comments regarding Long Term Care Insurance Multistate Rate Review Framework

Background

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

RRC Comments

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

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

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

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

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

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



Long-Term Care Insurance Multistate Rate Review Framework

Draft as of December 2021

NAIC Long-Term Care Insurance (EX) Task Force

PREFACE

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

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

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I. INTRODUCTION

A. Purpose

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

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

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

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

B. State Participation in the MSA Review

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

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

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

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

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

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

C. General Description of the MSA Review

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

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

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

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

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

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

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

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

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

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

D. Benefits of Participating in the MSA Review

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

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

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

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

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

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

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

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

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

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

Information Sharing Between State Insurance Departments

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

Confidentiality of the Rate Proposal

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

Confidentiality of the MSA Reports

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

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

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

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

II. MSA TEAM

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

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

A. Qualifications of an MSA Team Member

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

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

Additionally, the following qualifications are preferred:

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

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

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

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

B. Duties of an MSA Team Member

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

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

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

C. Participation of an MSA Team Member

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

D. MSA Associate Program

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

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

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

Authority of the MSA Team

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

Disclosures and Confidentiality Obligations, as Applicable

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

Conflict of Interest Avoidance Procedures and Certifications

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

F. Required NAIC and Compact Resources

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

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

III. REQUESTING AN MSA REVIEW

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

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

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

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

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

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

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

B. Process for Requesting an MSA Review

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

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

C. Certification

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

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

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

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

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

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

B. Completion of the MSA Review

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

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

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

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

C. Preparation and Distribution of the MSA Advisory Report

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

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

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

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

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

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

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

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

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

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

E. Feedback to the MSA Team

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

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

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

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

V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

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

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

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

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

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

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

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

Consideration of Solvency Concerns

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

Follow-Up Proposals on the Same Block

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

B. Loss Ratio Approach

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

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

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

C. Minnesota Approach

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

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

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

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

D. Texas Approach

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

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

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

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

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

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

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

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

E. RBOs

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

RBOs in the MSA Advisory Report

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

Future RBOs

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

F. Non-Actuarial Considerations

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

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

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

Considerations in the MSA Advisory Report

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

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

Future Non-Actuarial Considerations

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

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

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

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

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

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

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

Information Required for an MSA Review of a Rate Proposal

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

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

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

⁶ https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx

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

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

- b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.
12. The Guidance Manual checklist items: 1) summaries (including past rate adjustments); 2) average premium; 3) distribution of business, including rate increases by state; 4) underwriting; 5) policy design and margins; 6) actuarial assumptions; 7) experience data; 8) loss ratios; 9) rationale for increase; and 10) reserve description.
13. Assert that analysis complies with Actuarial Standards of Practice (ASOPs), including 18 and 41.

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

Supplemental Information

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

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

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

Minnesota Approach

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

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

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

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

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

Texas PPV Formula

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

For rate stabilized policies:

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

Where:

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

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

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

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

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

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

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

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

Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
 - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
 - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.

2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
 - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.

3. Clarity of communication with policyholders eligible for an RBO:
 - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
 - Companies should present RBOs in clear and simple language, format, and content, with clear instructions on how to proceed and whom to contact for assistance.

4. Consideration of encouragement or requirement for an insurer to offer certain RBOs:
 - State insurance regulators should evaluate legal constraints, the impact on remaining policyholders and insurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.

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

Widely Established RBOs in Lieu of Rate Increases

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

Less Common RBOs for Potential Discussion

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

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

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

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

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

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

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

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

Filing Rate Action Letters

Insurers should consider:

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

Readability and Accessibility

Insurers should consider:

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

Identification

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

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

Communication Touch and Tone

Insurers should consider:

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

Consultation and Contact Information

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

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

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

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

Understanding Policy Options

Insurers should consider the presentation of the communication by:

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

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

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

Insurers should consider including disclosures regarding rate increase history by:

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

Insurers should consider advising policyholders of their current benefits:

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

Insurers should consider personal needs decision-making by:

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

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

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

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

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

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

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT⁷

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

Executive Summary

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

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

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

Background

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

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

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

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

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

Insurer's Proposal

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

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

Workstream-Related Review Aspects

Actuarial Review

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

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

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

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

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

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

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

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

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

Consideration of Differences in Histories of States' Rate Increase Approvals

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

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

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

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

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

Non-actuarial & Valuation/Solvency Considerations

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

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

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

RBOs – Review for Reasonableness

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

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

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

Financial Impact for Insurer

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

Mix of Business

From the insurer's actuarial memorandum:

Enrollees:

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

Product type: Expense reimbursement:

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

Appendix 1

Drivers of Rate Increase Proposal – Summary

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

Details Regarding Minnesota Approach

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

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

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

Details Regarding Texas Approach

- Insurer Calculation (aggregate): 52%

PPV calculations

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

LHAO Comments

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

Texas rate stabilized PPV Formula:

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

Reconciliation of Minnesota and Texas Approaches

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

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

Correspondence Summary

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

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

Appendix 2

Examples of Rate Increases If an RBO is Not Selected

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

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

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

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

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

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

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

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

For more information, visit www.naic.org.

Draft: 10/29/21

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

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

1. Adopted the 2022 Proposed Charges

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

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

[06 LTCI\(EX\)TaskForce_102921_Minutes.docx](#)

Draft: 10/27/21

Adopted by the Executive (EX) Committee and Plenary, _____, _____
Adopted by the Long-Term Care Insurance (EX) Task Force, Oct. 29, 2021

2022 Proposed Charges

LONG-TERM CARE INSURANCE (EX) TASK FORCE

~~Ongoing Support of NAIC Programs, Products or Services~~

- ~~A. The Long-Term Care Insurance (EX) Task Force will:~~ Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, ~~this Task Force is charged to:~~

~~the mission of the Long-Term Care Insurance (EX) Task Force is to: 1) further develop and implement a coordinated national approach for reviewing LTCI rates; 2) monitor and evaluate the rate review process; 3) evaluate and recommend options to help consumers manage the impact of rate increases; and 4) monitor work performed by other NAIC groups to review the financial solvency of long-term care (LTC) insurers.~~

~~Ongoing Support of NAIC Programs, Products or Services~~

~~1. The Long-Term Care Insurance (EX) Task Force will:~~

- ~~A. Once adopted by the NAIC Executive (EX) Committee and Plenary, monitor, and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document. Monitor state insurance department rate review actions subsequent to implementation of the MSA Framework and MSA rate review recommendations.~~
- ~~A. 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. Deliver such a proposal to the Executive (EX) Committee by the 2021 Summer National Meeting.~~
- ~~B. Complete an evaluation. Further evaluate and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.~~
- ~~C. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination and communication of the review of the financial condition of LTC insurers. Deliver such a proposal to the Executive (EX) Committee by the 2021 Summer National Meeting.~~

~~Staff Support: Jeff Johnston, Jane Koenigsman~~

~~1. The Long-Term Care Insurance Financial Solvency (EX) Subgroup will:~~

- ~~2. Explore restructuring options and techniques to address potential inequities between policyholders in different states and techniques to mitigate policyholders' risk to state guaranty fund benefit limits, including states' pre-rehabilitation planning options. Evaluate the work of the consultant and report on the work to the Task Force.~~
- ~~3. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination /communication of the review of the financial condition of long-term care (LTC) insurers.~~
- ~~4. Complete its charges by the 2021 Summer National Meeting.~~

~~5.2. The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup will:~~

- ~~A. Develop/Finalize the development of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document which outlines 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. Implement the MSA rate review process -once adopted by the NAIC Executive (EX) Committee and Plenary.~~
- ~~B. Evaluate the progress of the MSA rate review process and provide ongoing maintenance and enhancements, as deemed necessary.~~
- ~~C. The Subgroup should complete its charges by the 2022+ Summer/Fall National Meeting.~~

~~Staff Support: Eric King~~

6.3. The Long-Term Care Reduced Benefit Options (EX) Subgroup will:

- A. ~~Further-Complete an~~ evaluate~~ion~~ and/or recommend~~ation of~~ options to help consumers manage the impact of rate increases. This includes:
 - 1. ~~The potential-Finalizing~~ 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.
 - 2. The potential development of mechanisms to help regulators and consumers objectively compare reduced benefit options (RBOs), including comparison of accepting a rate increase and retaining current benefits to electing an offered RBOs.
 - 3. ~~The further exploration of pursuing more uniformity in~~Finalizing the Ceonsumer N~~otices~~ Checklist for RBOs.
- B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding evaluation of RBOs.
- C. ~~The Subgroup should c~~omplete its charges by the 2022~~4 Summer~~Fall National Meeting.

Staff Support: Eric King

Draft: 12/8/21

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

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

1. Adopted a Draft LTC Wellness Program Issues Document

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

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

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

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

[07 12-07-21 LTCI RBO min.docx](#)

Issues related to LTC wellness benefits

7/22/2021 exposed draft with 10/04/21 edits

Objective:

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

Background:

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

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

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

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

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

Details:

1. Analysis of effectiveness

- a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
 - i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
 1. Expenses vary - in many cases are ~~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.
 - iv. Effectiveness may increase or decrease if targeting certain policyholders.
 - iii.v. Development of experience showing effectiveness will be a work in progress.
- c. Addressing of Issues
 - i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
 - ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?

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

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

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

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

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

3. Consumer confusion

- a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.
- b. Addressing of issues:
 - i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs

that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.
- ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.
- iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont's sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.
- iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

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

4. Rebating

- a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).
- b. Addressing issues:
 - i. NAIC Model Law. The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or

lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

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

insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

- iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, where the initiatives do not begin at the moment the policy is issued, and ~~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.
- b. Current observations:
 - i. There is little regulatory clarity or uniformity regarding LTC wellness programs.

c. Addressing issues

i. Idea:

1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
 - a. These issues include company plans to accumulate data on programs' effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.
2. States retain the right to conduct back-end reviews, targeting any critical areas of regulatory focus.
3. Companies and regulators need to ensure that this approach is in compliance with existing state laws.
 - a. The NAIC Model Unfair Trade Practices Law appears to contemplate either a "provide notice and opportunity for objection" approach or a "documented criteria must be maintained by the insurer and produced to the regulator upon request" approach, depending on the circumstances.

ii. Considerations:

1. Balance between holding companies accountable while not creating a burden that could prevent or slow up companies from pursuing beneficial programs.
2. There may be mixed policies regarding pre-approval or filing of documentation by state. An effort to make any filing process as efficient as possible for regulators and companies should be pursued to avoid any unconstructive burdens.
3. Companies being alerted that documentation must be available would likely ensure they at least attempt to address each of the issues prior to implementing a program.
4. Would states be interested in being provided notice of development of a new wellness program? Would states want to be notified of every change in or addition to a program? In what form would the notification occur?
5. Would a state have a right to object to an aspect of a program? If the objection leads to elimination of the program in that state, would that lead to other concerns, e.g., discrimination?

6. Would development of a uniform LTC wellness template help creating uniformity in how states interact with companies offering programs?

7. Need to determine consequences for a company that does not maintain the required documentation.

ii.iii. After experiencing several companies' pilot programs and identifying actual problem areas (as opposed to hypothetical issues), it is possible regulators will want to pursue a targeted pre-approval process or up-front receipt of documentation. That could be decided at a later date.

e.d. Next steps

i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.

ii. Consider developing a template that a company could fill in with narrative explanation of how they have considered identified issues in development of a LTC wellness program. An efficient manner to have this information received by interested regulators resulting from a single company filing (perhaps through SERFF or an NAIC portal) can be pursued.

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

8. Data privacy

- a. Issue: utilization of consumers' data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of Big data-Data or artificial intelligence to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
 - i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.
- b. Current observations
 - i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.
 - ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.
 - iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.
 - iii-iv. States' continuous adoption of data and privacy regulations will need to be available for insurers to assess the compliance of their wellness initiatives.
- c. Addressing of issues
 - i. Data Use to Identify Wellness Initiatives:
 - 1. Policyholders considerations:
 - a. Confusion about why they are being solicited for the initiative.
 - b. Suspicion about the motivation of the insurer.

- c. General lack of awareness that data is being collected, and what data is being collected.
 - d. General lack the awareness or understanding on how data is collected and used.
 - e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
 - f. Will the policyholder know what data is going to be used prior to participation?
 - g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?
 - h. Should policyholders have the ability to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information?
2. Insurer considerations:
 - a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
 - a.b. How should insurers use clear and concise notice about the collection, use, and disclosure of personal information?
 - b.c. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
 - c.d. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
 - d.e. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
 - e.f. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
 - f.g. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?
 - g.h. When using third party data providers, what screening or data protection programs are in place?
 - ii. Data Use During Wellness Initiative Development:
 1. Should insurers purchase policyholder specific information from third party data sources?
 - a. Data collected during purchases, search history, television programming, etc.
 - b. Should it always be headless, anonymized, or deidentified?

2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
 3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
 4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
 5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
 6. Does the insurer have procedures in place to notify the policyholders of a potential breach?
- iii. Wellness Results Data Use:
1. Should the results be sold? Aggregate vs specific demographic information?
 2. Should insurers use the results internally for cross marketing other wellness initiatives?
 3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
 4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
 5. How should the data be shared, if at all, with other vendors or service providers?
 6. How long will the data be retained? Will the data be destroyed or disposed?
- d. Dependencies
- i. Unfair Discrimination
 - ii. States' adoption of wellness initiatives could make it difficult to implement a program uniformly.
- e. Next steps:
- i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
 - ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
 - iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
 - iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
 1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
 - v. Can new contracts be written with evergreen access to some private data?

9. Other considerations

- a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
- b. Current observations
 - i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
 1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
 - ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
 - iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
- c. 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.

10. Miscellaneous topics

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



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

November 4, 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 second draft of the “Issues Related to LTC Wellness Benefits,” exposed by the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on October 5, 2021.

ACLI/AHIP continue to support the Subgroup’s work to explore the offering of innovative wellness benefit programs as part of long-term care insurance (LTCI). By discussing the issues and opportunities associated with wellness programs in LTCI, we learn how these benefits may contribute to policyholder health and strengthen the LTCI market.

OBJECTIVE

ACLI/AHIP request that the newly added objective statement be revised to reflect the document’s stated purpose in the Background section to work “together to explore some of these claim cost-reducing innovations.” Thus, we recommend the objective statement read, “The objective of this paper is to foster dialogue amongst regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.” Fostering discussion that supports insurance companies in developing pilot wellness programs should be the aim of this document, as opposed to increasing “clarity,” which could stifle innovation. As we have previously asserted, LTCI wellness initiatives are in their infancy and will require significant development and testing. Insurers are encouraged to develop wellness initiatives when the regulatory environment facilitates exploration, innovation, and targeted pilot programs.

With the goal of contributing to the discussion on wellness programs in LTCI, our comments on the second draft are as follows.

BACKGROUND

We appreciate the addition of “pre-insurance-claim” to describe the wellness interventions discussed in the document. The true value of wellness interventions comes in providing them pre-claim when they are most effective.

And while we recognize the Subgroup’s stated goal to address rate increases and solvency concerns with wellness programs, we continue to feel it is important that this discussion



document emphasize what should be wellness programs' primary goal, and that is the maintained or improved health and independence of policyholders. Whether or not wellness programs affect rate increases or solvency concerns remains to be seen. They are likely to be one of many factors, including necessary and actuarially justified rate increases, that strengthen the LTCI marketplace overall. Wellness programs should not be pursued as a "cure" to industry issues. What we can reasonably pursue, however, is the improved wellness of LTCI policyholders.

PREVENTION OF UNFAIR DISCRIMINATION RELATED TO EXTRA-CONTRACTUAL BENEFITS AND COSTS

ACLI/AHIP affirm the importance of avoiding unfair discrimination when offering LTCI wellness benefits. We also believe it is possible navigate discrimination concerns when targeting wellness programs to cohorts of similarly situated insureds. Our original comments asserted that certain wellness "programs may be most effective and most utilized if focused on those insureds with a particular condition, age range, or sex. Targeted wellness programs could more effectively reduce claims costs and maximize the health of policyholders." The ability to target wellness programs, while avoiding unfair discrimination, is key to encouraging LTC insurers to implement wellness programs. Insurers are unlikely to attempt a wellness program if they cannot first experiment with a small, targeted pilot program before scaling up.

While we agree with efforts to better support underserved markets, we disagree with the newly added language in this section that suggests "selection for pilots should consider including a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected." While a broad range of characteristics might be appropriate for many benefit programs, it is not appropriate in all instances, particularly pilot programs. Often, meaningful data is best collected and analyzed when it is targeted. Certain benefits are also likely to be more effective at improving wellness if targeted.

The LTCI industry needs assurance from regulators that focusing wellness benefits on a cohort of similarly situated policyholders successfully navigates unfair discrimination requirements. Regulatory guidance on how to classify policyholders for a targeted wellness program is unnecessary and would hamper industry efforts to innovate.

REGULATORY ROLE IN APPROVING OR EVALUATING LTC WELLNESS APPROACHES

We welcome the edits made to this section that both express a goal to avoid unconstructive regulatory and filing burdens and, also, remove the suggestion that receiving an actuarially justified rate increase be contingent on an insurer's innovation efforts.

To reiterate, ACLI/AHIP believe that tying wellness benefit programs to rate increases is inappropriate for a few reasons. First, a rate increase request for an individual block of business may not have an associated wellness program. Second, wellness programs might only be offered to new customers. Third, wellness programs are primarily structured to improve



wellness, not address actuarially justified rate increases. Fourth, it could lead to inequities between companies with varying participation levels in the wellness realm. And fifth, the data needed to justify a correlation between wellness programs and rate increases, will, if such a correlation exists, take time to gather and analyze.

CONCLUSION

ACLI/AHIP affirm their commitment to continuous collaboration with regulators and other interested parties in developing the thinking about wellness programs in LTCL. Thank you for the opportunity to provide these comments. ACLI/AHIP look forward to discussing our comments with you soon.

Sincerely,

Jan M. Graeber
Senior Actuary, ACLI

Susan Coronel
Executive Director, Product Policy, AHIP

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.

Draft: 12/8/21

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

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

1. Adopted the RBO Consumer Notices Checklist.

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

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

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

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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 (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 ^[A1] consider the checklist excessive, deficient, or not focused on issues specific to consumer experiences in a particular ^[A2] 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 ^[A3] ^[A4] complaints, improve the quality of the consumer communications, and to ensure the information presented. The checklist seeks to that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Present Identifies if the options are presented ^[A5] ^[A6] fairly and without subtle coercion.
- ~~Includes~~ appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

~~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, improve the quality of the consumer communications, and to ensure the information ^[A7] ^[A8] 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 [A9][A10][A11][A12] Subgroup?]~~ **RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and ~~adopt~~ use the checklist [A13][A14] 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.

DRAFT

Checklist for Premium Increase Communications

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

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all <u>required</u> materials to including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested <u>expected</u> if communication refers policyholder to website for more information _{[A15][A16]})? _{[A17][A18]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will <u>notice of</u> _{[A19][A20]} the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)? _{[A21][A22][A23][A24]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all <u>new</u> <u>innovative</u> _{[A25][A26]} <u>RBO</u> options presented in the communication been mentioned prominently as part of <u>clearly explained in</u> _{[A27][A28]} the filing? Have they been vetted by policy and actuarial staff? _{[A29][A30][A31]}	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Are there sample policyholder communications with a statement of variability? ^{[A32][A33][A34][A35][A36]} Do reviewers understand any variable information that appears in the letter communication?	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	6. Are there insurer rules ^[A37] and training ^[A38] for customer service interactions regarding RBOs? ^{[A39][A40][A41][A42][A43][A44]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.6. Were state-specific <u>or contract-specific</u> pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60Y-days before effective date. PA posts filed rate increase details on their website. ^{[A45][A46][A47]}	
Yes	No	N/A	READABILITY AND ACCESSIBILITY ^{[A48][A49]}	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.7. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded? ^{[A50][A51]} <u>Is the primary message of the communication presented first and clearly worded?</u> ^{[A52][A53]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9.8. Are all <u>technical</u> insurance technical ^{[A54][A55]} terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10.9. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11.10. Is the communication in an easily readable font? <u>For example: Is the type in</u> at least {11-point} type? ^{[A56][A57]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12.11. Does the communication use headings to help the reader find information easily?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13.12. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14.13. Are tables, charts, and other graphics, easy to read and understand[A58][A59][A60][A61]? (See question 18 for reference).	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15.14. Are the grade level and reading ease scores appropriate according to state readability standards? -D([8th grade] or lower; Flesch reading ease score [60] or higher)?[A62][A63][A64][A65][A66][A67][A68][A69][A70]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16.15. Are there side-by-side illustrations of options compared with current benefits? Are reduced benefit options they clear and not misleading?[A71][A72] For example: Are there side-by-side illustrations of options compared with current benefits?	
			16. Does the communication include diminished contrast features that may make it harder to read? Examples include: <ul style="list-style-type: none"> • Use of Italics • Narrow margins (top and bottom less than 1.5 inches) • All caps (all bold is acceptable) • Difficult to read text (fonts other than Sans Serif or Courier) • Glossy paper • Different colors throughout (print to test) • Small font 	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. If FAQs are included, are they succinct and easy to understand?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language?[A73][A74] For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or	

			macular degeneration, low vision, ^{[A75][A76]} deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language? ^{[A77][A78]}	
Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20.19. Does the communication answer what is happening?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21.20. Does the communication answer why the consumer is receiving a rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22.21. Does the communication reflect negatively ^{[A79][A80]} on the Department of Insurance? ^{[A81][A82]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23.22. Does the communication indicate when the rate increase will be effective?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24.23. Does the communication clearly indicate the <u>policyholder</u> has <u>ve</u> options? ^{[A83][A84][A85][A86][A87]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25.24. Does the communication clearly indicate how <u>the consumer may</u> to elect an option? Does the election documentation <u>allow the consumer</u> consumer to clearly indicate <u>his or her choice</u> ? Does the <u>election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form?</u> For example, when check boxes are used to indicate a choice there may <u>should be some way to verify that choice on the form returned to the insurer to avoid mistakes, the consumer's choice?</u> ^{[A88][A89][A90][A91][A92][A93]}	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><u>25. Does the communication clearly explain that the consumer is not being singled out for the increase?'</u></p> <p>26. Does the communication clearly describe "class-basis"? Are consumers being singled out for the increase? Suggested text: "Overall experience of all contracts^{[A94][A95]} in your class..."</p>	
Yes	No	N/A	COMMUNICATION TOUCH AND TONE	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>27.26. Does the communication remind consumers to reflect ^{[A96][A97][A98][A99]} on <u>why they may have purchased the original reason they bought^{[A100][A101]} the policy?</u></p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>28.27. Does the communication express <u>empathy and understanding of the difficulty of evaluating choices^{[A102][A103]}</u>?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>29.28. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>30.29. Are the options represented fairly? ^{[A104][A105][A106]} <u>Options are not presented fairly</u> ifs one option <u>is</u> emphasized, mentioned multiple times or bolded when <u>re</u> the others <u>options</u> are not? ^{[A107][A108][A109]}</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>31.30. Are <u>the^[A110]</u> words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i>? For instance, consider <u>demonstrating immediacy by using the word "now," instead of and avoiding words like "must^{[A111][A112][A113][A114]}</u>. Consider <u>"mitigation options^{[A115][A116][A117]}</u>, <u>"offset premium impact^{[A118][A119][A120][A121]}</u>, or "manage an increase" instead of "avoid an increase."</p>	

Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>32.31. Is the insurer’s consumer service number [A122][A123][A124][A125] easy to find? Is it clear what hours and days consumer service is open [A126][A127][A128]? [A129][A130] <u>Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times. rather than a phone tree</u></p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>33.32. Are website links and phone numbers accurate and functional? [A131][A132]</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>34.33. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner <u>advisor</u>, producer, <u>state SHIP program (-where applicable)</u> [A133][A134][A135][A136] <u>with the state-specific name of the program,</u> or trusted family member [A137][A138][A139]? <u>Is that information communicated clearly</u></p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>35.34. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments [A140][A141][A142] can only give general information? [A143][A144][A145][A146]</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>36.35. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of [A147][A148] Partnership status? [A149][A150]</p>	
Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes

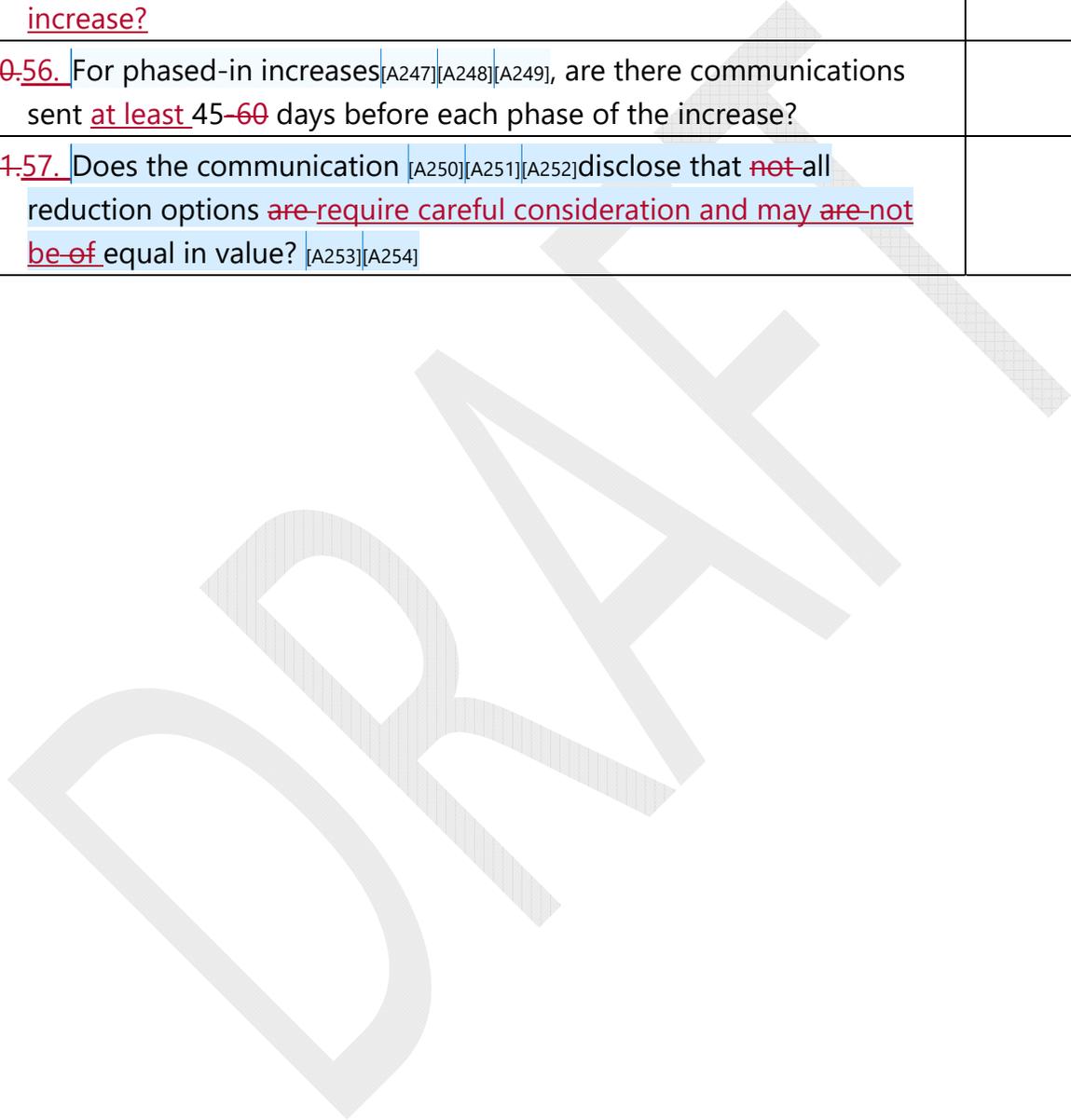
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>37.36. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>38.37. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>39.38. Are the number of options presented reasonable (5-7 options)? If there are less than 3, but or more than 57, engage with insurer to understand what is being presented.</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>40.39. Is the Rright to Rreduce Ccoverage at Any Time at any time of a policyholder's choosing clear? Are the instructions about how to do that clear?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>41.40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on choose an option?</p>	
Yes	No	N/A	<p>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>42.41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear? 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?</p>	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43.42. Does the communication include a 10-year nationwide rate increase history for this and similar forms? ^{[A172][A173][A174][A175][A176][A177]} <u>(if not in the model for policy increases, okay to remove)</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44.43. Does the communication disclose the policy is guaranteed renewal <u>renewable and clearly explain guaranteed renewable</u> ^{[A178][A179]} ? ^{[A180][A181]}	
Yes	No	N/A	UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45.44. Does the communication indicate what the reader must do <u>to elect an option and provide a and the</u> deadline to do it? ^{[A182][A183]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46.45. For <u>if</u> options that are only available during the decision window, is it <u>that limitation</u> clear to consumers? ^{[A184][A185]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47.46. Does the communication ^{[A186][A187]} answer <u>indicate address</u> what happens if <u>the policyholder does not send payment no payment is sent?</u> <u>For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?</u> For example, if no payment is received within 120 days, does the communication explain that it advise Contingent Non-Forfeiture will apply and what that means? ^{[A188][A189]}	
Yes	No	N/A	UNDERSTANDING OPTIONS – CURRENT BENEFITS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48.47. Does the communication ^{[A190][A191][A192]} include all <u>relevant</u> the following <u>applicable</u> information? Current <u>policy</u> ^{[A193][A194]} benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) <u>in list form</u> ?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49.48. If current benefits [A195][A196][A197][A198] have an inflation option, <u>does the communication [A199][A200] clearly explain include the [A201][A202] impact that changes to this inflation option may have on benefits now and in the future lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?</u> [A203][A204]	
Yes	No	N/A	UNDERSTANDING OPTIONS – PERSONAL DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50.49. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown sent options that are not available to them)? <u>Are the [A205][A206] options presented available [A207][A208] to the policyholder?</u>	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	51. <u>Does the communication [A209][A210] contain descriptions of the consumer's options (including changes in the [A211][A212] daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</u> [A213][A214][A215][A216]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52.50. Does the communication [A217][A218][A219] 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 <u>for and cost of for institutionalized care?</u>	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	53. <u>Does the communication [A220][A221][A222][A223] provide an unbiased resource(s) for policyholders to research the cost of care?</u>	
Yes	No	N/A	UNDERSTANDING OPTIONS – VALUE OF OPTIONS	Page Reference and Filing Notes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>54.51. Do options clearly [A224][A225][A226] indicate value for consumers? Does Does the narrative describing the [A227][A228] Contingent Nonforfeiture (CNF) and other limited benefit options clear that there is a reduction in the current policy's LTC benefits. available ly describe if there is a reduction in available the current policy's LTC benefits? value (benefit period)? [A229] The description narrative of the CNF re does not need to behave a to include quantitative the dollar value for CNF.s information in the communication, such as the specific benefit amount reduced with each option.</p>	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<p>55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options [A230][A231], or help understand their options? [A232][A233][A234]</p>	
Yes	No	N/A	<p>UNDERSTANDING OPTIONS – IMPACT OF DECISION</p>	<p>Page Reference and Filing Notes</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>56.52. Is there a prominent statement telling policyholders they can maintain their [A235][A236] current benefits by paying the increased premium?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>57.53. Do the options reflect the impact of removing or reducing the inflation option in terms of on the growth or reduction if the option is to remove or reduce inflation of future benefits? [A237][A238]</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>58.54. If dropping inflation protection results in the loss of accumulated benefit amount, is that clearly explained disclosed? [A239][A240][A241]</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>59.55. For phased-in increases [A242][A243][A244][A245][A246]: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first</p>	

			<u>rate increase or will only be available during each phase of the rate increase?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60.56. For phased-in increases ^{[A247][A248][A249]} , are there communications sent <u>at least 45-60</u> days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61.57. Does the communication ^{[A250][A251][A252]} disclose that not all reduction options <u>are require careful consideration and may are not be of</u> equal in value? ^{[A253][A254]}	



Draft: 10/29/21

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

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

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

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

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

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

[09 10-19-21 LTCI RBO min.docx](#)

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 who^[A1] consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular their^[A2] 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^[A3]^[A4] complaints, improve the quality of the consumer communications, and to ensure the information presented. The checklist seeks to that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented^[A5]^[A6] fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

~~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, improve the quality of the consumer communications, and to ensure the information^{[A7][A8]} 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^{[A9][A10][A11][A12]} Subgroup?] RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt use the checklist^{[A13][A14]} when reviewing filed Long-Term Care Insurance RBO Communications.

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

Checklist for Premium Increase Communications

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

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all <u>required</u> materials to including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested <u>expected</u> if communication refers policyholder to website for more information _{[A15][A16]})? _{[A17][A18]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will <u>notice of</u> _{[A19][A20]} the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)? _{[A21][A22][A23][A24]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all <u>new</u> <u>innovative</u> or _{[A25][A26]} <u>RBO</u> options presented in the communication been mentioned prominently as part of <u>clearly explained in</u> _{[A27][A28]} the filing? Have they been vetted by policy and actuarial staff? _{[A29][A30][A31]}	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. <u>Are there sample policyholder communications with a statement of variability?</u> ^{[A32][A33][A34][A35][A36]} <u>Do reviewers understand any variable information that appears in the letter communication?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Are there insurer rules <u>and training</u> ^{[A37][A38]} for customer service interactions regarding RBOs? ^{[A39][A40][A41][A42][A43][A44]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>45-60Y-days</u> before effective date. PA posts filed rate increase details on their website. ^{[A45][A46][A47]}	
Yes	No	N/A	READABILITY AND ACCESSIBILITY ^{[A48][A49]}	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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)? <u>Is the primary message of the communication presented first and clearly worded?</u> ^{[A50][A51][A52][A53]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all <u>technical</u> insurance technical ^{[A54][A55]} terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is the communication in an easily readable font? <u>For example: Is the type in</u> at least {11-point}-type? ^{[A56][A57]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Does the communication use headings to help the reader find information easily?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are tables, charts, and other graphics, <u>easy to read and understand</u> ^{[A58][A59][A60][A61]} ? <u>(See question 18 for reference).</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are the grade level and reading ease scores appropriate <u>according to state readability standards? -D</u> <u>([8th grade] or lower; Flesch reading ease score [60] or higher)</u> ? ^{[A62][A63][A64][A65][A66][A67][A68][A69][A70]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Are there side-by-side illustrations of options compared with current benefits? Are <u>reduced benefit options</u> they clear and not misleading? ^{[A71][A72]} <u>For example: Are there side-by-side illustrations of options compared with current benefits?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. If FAQs are included, are they succinct and easy to understand?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? ^{[A73][A74]} For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or <u>macular degeneration</u> <u>low vision</u> ^{[A75][A76]} , deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language? ^{[A77][A78]}	
Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Does the communication answer what is happening?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Does the communication answer why the consumer is receiving a rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Does the communication reflect negatively ^{[A79][A80]} on the Department of Insurance? ^{[A81][A82]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Does the communication indicate when the rate increase will be effective?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Does the communication clearly indicate the <u>policyholder</u> has <u>ve</u> options? ^{[A83][A84][A85][A86][A87]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Does the communication clearly indicate how <u>the consumer may to</u> elect an option? Does the election documentation <u>allow the consumer</u> to clearly indicate <u>his or her choice</u> ? For example, when check boxes are used to indicate a choice there <u>may should</u> be some way to verify that choice on the form returned to <u>the insurer to avoid mistakes. the consumer's choice</u> ? ^{[A88][A89][A90][A91][A92][A93]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Does the communication clearly explain that the consumer is not being singled out for the increase?" 26. Does the communication clearly describe "class basis"? Are consumers being singled out for the increase? Suggested text: "Overall experience of all <u>contracts</u> ^{[A94][A95]} in your class..."	
Yes	No	N/A	COMMUNICATION TOUCH AND TONE	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication remind consumers to reflect ^{[A96][A97][A98][A99]} on <u>why they may have purchased the original reason they bought</u> ^{[A100][A101]} the policy?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Does the communication express <u>empathy and understanding of the difficulty of evaluating choices</u> ^{[A102][A103]} ?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are the options represented fairly? ^{[A104][A105][A106]} <u>Options are not presented fairly</u> Ifs one option <u>is</u> emphasized, mentioned multiple times or bolded when re the others <u>options</u> are not? ^{[A107][A108] [A109]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Are <u>the</u> ^[A110] -words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider <u>demonstrating immediacy by using the word "now," instead of and avoiding words like "must,</u> ^{[A111][A112][A113][A114]} ." Consider <u>"mitigation options,</u> ^{[A115][A116][A117]} ," <u>"offset premium impact,</u> ^{[A118][A119][A120][A121]} " or "manage an increase" instead of "avoid an increase."	
Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Is the insurer's consumer service <u>number,</u> ^{[A122][A123][A124][A125]} easy to find? Is it clear what hours and days consumer service is <u>open,</u> ^{[A126][A127][A128]} ? ^{[A129][A130]} <u>Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times.</u> rather than a phone tree	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Are website links and phone numbers accurate and functional? ^{[A131][A132]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner <u>advisor,</u> producer, <u>state SHIP program (-where applicable)</u> ^{[A133][A134][A135][A136]} <u>with the state-specific name of the program,</u> or	

			trusted family member ^{[A137][A138][A139]} ? <u>Is that information communicated clearly</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments^{[A140][A141][A142]} can only give general information?^{[A143][A144][A145][A146]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 ^{[A147][A148]} Partnership status? ^{[A149][A150]}	
Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Are the number of options presented reasonable ^{[A151][A152][A153][A154][A155][A156]} but no more than (5-7 options^{[A157][A158][A159]}) ? <u>If there are less than 3, but more than 57, engage with insurer to understand what is being presented.</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is the R right to R reduce C coverage at Any Time <u>at any time of a policyholder's choosing</u> ^{[A160][A161]} clear ^{[A162][A163]} ? ^{[A164][A165]} <u>Are the instructions about how to do that clear?</u> ^{[A166][A167]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>choose</u> ^[A168] ^[A169] an option?	
Yes	No	N/A	UNDERSTANDING OPTIONS – PAST RATE ACTIONS	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a statement that premiums may increase in the future? <u>Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear? 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?</u> ^[A170] ^[A171]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms? ^[A172] ^[A173] ^[A174] ^[A175] ^[A176] ^[A177] <u>(if not in the model for policy increases, okay to remove)</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication disclose the policy is guaranteed renewal <u>renewable</u> and clearly explain guaranteed renewable ^[A178] ^[A179] ? ^[A180] ^[A181]	
Yes	No	N/A	UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. Does the communication indicate what the reader must do <u>to elect an option and provide a</u> and the deadline to do it? ^[A182] ^[A183]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. For <u>If</u> options that are only available during the decision window, is that limitation clear to consumers? ^[A184] ^[A185]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication ^[A186] ^[A187] answer <u>indicate</u> address what happens if <u>the policyholder does not send payment</u> no payment is sent ? <u>For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?</u> For example, if	

			no payment is received within 120 days, does the communication explain that it advise Contingent Non-Forfeiture will apply and what that means? [A188][A189]	
Yes	No	N/A	UNDERSTANDING OPTIONS – CURRENT BENEFITS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. Does the communication [A190][A191][A192] include all <u>relevant</u> the following <u>applicable</u> information? Current <u>policy</u> [A193][A194] benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. If current benefits [A195][A196][A197][A198] have an inflation option, <u>does the communication</u> [A199][A200] include <u>the</u> [A201][A202] lifetime maximum benefit in dollars illustrated both five and fifteen years into the future? [A203][A204]	
Yes	No	N/A	UNDERSTANDING OPTIONS – PERSONAL DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown sent options that are not available to them)? Are the [A205][A206] options presented available [A207][A208] to the policyholder?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Does the communication [A209][A210] contain descriptions of the consumer's options (including changes in the [A211][A212] daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)? [A213][A214][A215][A216]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Does the communication [A217][A218][A219] prompt the policyholder to consider their personal situation, such as: current age, health	

			conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of for institutionalized care?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. Do options clearly indicate value for consumers? Does Does the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options clear that there is a reduction in the current policy's LTC benefits. available ly describe if there is a reduction in available the current policy's LTC benefits? value (benefit period)? The description narrative of the CNF re does not need to behave a to include quantitative the dollar value for CNF.s information in the communication, such as the specific benefit amount reduced with each option.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Do the options reflect the impact of <u>removing or reducing the inflation option in terms of on the growth or reduction if the option is to remove or reduce inflation of future benefits?</u> [A237][A238]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that <u>clearly explained-disclosed?</u> [A239][A240][A241]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59. For <u>phased-in increases</u> [A242][A243][A244][A245][A246]: Is there a table with all phase-in dates and premium amounts <u>if no RBO is selected?</u> <u>Does the communication clearly state if RBO(s) are limited to only the first rate increase or will only be available during each phase of the rate increase?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60. For <u>phased-in increases</u> [A247][A248][A249], are there communications sent <u>at least 45-60</u> days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61. Does the communication [A250][A251][A252] disclose that <u>not all reduction options are require careful consideration and may are not be of equal in value?</u> [A253][A254]	

Draft: 10/28/21

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

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

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

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

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

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

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

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

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

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

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

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

[10 10-04-21 LTCI RBO min.docx](#)

Issues related to LTC wellness benefits

7/22/2021 exposed draft with 10/04/21 edits

Objective:

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

Background:

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

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

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

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

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

Details:

1. Analysis of effectiveness

- a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
 - i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
 - 1. Expenses vary - in many cases are ~~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.
 - iv. Effectiveness may increase or decrease if targeting certain policyholders.
 - iii.v. Development of experience showing effectiveness will be a work in progress.
- c. Addressing of Issues
 - i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
 - ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?

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

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

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

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

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

3. Consumer confusion

- a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.
- b. Addressing of issues:
 - i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs

that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.
- ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.
- iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont's sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.
- iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

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

4. Rebating

- a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).
- b. Addressing issues:
 - i. NAIC Model Law. The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or

lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance.⁴ As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law's anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state's rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:

a. **Alaska:** Statutorily excludes "a reward under a wellness program established under a health care plan that favors an individual" from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.

b. **Maine:** Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.

2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction's rebating law and if there are any state specific requirements for offering such an initiative.

iii. Trends in State Law. Notwithstanding the variation in individual state's laws and if and how they have been amended or interpreted, there does appear to be a general trend that "services are not prohibited if they are directly related to the

insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

- iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, where the initiatives do not begin at the moment the policy is issued, and ~~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.
- b. Current observations:
 - i. There is little regulatory clarity or uniformity regarding LTC wellness programs.

c. Addressing issues

i. Idea:

- 1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
 - a. These issues include company plans to accumulate data on programs' effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.
- 2. States retain the right to conduct back-end reviews, targeting any critical areas of regulatory focus.
- 3. Companies and regulators need to ensure that this approach is in compliance with existing state laws.
 - a. The NAIC Model Unfair Trade Practices Law appears to contemplate either a "provide notice and opportunity for objection" approach or a "documented criteria must be maintained by the insurer and produced to the regulator upon request" approach, depending on the circumstances.

ii. Considerations:

- 1. Balance between holding companies accountable while not creating a burden that could prevent or slow up companies from pursuing beneficial programs.
- 2. There may be mixed policies regarding pre-approval or filing of documentation by state. An effort to make any filing process as efficient as possible for regulators and companies should be pursued to avoid any unconstructive burdens.
- 3. Companies being alerted that documentation must be available would likely ensure they at least attempt to address each of the issues prior to implementing a program.
- 4. Would states be interested in being provided notice of development of a new wellness program? Would states want to be notified of every change in or addition to a program? In what form would the notification occur?
- 5. Would a state have a right to object to an aspect of a program? If the objection leads to elimination of the program in that state, would that lead to other concerns, e.g., discrimination?

- 6. Would development of a uniform LTC wellness template help creating uniformity in how states interact with companies offering programs?
- 7. Need to determine consequences for a company that does not maintain the required documentation.
- ii-iii. After experiencing several companies' pilot programs and identifying actual problem areas (as opposed to hypothetical issues), it is possible regulators will want to pursue a targeted pre-approval process or up-front receipt of documentation. That could be decided at a later date.

e-d. Next steps

- i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.
- ii. Consider developing a template that a company could fill in with narrative explanation of how they have considered identified issues in development of a LTC wellness program. An efficient manner to have this information received by interested regulators resulting from a single company filing (perhaps through SERFF or an NAIC portal) can be pursued.
- ~~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.
 - iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.
- d. Next steps
- i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy

- a. Issue: utilization of consumers' data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of Big data-Data or artificial intelligence to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
 - i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.
- b. Current observations
 - i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.
 - ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.
 - iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.
 - iv. States' continuous adoption of data and privacy regulations will need to be available for insurers to assess the compliance of their wellness initiatives.
- c. Addressing of issues
 - i. Data Use to Identify Wellness Initiatives:
 - 1. Policyholders considerations:
 - a. Confusion about why they are being solicited for the initiative.
 - b. Suspicion about the motivation of the insurer.

- c. General lack of awareness that data is being collected, and what data is being collected.
 - d. General lack the awareness or understanding on how data is collected and used.
 - e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
 - f. Will the policyholder know what data is going to be used prior to participation?
 - g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?
 - h. Should policyholders have the ability to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information?
2. Insurer considerations:
- a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
 - ~~a-b.~~ How should insurers use clear and concise notice about the collection, use, and disclosure of personal information?
 - ~~b-c.~~ Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
 - ~~e-d.~~ How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
 - ~~d-e.~~ Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
 - ~~e-f.~~ Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
 - ~~f-g.~~ How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?
 - ~~g-h.~~ When using third party data providers, what screening or data protection programs are in place?
- ii. Data Use During Wellness Initiative Development:
1. Should insurers purchase policyholder specific information from third party data sources?
 - a. Data collected during purchases, search history, television programming, etc.
 - b. Should it always be headless, anonymized, or deidentified?

2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
 3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
 4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
 5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
 6. Does the insurer have procedures in place to notify the policyholders of a potential breach?
- iii. Wellness Results Data Use:
1. Should the results be sold? Aggregate vs specific demographic information?
 2. Should insurers use the results internally for cross marketing other wellness initiatives?
 3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
 4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
 5. How should the data be shared, if at all, with other vendors or service providers?
 6. How long will the data be retained? Will the data be destroyed or disposed?
- d. Dependencies
- i. Unfair Discrimination
 - ii. States' adoption of wellness initiatives could make it difficult to implement a program uniformly.
- e. Next steps:
- i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
 - ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
 - iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
 - iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
 1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
 - v. Can new contracts be written with evergreen access to some private data?

9. Other considerations

- a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
- b. Current observations
 - i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
 - 1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
 - ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
 - iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
- c. 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.

10. Miscellaneous topics

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

September 1, 2021

Dear Interested NAIC Regulators, the Long-Term Care Insurance (LTCI) Reduced Benefit Options (EX) Subgroup, Senior Issues (B) Task Force, Health Actuarial (B) Task Force, and Interested Parties:

This letter is in response to the draft long term care insurance (LTCI) wellness program document circulated on 7/22/2021. We are a group of physicians who specialize in cognitive and neurological issues in adults. Many of our patients require home care, assisted living, or long-term care eventually in their lifetime. LTCI has been beneficial for our patients that need custodial care.

Regarding the cognitive wellness initiatives specifically related to “Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis”, we have the following concerns:

- Insurance carriers are implementing various digital technologies such as wearables, eye-tracking, and other digital biomarkers as the sole means to flag patients with cognitive risk. These technologies are rapidly evolving, experimental and, at most, should be considered data points that are used for decision support. We highly recommend that insurance carriers urge their members to see their physician for a proper cognitive risk evaluation.
- Research from the Alzheimer’s Association has demonstrated approximately 50% of cognitive impairment cases are undiagnosed. New cognitive wellness programs in LTCI that identify patients for cognitive risk could potentially do so before a physician has diagnosed or disclosed the medical condition to the patient. This brings up a variety of legal risks to both the insurance carrier, cognitive wellness coaches, and for the patient.
- As part of cognitive impairment guidelines from the American Academy of Neurology, there is bloodwork and imaging to do as part of the medical workup, as well as ruling out common conditions that “mimic” cognitive impairment (i.e., delirium, vitamin deficiencies, depression). This process is not being verified by insurance carriers or cognitive wellness programs. This gap in care may result in a high number of patients incorrectly flagged as having cognitive risk (false positives). This may also have downstream financial implications for patients through increased insurance premiums.

- Social workers and nurses should not be flagging, diagnosing, or telling patients they have cognitive impairment without a proper medical evaluation and workup by their physician using evidence-based clinical practice guidelines. This gap in care is currently underway at LTCI third-party administrators (during face-to-face assessments) and in internal claims processing workflows during chronic illness verification and the adjudication process. In 2020, an independent external medical advisory task force found 20-30% of potential claims to have a possible “treatable” condition to their cognitive impairment (delirium, depression, vitamin deficiencies etc.). These patients may have received an incorrect label of irreversible cognitive impairment.
- There are ethical and legal consequences to consider in telling someone they are at risk for dementia or have cognitive impairment before a physician does so. Some states require clinicians to report the patient’s medical condition to the DMV or alert banks regarding mental capacity.

As advocates for patient safety and care representing several U.S territories, we are concerned that these issues will put our patients in harm rather than benefiting them. We suggest to the committee that they seek the advice from an external independent medical advisory board before implementing any nationally approved cognitive wellness programs.

Yours respectfully,

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From: [Andersen, Frederick \(COMM\)](#)
To: [King, Eric](#)
Subject: LTCEX RBO Wellness document comments
Date: Friday, August 27, 2021 4:07:24 PM

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Eric, here are some comments I received on the LTC Wellness exposure. The submitter (for some reason) wanted to be anonymous.

- Clarify definition of wellness benefits by calling them pre-claim wellness initiatives.
- Perhaps define pre-claim wellness initiatives as providing pre-claim support to assist regarding the declining independence of the insured.
- Wellness benefits (home modification, caregiver training, care management) are often available in today's LTC products but are not available until the insured is benefit eligible, which is too late to benefit the insured or their family. It should be offered when there's an initial need.
- Pre-claim (pre-2 ADL) access to caregiver training and home modifications can delay the need for formal care and may provide fairly reliable claim cost savings.
- Rebating would tend to come into play if extra benefits were available day 1, not "later on but pre-claim".
- Supplement or replace reliance on technology to identify high risk policyholders by having insureds self-identify or opt in.
- If the initiative is one of early support, broad communication and outreach is key. If the initiative is age- or condition-based, it should be offered consistently.
- Health plans already offer caregiver training, home modifications, or wellness programs without tax consequences – what's different about LTC?

Another issue brought up is whether hybrid products should be brought into the conversation. I think, considering LTC TF is focused on standalone LTC, focus there for now and don't enter life insurance policy issues into the conversation when standalone LTC is the focus. Do you have thoughts on this?

Thanks.



Larry Nisenson
Assured Allies
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To the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, Senior Issues (B) Task Force, Health Actuarial (B) Task Force, Interested Regulators, and Interested Parties:

Assured Allies mission is to transform the aging process and improve lives for every American as they age. We aspire to do this by reinventing the aging experience for the estimated 20+ million US consumers the vast majority of which are unprepared to finance their long term care costs.

While the precise number of Americans that need assistance as they age is debatable, there is no question that we need a creative and modern approach to solve this societal problem. Assured allies may be new to the long term care space, but our team is rich and deep in experience solving issues for health care and aging. Our products are built with the consumer in mind and thereby use a data driven engagement approach with the singular aim of helping our consumers live healthier lives and age in place.

While our programs fall under the heading of “wellness programs”, we believe our science based wellness solutions provide much more. In fact, we are the first company to take longstanding solutions in the healthcare space, modernize them and apply them to aging and long term care. We build trusted relationships with our consumers and engage and coach them on their respective aging journey. We partner with trusted vendors across the nation to offer meaningful value added discounts to help the consumer as they age and reward the policyholder for healthy decisions. We look to change the trajectory of aging and demonstrate to our consumers that they personally can impact how they age and even where they age. We look to deliver these services, tied to the insurable risk of needing long term care services and partner with insurance carriers to offer new insurance products and help manage current legacy blocks of business. Our new approach and product design will change how long term care is financed and even the aging process.

Insurance regulators are rightly concerned with data use, sources and protections/privacy. We appreciate the data concerns expressed by state regulators and believe through positive consumer consent and transparency we can strike the right balance of protection and innovation that will ultimately benefit our policyholders. We also appreciate the rebating concerns highlighted in the document and believe that our program, which is designed to benefit all policyholders navigates through this complex issue as well. Our program, services and benefits are all tied directly the underlying insurable risk in the insurance contract. We believe it is important to look holistically at how we finance long term care and move beyond premium increases, cutting benefits and try to improve peoples’ lives.

As a new emerging technology company focused on helping older adults age with dignity and independence, we’d appreciate an opportunity to discuss the data privacy and rebating concerns and why we believe our innovative approach to aging is good for consumers, carriers and state insurance departments.

Thank you for your consideration.

Larry Nisenson
Chief Growth Officer

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

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?

- 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.

We suggest another next step would be to explore the potential effect of wellness programs offered at independent living/senior facilities and identification of programs that delay or reduce the length of stays in long-term care facilities. We also support the use of pilot programs to help identify successful programs.

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

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

1. Policyholders of “the same class and of essentially the same hazard” must be treated equally. See NAIC Model Unfair Trade Practices Act (#880) (“Model Law”).
2. How may an insurer “classify” policyholders post underwriting?
 - 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.

- 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.

We agree that a determination must be made regarding to whom any pilot or permanent program is offered to ensure no unfair discrimination. Including a wide range of individuals from various geographic, economic, social, age, racial, and ethnic populations is necessary to determine the usefulness of such a program, the credibility of data collected, and whether the program is valuable for all or some.

Additionally, to ensure no unfair discrimination, consideration regarding the availability of internet and smart devices, as well as the technical skills needed to use any devices will be necessary. This includes consideration that aging may impact/change a person’s previous tech skills. Also, a person’s financial position may change, limiting the ability to purchase current/up-to-date technology devices or equipment.

Consideration in selecting pilot participants should also include younger consumers; those who purchase LTC coverage long before their senior years.

3. Consumer confusion

- a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.
- b. Addressing of issues:
 - i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs

that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.
- ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.
- iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont's sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.
- iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

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

We agree significant consumer education must be done to ensure understanding of the product, the wellness benefit and any associated technology, and the intent of the wellness benefit and its potential impact on future rate changes. A variety of education methods should be developed and utilized; consumer outreach will be critical.

4. Rebating

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

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

- ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance.¹ 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. **California**: Repealed certain anti-rebating provisions via Proposition 103 in 1988.²

¹ A variety of states have other prohibitions on rebates, gifts, and inducements. Trade association ACLI had cataloged a list that the authors found online from 2015 here. https://cdn2.hubspot.net/hubfs/193810/documents/producer/2018/ACLI_Inducements_Gifts_Rebates.pdf.

² But note that one California attorney warned that recent actions by the CA DOI reflect the state’s still existing anti-rebating statutes in specific areas, like title insurance and home protection contracts. See <https://www.insurereinsure.com/2021/03/24/warning-shot-across-the-bow-the-ca-dept-of-insurance-and-rebating/>.

state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

We agree it must be determined if offering a benefit requiring a device or app violates anti-rebating or uniform trade practices statutes.

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.

We agree that understanding the tax consequences of new benefits will be critical to the success of any pilot or permanent wellness program.

6. Regulatory role in approving or evaluating LTC wellness approaches

- a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
- b. Current observations:
 - i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
- c. Addressing issues *[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.

Uniformity on prior approval of LTC wellness benefits would be helpful.

7. Actuarial considerations

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

As noted under Section 1, we suggest some data might or could be available from independent living/senior communities related to classes or programs offered that may help improve or stabilize health issues resulting in mitigation of loss or severity of loss.

Consideration should be given to both the cost of developing and implementing wellness programs and the value of wellness programs related to premium/rates.

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. Data Use to Identify Wellness Initiatives:
 - 1. Policyholders considerations:
 - a. Confusion about why they are being solicited for the initiative.
 - b. Suspicion about the motivation of the insurer.
 - c. General lack of awareness that data is being collected, and what data is being collected.
 - d. General lack the awareness or understanding on how data is collected and used.
 - e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
 - f. Will the policyholder know what data is going to be used prior to participation?
 - g. Should the policyholder have the option to "opt in/out" of their data being used internally for other initiatives or for external sale or use?
 - 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. Data Use During Wellness Initiative Development:
1. Should insurers purchase policyholder specific information from third party data sources?
 - a. Data collected during purchases, search history, television programming, etc.
 - b. Should it always be headless, anonymized, or deidentified?
 2. When considering big data, are there unacceptable "correlations"? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
 3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
 4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder's claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
 5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
 6. Does the insurer have procedures in place to notify the policyholders of a potential breach?
- iii. Wellness Results Data Use:
1. Should the results be sold? Aggregate vs specific demographic information?
 2. Should insurers use the results internally for cross marketing other wellness initiatives?
 3. Should the policyholder be notified and have the option to "opt in/out" of letting the insurer use the data?
 4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?

5. How should the data be shared, if at all, with other vendors or service providers?
 6. How long will the data be retained? Will the data be destroyed or disposed?
- d. Dependencies
- i. Unfair Discrimination
- 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?

We recognize the trend toward use of technology but are concerned with wellness programs reliance on technology and AI. Seniors must be comfortable with the use of and security of their personal data for these programs to succeed.

9. Other considerations

- a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
- b. Current observations
 - i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
 1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
 - ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
 - iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
- c. 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



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

November 4, 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 second draft of the “Issues Related to LTC Wellness Benefits,” exposed by the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on October 5, 2021.

ACLI/AHIP continue to support the Subgroup’s work to explore the offering of innovative wellness benefit programs as part of long-term care insurance (LTCI). By discussing the issues and opportunities associated with wellness programs in LTCI, we learn how these benefits may contribute to policyholder health and strengthen the LTCI market.

OBJECTIVE

ACLI/AHIP request that the newly added objective statement be revised to reflect the document’s stated purpose in the Background section to work “together to explore some of these claim cost-reducing innovations.” Thus, we recommend the objective statement read, “The objective of this paper is to foster dialogue amongst regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.” Fostering discussion that supports insurance companies in developing pilot wellness programs should be the aim of this document, as opposed to increasing “clarity,” which could stifle innovation. As we have previously asserted, LTCI wellness initiatives are in their infancy and will require significant development and testing. Insurers are encouraged to develop wellness initiatives when the regulatory environment facilitates exploration, innovation, and targeted pilot programs.

With the goal of contributing to the discussion on wellness programs in LTCI, our comments on the second draft are as follows.

BACKGROUND

We appreciate the addition of “pre-insurance-claim” to describe the wellness interventions discussed in the document. The true value of wellness interventions comes in providing them pre-claim when they are most effective.

And while we recognize the Subgroup’s stated goal to address rate increases and solvency concerns with wellness programs, we continue to feel it is important that this discussion



document emphasize what should be wellness programs' primary goal, and that is the maintained or improved health and independence of policyholders. Whether or not wellness programs affect rate increases or solvency concerns remains to be seen. They are likely to be one of many factors, including necessary and actuarially justified rate increases, that strengthen the LTCI marketplace overall. Wellness programs should not be pursued as a "cure" to industry issues. What we can reasonably pursue, however, is the improved wellness of LTCI policyholders.

PREVENTION OF UNFAIR DISCRIMINATION RELATED TO EXTRA-CONTRACTUAL BENEFITS AND COSTS

ACLI/AHIP affirm the importance of avoiding unfair discrimination when offering LTCI wellness benefits. We also believe it is possible navigate discrimination concerns when targeting wellness programs to cohorts of similarly situated insureds. Our original comments asserted that certain wellness "programs may be most effective and most utilized if focused on those insureds with a particular condition, age range, or sex. Targeted wellness programs could more effectively reduce claims costs and maximize the health of policyholders." The ability to target wellness programs, while avoiding unfair discrimination, is key to encouraging LTC insurers to implement wellness programs. Insurers are unlikely to attempt a wellness program if they cannot first experiment with a small, targeted pilot program before scaling up.

While we agree with efforts to better support underserved markets, we disagree with the newly added language in this section that suggests "selection for pilots should consider including a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected." While a broad range of characteristics might be appropriate for many benefit programs, it is not appropriate in all instances, particularly pilot programs. Often, meaningful data is best collected and analyzed when it is targeted. Certain benefits are also likely to be more effective at improving wellness if targeted.

The LTCI industry needs assurance from regulators that focusing wellness benefits on a cohort of similarly situated policyholders successfully navigates unfair discrimination requirements. Regulatory guidance on how to classify policyholders for a targeted wellness program is unnecessary and would hamper industry efforts to innovate.

REGULATORY ROLE IN APPROVING OR EVALUATING LTC WELLNESS APPROACHES

We welcome the edits made to this section that both express a goal to avoid unconstructive regulatory and filing burdens and, also, remove the suggestion that receiving an actuarially justified rate increase be contingent on an insurer's innovation efforts.

To reiterate, ACLI/AHIP believe that tying wellness benefit programs to rate increases is inappropriate for a few reasons. First, a rate increase request for an individual block of business may not have an associated wellness program. Second, wellness programs might only be offered to new customers. Third, wellness programs are primarily structured to improve



wellness, not address actuarially justified rate increases. Fourth, it could lead to inequities between companies with varying participation levels in the wellness realm. And fifth, the data needed to justify a correlation between wellness programs and rate increases, will, if such a correlation exists, take time to gather and analyze.

CONCLUSION

ACLI/AHIP affirm their commitment to continuous collaboration with regulators and other interested parties in developing the thinking about wellness programs in LTCI. Thank you for the opportunity to provide these comments. ACLI/AHIP look forward to discussing our comments with you soon.

Sincerely,

Jan M. Graeber
Senior Actuary, ACLI

Susan Coronel
Executive Director, Product Policy, AHIP

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.



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

September 7, 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 “Issues Related to LTC Wellness Benefits,” exposed by the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on July 22, 2021.

ACLI/AHIP applaud the work of the Subgroup in exploring innovative wellness benefit programs in long-term care insurance. It is our belief that as regulators and industry work together to consider and develop these programs, they will prove beneficial to policyholders and contribute to a strong LTC market.

GENERAL

Overall, ACLI/AHIP found the draft to be a balanced and comprehensive outline of issues related to wellness benefit programs in the LTC insurance realm. We do have three general observations about the draft.

First, we wish to reinforce the understanding that many wellness initiatives are in their infancy and will require significant development and testing. Insurers should be allowed to explore and develop these initiatives on a voluntary basis without regulatory mandates if they determine such initiatives are viable and appropriate for their businesses and policyholders.

Second, as the Subgroup’s work on wellness programs continues, we would like to discuss what form the ultimate deliverable will take. Since wellness benefit programs don’t directly correlate with rate actions, tying them together would unnecessarily encumber both. Therefore, we suggest that wellness initiatives not be incorporated into or made dependent on the RBO Checklist or MSSR process. Ideally, the final deliverable encourages uniform state approaches for wellness programs and discourages state-by-state reviews that could stymie uniformity.

And third, because LTC wellness benefit programs are in their infancy, and there is still much to do, we suggest prioritizing the issues explored in the draft. Issues related to the upfront design of programs, such as rebating and discrimination, are a top priority as they are necessary to get started. Those issues related to results, such as actuarial issues and consumer acceptance/confusion, should be a secondary priority because they will be easier to ascertain and address after we have made some progress.



With these general concepts in mind, we offer our analysis of the draft, by section, below.

BACKGROUND

Hybrid products constitute 80% of LTC products sold today. Given their key role in the LTC market, we suggest incorporating hybrid products into the background section.

Timing is an important component of wellness benefit programs that should be mentioned in this section. Many LTC policies provide some form of home modification and caregiver training benefits. The true value of these initiatives comes in providing them pre-claim when they are most effective.

This section refers to wellness initiatives as “claim cost-reducing innovation.” In addition to reducing claim costs for insurers, wellness initiatives help policyholders by potentially extending their independence at home and preventing severe impairment. Providing early access to existing benefits, such as caregiver training and home modifications, may postpone the need for formal care and enable insureds to remain in their homes under the care of their families. In addition to maintaining or improving the health and well-being of insureds, wellness initiatives ultimately benefit family members in caring for loved ones.

ANALYSIS OF EFFECTIVENESS

A major concern about developing wellness programs is determining how effective they will be. While there are certain desired results that could require years of study and implementation to ascertain whether they can be achieved, other results can be realized quickly. For instance, the affect wellness programs might have on reducing early claims or encouraging cost-effective home care could be known within months of implementation.

Further, the draft refers to upfront, significant costs associated with wellness programs. While this may be true, there are some wellness offerings that are not expensive and can be tested without much financial risk. For example, health education programs or immunization incentives would not cost much. And while individual blocks of LTC insurance policies might be unique, there could be wellness programs that are effective for most, if not all of them, such as stress management and certain medical screenings.

Paragraph (b)(iii) of this section mentions the stand-alone LTC insurance market. As previously mentioned, it’s important to account for the thriving hybrid LTC market. Carriers selling hybrid products can and should contribute to the industry’s wellness initiatives. The flexible design of hybrid products makes them uniquely suited to offer wellness programs that maintain policyholders’ independence at home. For example, the life component of the hybrid product could finance the wellness initiative. Alternatively, additional riders could be added to the hybrid policy to cover wellness programs.



In addition, there is likely much to be learned from wellness programs currently offered under life insurance policies, whether hybrid or not. LTC certainly has components that differentiate it from life and major medical insurance, but to the extent possible, learning from the experience of life and health insurance wellness programs would be advantageous, saving the LTC industry time and money, while expediting health outcomes. In addition to Medicaid and Medicare Advantage mentioned in the draft, there are other products and programs, such as workplace wellness programs and disability income insurance to look to for learning.

We recommend adding another “next step” to this section to better define what is meant by wellness. We need to be clear on what we are hoping to achieve. We are happy to work with the subgroup on a definition.

There are two additional factors to consider when looking at the effectiveness of wellness programs. First, it should be noted that the goal of wellness programs is to improve the health outcomes of policyholders, which could affect loss ratios for insurers. Second, regulators and all participants should be cautious to avoid, even inadvertently, setting overly optimistic expectations as to what the ultimate impacts of any wellness initiatives might be. More innovative wellness programs may take months or years to pilot and assess before any actuarially meaningful results are revealed. They are likely to be one of many factors, in addition to necessary and actuarially justified rate increases, that may ultimately improve the LTC marketplace. However, wellness programs alone should not be considered a “cure” to industry issues.

PREVENTION OF UNFAIR DISCRIMINATION RELATED TO EXTRA-CONTRACTUAL BENEFITS AND COSTS

Unfair discrimination is an important concern to navigate in LTC wellness programs if the same wellness benefits will not be offered to all policyholders. While certain preventative health programs might be offered to all insureds, other programs may be most effective and most utilized if focused on those insureds with a particular condition, age range, or sex. Targeted wellness programs could more effectively reduce claims costs and maximize the health of policyholders. Limiting wellness programs by geographic region, for example, might be necessary to test the effectiveness of programs before scaling up. To do so, insurers would need regulatory support that programs or initiatives focused on similarly situated insureds, for example, those in the “same class,” would not be considered unfair discrimination. Health insurers have a long history of targeting wellness programs aimed at those deemed high risk while avoiding unfair discrimination.

One issue for further study are the characteristics that can rightfully be used to define an acceptable cohort for a wellness initiative. For example, could an insurer only offer certain benefits to insureds without a spouse or other informal caregiver? Would differing methods of contacting policyholders, for example mail vs. email, be considered unfair discrimination? Also, what are the implications if policyholders share the cost of a more expensive wellness



intervention? Similarly, what would the implications be, if, after a pilot program ends, policyholders wish to continue the wellness program by covering the cost themselves?

CONSUMER CONFUSION

Consumer communication and education are vital to precluding confusion. Giving consumers the option to opt-in a program after they fully understand it is one way to ensure consumers are comfortable. Another option is to allow insureds to self-identify their conditions before a wellness initiative begins. An example of self-identification is optional testing for early dementia where early intervention is effective.

Clearly communicating with informal caregivers is also important. Depending on the wellness benefit program and condition of the insured, a caregiver may be the one utilizing the technology and other tools offered by a wellness program. We would suggest consulting caregiving groups, such as the National Alliance for Caregiving, which supports family caregivers, or the Paraprofessional Healthcare Institute, which represents direct care workers, to give stakeholders valuable insight into fostering caregiver engagement in wellness programs.

REBATING

One can make a strong case that the wellness initiatives our industry is currently contemplating do not violate anti-rebating laws. Wellness benefit programs are intended to encourage behavioral changes that improve the insured's health, thereby reducing the risk the insured will need LTC. Many states allow insurers to provide value-added services and programs for loss mitigation and rate reduction purposes to insureds at no additional charge or a discounted rate under certain conditions. The ACLI maintains a law survey on the subject of rebating that could prove useful to companies with access to the law survey when assessing the different requirements between states. Additionally, as the draft mentions, the NAIC Model Unfair Trade Practices Act explicitly exempts certain wellness benefits.

Another factor to consider is that many, if not most, wellness initiatives would *not* begin the moment a policy becomes effective. This factor is further evidence that wellness benefits are not rebates.

TAX CONSIDERATIONS

Many wellness and similar initiatives designed to reduce the onset or severity of chronic illness can be undertaken today consistently with federal tax requirements for qualified long-term care insurance, but for others clarifying guidance from the Treasury Department or IRS would be helpful or amendment of tax requirements by Congress may be needed.

As noted, however, certain wellness initiatives are permissible under current tax law. For example, though not considered precedent, [PLR 201105026](#) and [PLR 201105027](#) describe certain wellness benefits as permissible under federal tax law. The IRS Private Letter Rulings both comment, "It would be inconsistent with the stated goal of § 7702B to deny qualification



to a long-term care insurance contract because it provided ancillary mechanisms aimed at minimizing long-term care needs.”

To summarize, we caution the Subgroup to not purport to interpret existing federal tax requirements regarding wellness initiatives, although we think the NAIC and state regulators can perform an important informational role with respect to non-tax aspects of such initiatives in connection with any future efforts to obtain clarifying IRS/Treasury guidance or legislative changes, there may be tax consequences if benefits are provided to an insured who is not chronically ill as defined in 26 U.S.C.A. §7702B(c)(2), that is, outside the federal tax definition of qualified LTC benefits. Federal legislative changes to section 7702B could be required to ensure policyholders can receive wellness benefits without tax consequence.

REGULATORY ROLE IN APPROVING OR EVALUATING LTC WELLNESS APPROACHES

Ideally, the effort to incorporate wellness initiatives in LTC results in a process that minimizes or eliminates state-by-state reviews of wellness programs and fosters flexibility for insurers wanting to offer these incentives.

The draft posits the question of whether a company’s commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase. It may ultimately be just one factor, of many, to consider in a rate decision. And, first, it would be necessary to establish objective criteria to evaluate companies fairly.

The following items should be considered as wellness initiatives are more fully developed:

- Wellness initiatives are designed to improve the health of policyholders and the impact on claims and loss ratios are still unknown. Linking rate increases to wellness offerings will not be appropriate for some time.
- Formal regulator approval of a wellness offering could stifle innovation. Rather than a formal approval process, companies could provide information to regulators on an as needed basis or upon request.
- Because the impact on claims is unknown at this time, there should not be an assumption that wellness programs are available to all or that engagement in the wellness initiative will be high.
- Finally, characterization of LTC insurance in (d)(iii) as being in a “desperate situation” discounts the vibrant hybrid market.

ACTUARIAL CONSIDERATIONS

First, as with any other actuarial assumption, actuaries must have a valid justification for the impact of the wellness initiative, especially as it relates to in-force rate increases. As discussed throughout the draft, this will take time to develop.

Second, while a wellness program could be tied to a reduced benefit option, there should not be an expectation that it will be. This determination is best made by the insurer.



DATA PRIVACY

Data privacy is a fundamental and legitimate concern in the development and implementation of wellness benefit programs. Because these programs are an emerging innovation, starting small by allowing insureds to participate at their discretion and/or self-attest to their medical conditions is key.

In this section of the draft, there are multiple questions raised that likely already have adequate regulations in place to address them. (e.g. “Should insurers purchase data regarding their policyholders?” and “Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company?”) For issues that have already been addressed, we suggest specifying that their inclusion in the draft is to give a comprehensive overview on the topic, alert regulators for oversight focus, or for some other stated purpose.

Along those same lines, the draft would benefit from bifurcation between issues governed by clear regulations vs. those that are not (either because the issue falls within a gray area or no regulation exists). Similarly, if the NAIC has already addressed substantially similar topics, the draft should refer to the NAIC’s work rather than replicate their efforts. (e.g. “When considering big data, are there unacceptable ‘correlations’”? “How will insurers recognize relevant correlations vs. irrelevant statistically significant correlations?”)

The ability to collect and analyze data is essential to test pilot programs and eventually implement fully developed wellness initiatives. In data privacy matters that are unsettled, insurers need assurance they can move forward without fear of adverse legal or regulatory action. The ongoing efforts of regulators and industry stakeholders to coordinate and balance the public policies of data privacy, improved health, and lower LTC costs can give that assurance.

As we move forward, guiding principles are vital. ACLI/AHIP are strongly committed to the proper use and protection of consumer data. We encourage clear and concise notice about the collection, use, and disclosure of personal information. We also support the ability for consumers to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information.

OTHER CONSIDERATIONS

At this time, ACLI/AHIP have no comments on this section of the draft.



CONCLUSION

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

Sincerely,

Jan M. Graeber
Senior Actuary, ACLI

Susan Coronel
Executive Director, Product Policy, AHIP

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.



September 8, 2021

Commissioner Altman: Chair
Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

Cc: Eric King

Comments to NAIC Draft- Issued Related to Wellness Benefits In LTCI Contracts

Dear Commissioner Altman:

We appreciate the opportunity to comment on the subgroup's draft exposure document on issues related to wellness benefits in long-term care insurance policies. We are encouraged that insurers are interested in this issue and that some have already had limited experience with pilot projects. We do think that new ideas and benefits like these need close cooperation between industry and regulators to avoid unintended consequences and to explore and encourage what's possible. Consumer groups can help industry and regulators understand a wide variety of situations and services that can help policyholders age in place and potentially delay some claims and could perhaps also delay the need for more extensive care or institutional care.

Long-term care imposes a need for care that is not covered as medical care because it deals with disabling conditions that occur with aging, such as breakdowns in functional ability or the onset of dementia. Care needs are supportive in nature and generally require the assistance of another person. The need for institutional care, often delivered in memory care units of assisted living facilities or other institutional settings, is often the result of advancing dementias.

The eventual need for long-term care is personally unpredictable and difficult to plan and prepare for. Federal data shows that 70% of people over the age of 65 will develop severe needs for long-term care services and supports before they die, and 48% will use some paid care over their lifetime. Individuals however cannot accurately predict their own future need for care. For most people this future risk is a frighteningly expensive uncertainty. Insurance to pay for this kind of care has escalated beyond the ability of most middle income Americans to pay for it, and those who have it are challenged to keep it with the rising cost of premiums.

When asked, most people say they intend to remain in their own homes if they need care. However, they have no clear idea if that will be possible, what kind of care they will need, how they will get that care, or more importantly how they will pay for it. Currently, most people with insurance have bought an income stream to pay for care, but their family will have to build out the care system for the impaired family member and bill and distribute any insurance payment. The type and quality of care providers available to them will depend on where they live, their knowledge of long-term care services and supports, and the availability of those services where the impaired person lives.

Early access to home modification and technology can be useful to help people remain in their homes, both before the need for long-term care begins, and later to delay or prevent the need for a greater amount of care or for institutional care. These newer types of services and devices can support

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caregivers and help an impaired person remain in their own home, or delay or prevent further impairment. Services such as fall prevention assessment programs, supportive equipment to prevent falls, electronic monitoring systems, technological alarms and sensors, community services and senior centers that encourage socialization all have the potential to delay, mitigate, or even prevent a later claim for long-term care benefits.

Care coordination is an important component and can help families of an impaired person utilize all the services, equipment, supplies, and benefits that may be available to them through private or public means. Care management and coordination can bring organization and efficiency to finding and utilizing services, constructing and monitoring an individualized system of care. Helping people age in place is an important factor in delaying or keeping people out of more expensive institutional settings.

We are encouraged by the idea of new benefits or services that can support policyholders in their own home, that help them maintain their independence, and that support caregivers who in the majority of families are younger family members often sacrificing their own economic condition to care for an older family member. New technology and devices might help a family caregiver remain at work with the ability to monitor an impaired family member at home. New systems of care such as the Villages movement, paid transportation like Uber and Lyft, and emerging meal delivery systems can all contribute to this expanding discussion of how to help people age in place and how to construct systems that can provide for these new ways of providing care.

We think important issues have been identified in the draft document for industry and regulators. We are however concerned that any new benefits be appropriately described in a contract, and fairly applied and available when needed. We are also concerned about how new enticing benefits are advertised, both by agents and brokers and by companies. As we've seen with MA plans, benefits can be portrayed as universally available when in practice those same benefits are limited in application to specific sets of circumstances.

While we understand that some services and benefits are likely to result in increased premium cost and an increase in claims costs, some claims costs might be offset by these newer services by delaying or moderating the need for paid care. Actuarial scrutiny of all these factors and subsequent trends will be an important component of regulatory review. We plan to be an active participant as the subgroup explores these ideas that could become part of pre-claim benefits, or become a common covered benefit in future long-term care insurance contracts.

Sincerely,

Bonnie Burns, Consultant
California Health Advocates

Summary of Comments on LTC Wellness Exposure - July 22, 2021
- See comment letters for full text

General Comments on LTC Wellness - Fred lead			Edit doc in response?	Where / How Addressed in Framework
1	Bonnie Burns / CA Health Advocates	Encouraged by the idea of new benefits or services that can support policyholders in their own home, help them maintain independence, and support caregivers who in the majority of families are younger family members often sacrificing their own economic condition to care for an older family member.	N	Supports current wording
2	Bonnie Burns	Early access to home modification and technology can help people remain in their homes (where care is less expensive) before or after a greater need for care begins. Fall prevention assessment or equipment, electronic monitoring, tech alarms/sensore, community services, senior centers encouraging socialization are examples / can delay, mitigate, or prevent later LTC claims.	Y	Added wording on delaying LTC claims
3	Bonnie Burns	Care coordination helps families utilize all the public & private services, equipment, supplies, & benefits available in an organized & efficient manner, constructing and monitoring an individualized plan.	N	Supports current wording
4	Bonnie Burns	New technology and devices might help a family caregiver remain at work with the ability to monitor an impaired family member at home.	N	Supports current wording
5	Bonnie Burns	Important issues have been identified in the draft document for industry and regulators. New benefits be appropriately described in a contract, and fairly applied and available when needed. Concerned about how new enticing benefits are advertised, both by agents and brokers and by companies.	N	Reach out to Bonnie - are these concerns mainly related to additional costs to policyholders?
6	Assured Allies	A creative and modern approach is needed to solve this societal problem.	N	Supports current wording
7	Dr. Anitha Rao & physicians specializing in cogn.and neuro. issues	There are ethical and legal consequences to consider in telling someone they are at risk for dementia or have cognitive impairment before a physician does so. Some states require clinicians to report the patient's medical condition to the DMV or alert banks regarding mental capacity.	See below	Edited wording to mention physician's role
8	Dr. Anitha Rao, et al	Recommends re-wording of aspect of cognitive wellness issues related to technological solutions section	Y	Edited wording to mention physician's role

9	Dr. Anitha Rao, et al	Recommend that insurance carriers urge their members to see their physician for a cognitive risk evaluation instead of over-reliance on non-fully-tested tech meant to flag cognitive risk	See above	Edited wording to mention physician's role
10	Dr. Anitha Rao, et al	Legal risks if the insurer identifies cognitive risk before the policyholder is aware or diagnosed	See above	Edited wording to mention physician's role
11	Dr. Anitha Rao, et al	Gap in care may result in a high number of patients incorrectly flagged as having cognitive risk (false positives). Ruling out common conditions that mimic cognitive impairment should be performed thru a proper medical evaluation	See above	Edited wording to mention physician's role
12	Dr. Anitha Rao, et al	TPAs and claims processing workflows, using shortcuts, have been found to mislabel a significant of treatable conditions as irreviesible cognitive impairment	See above	Edited wording to mention physician's role
13	Dr. Anitha Rao, et al	Recommend that insurers seek advice from an external independent medical advisory board before implementing any nationally approved cognitive wellness programs.	See above	Edited wording to mention physician's role
14	ACLI/AHIP	Found the draft to be a balanced and comprehensive outline of issues related to wellness benefit programs in the LTC insurance realm.	N	Supports current wording
15	ACLI/AHIP	Reinforce the understanding that many wellness initiatives are in their infancy and will require significant development and testing. Insurers should be allowed to explore and develop these initiatives on a voluntary basis without regulatory mandates if they determine such initiatives are viable and appropriate for their businesses and policyholders.	Y	Wording TBD
16	ACLI/AHIP	Clarity on the ultimate deliverable will be would be helpful	Y	Added an objective paragraph at the beginning of the document
17	ACLI/AHIP	Incorporate hybrid products in the background section	Y	Added wording at the end of the document
18	ACLI/AHIP	Emphasize in the background section that the pre-claim timing of wellness benefits are a key aspect	Y	Added wording in the background section
19	ACLI/AHIP	In addition to potentially reducing claim costs, wellness initiatives may extend independence at home, prevent severe impairment, postpone formal care, and benefits family caregivers	Y	Added wording on postponing/delaying care being a potential benefit of wellness
Comments on Analysis of Effectiveness - Fred Lead			Edit doc in response?	Where / How Addressed in Framework

20	Michigan	Explore the potential effect of wellness programs offered at independent living/senior facilities and identification of programs that delay or reduce the length of stays in LTC facilities. Michigan supports the use of pilot programs to help identify successful programs.	Y	Added wording re: looking into indep living / senior facility experience
21	ACLI/AHIP	Costs of wellness initiatives vary, e.g., health education can have low cost	Y	Tweaked wording to mention expenses vary
22	ACLI/AHIP	Wellness initiatives are applied to hybrid products, too	Y	Added wording in the background section on hybrid products
23	ACLI/AHIP	Can learn from wellness initiatives in life insurance, health insurance, Medicaid, and Medicare	Y	Added wording re: looking into health & life ins experience
24	ACLI/AHIP	Clarifying meaning of "wellness" should be included in next steps	Y	Clarify that the initiatives are pre-claim; perhaps mention that they assist regarding the declining independence of the insured
25	ACLI/AHIP	Development of experience showing effectiveness will be work in progress	Y	Added this wording in a new bullet
Comments on preventing unfair discrimination - Shannen & Tom lead			Edit doc in response?	Where / How Addressed in Framework
26	Michigan	A determination must be made regarding to whom any pilot or permanent program is offered to ensure no unfair discrimination. Including a wide range of individuals from various geographic, economic, social, age, racial, and ethnic populations is necessary to determine the usefulness of such a program, the credibility of data collected, and whether the program is valuable for all or some.		Added wording to 2(c)(ii)
27	Michigan	To ensure no unfair discrimination, consideration regarding the availability of internet and smart devices, as well as the technical skills needed to use any devices will be necessary. This includes consideration that aging may impact/change a person's previous tech skills. Also, a person's financial position may change, limiting the ability to purchase current/up-to-date technology devices or equipment.		Added wording to 2(c)(iii)
28	Michigan	Consideration in selecting pilot participants should also include younger consumers; those who purchase LTC coverage long before their senior years.		Added wording to 2(c)(ii)

29	Bonnie Burns	As seen with MA plans, benefits can be portrayed as universally available when in practice those same benefits are limited in application to specific sets of circumstances.		Added wording to 2(c)(ii)
30	ACLI/AHIP	Addressing preventing unfair discrimination should be a top priority because it is related to upfront design, e.g., when all benefits will not be available to all policyholders		Added wording to 2(c)(ii)
31	ACLI/AHIP	Effectiveness of programs (reducing claim costs / improving health) may increase if targeted to those with particular condition, age range, and gender.		Added wording to 2(d)
32	ACLI/AHIP	Need regulatory help to ensure programs focused on those in "same class" would not be considered unfairly discriminatory - appears to be similar to approved health insurer programs		Added wording to (c)(i)
33	ACLI/AHIP	Characteristics of acceptable cohort? Without spouse?		Added wording to 2(c)(ii)
34	ACLI/AHIP	Differences in contacting policyholders - mail vs. e-mail		Added wording to 2(c)(iii)
35	ACLI/AHIP	Is sharing wellness intervention costs ok, including policyholders taking over the costs after a pilot expires?	Y	Added wording to 2(d)
Comments on preventing consumer confusion - Anna and Emily lead			Edit doc in response?	Where / How Addressed in Framework
36	Michigan	Significant consumer education must be done to ensure understanding of the product, the wellness benefit and any associated technology, and the intent of the wellness benefit. A variety of education methods should be developed and utilized; consumer outreach will be critical.		
37	ACLI/AHIP	Address consumer confusion issues after upfront design issues (anti-discrimination, rebating)		
38	ACLI/AHIP	Opt in, self identify conditions, e.g., early dementia; communicate with informal caregivers; work with caregiver groups such as Paraprofessional Healthcare Institute, so they can engage in wellness efforts		
Comments on potential rebating issue - Matt and Tom lead			Edit doc in response?	Where / How Addressed in Framework
39	Michigan	Must be determined if offering a benefit requiring a device or app violates anti-rebating or uniform trade practices statutes	N - this comment appears to be more relevant to unfair discrimination, where that type of technology access problem is already addressed.	

40	Assured Allies	We appreciate the rebating concerns highlighted in the document and believe that our program, which is designed to benefit all policyholders navigates through this complex issue as well.	N - we shouldn't comment on whether any particular program, especially one that is not fully described, does or does not effectively address the concerns we have identified	
41	ACLI/AHIP	Addressing any potential rebating issues should be a top priority because it is related to upfront design.	N - Agreed, but the document is already doing this.	
42	ACLI/AHIP	Strong case that LTC wellness initiatives do not violate anti-rebating laws, including fact that wellness initiatives typically do not begin at moment policy is issued	Y	While the general point that there is a strong case that wellness initiatives will not create a rebating concern is already made, the timing point as additional evidence of this has been added to Section 4.B.iv Policy Considerations. That section previously mentioned that consideration of these offerings only began after the policies were sold indicating that they are not the type of conduct anti-rebating statutes were concerned with. It now also flags the related point that the initiatives themselves do not begin at the moment the policy is issued.
43	ACLI/AHIP	Many states allow insurers to provide value-added services and programs for loss mitigation at no or discounted charge	N - this point is already made in Section 4.B.iii Trends in State Law	

Comments on tax considerations	Edit doc in response?	Where / How Addressed in Framework
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44	Michigan	Agree that understanding the tax consequences of new benefits will be critical to the success of any pilot or permanent wellness program.		
45	ACLI/AHIP	Many wellness initiatives to reduce onset/severity of chronic illness are consistent with tax-qualified LTC; IRS private letter rulings 201105026 & 201105027 describe certain wellness benefits as permissible under federal tax law - both comment, "It would be inconsistent with the stated goal of § 7702B to deny qualification to a long-term care insurance contract because it provided ancillary mechanisms aimed at minimizing long-term care needs."		
46	ACLI/AHIP	Some wellness programs would likely require clarifying guidance from Treasury / IRS		
47	ACLI/AHIP	Cautions regulators to not purport to interpret existing federal tax requirements regarding wellness initiatives, although the NAIC and state regulators can perform an important informational role with respect to non-tax aspects of such initiatives in connection with any future efforts to obtain clarifying IRS/Treasury guidance or legislative changes		
48	ACLI/AHIP	There may be tax consequences if benefits are provided to an insured who is not chronically ill as defined in 26 U.S.C.A. §7702B(c)(2), that is, outside the federal tax definition of qualified LTC benefits.		
49	ACLI/AHIP	Federal legislative changes to section 7702B could be required to ensure policyholders can receive wellness benefits without tax consequence.		
Comments on regulatory role in evaluating LTC wellness approaches - Fred lead			Edit doc in response?	Where / How Addressed in Framework
50	Michigan	Uniformity on prior approval of LTC wellness benefits would be helpful		
51	ACLI/AHIP	Ideally, the final deliverable encourages uniform state approaches for wellness programs and discourages state-by-state reviews that could stymie uniformity.		
52	ACLI/AHIP	Question of contingency to receive full rate increase - could be one factor down the road after experience develops		
53	ACLI/AHIP	Formal regulator approval of a wellness offering could stifle innovation. Rather than a formal approval process, companies could provide information to regulators on an as needed basis or upon request.		

54	ACLI/AHIP	Because the impact on claims is unknown at this time, there should not be an assumption that wellness programs are available to all or that engagement in the wellness initiative will be high.		
55	ACLI/AHIP	Hybrid market is not desperate		
Comments on actuarial considerations - Fred lead			Edit doc in response?	Where / How Addressed in Framework
56	Michigan	Suggest some data could be available from independent living/senior communities related to classes or programs offered that may help improve or stabilize health issues resulting in mitigation of loss or severity of loss.		
57	Michigan	Consideration should be given to both the cost of developing and implementing wellness programs and the value of wellness programs related to premium/rates.		
58	Michigan	Impacts of various aspects on rate increases should be understood.		
59	Bonnie Burns	While we understand that some services and benefits are likely to result in increased premium cost and an increase in claims costs, some claims costs might be offset by these newer services by delaying or moderating the need for paid care. Actuarial scrutiny of all these factors and subsequent trends will be an important component of regulatory review.		
60	ACLI/AHIP	At this time, wellness initiatives should not be tied into rate increases		
61	ACLI/AHIP	Address actuarial issues after upfront design issues (anti-discrimination, rebating)		
62	ACLI/AHIP	Must justify impact on rates, but this will take time to develop		
63	ACLI/AHIP	Should be insurer's choice whether to tie a wellness program to an RBO		
Comments on data privacy - Shannen and Julie lead			Edit doc in response?	Where / How Addressed in Framework
64	Michigan	Recognition of the trend toward use of technology but concern with wellness programs' reliance on technology and AI. Seniors must be comfortable with the use of and security of their personal data for these programs to succeed.		Updated 8a.
65	Assured Allies	We appreciate the data concerns expressed by state regulators and believe through positive consumer consent and transparency we can strike the right balance of protection and innovation that will ultimately benefit our policyholders.		Agree with comments
66	ACLI/AHIP	Fundamental and legitimate concern		Agree with comments

67	ACLI/AHIP	At early stages of program, allowing insureds to participate at their discretion and/or self-attest to medical conditions is key		Agree with comments
68	ACLI/AHIP	For issues that have already been addressed, suggest specifying that their inclusion in the draft is to give a comprehensive overview on the topic, alert regulators for oversight focus, or for some other stated purpose.		Should we consider adding in a "process" section that talks about how insurers can bring back findings and issues, so we can update the document?
69	ACLI/AHIP	The draft would benefit from bifurcation between issues governed by clear regulations vs. those that are not (either because the issue falls within a gray area or no regulation exists). Also refer to NAIC's other work rather than replicate		Updated section 8b
70	ACLI/AHIP	In data privacy matters that are unsettled, insurers need assurance they can move forward without fear of adverse legal or regulatory action. The ongoing efforts of regulators and industry stakeholders to coordinate and balance the public policies of data privacy, improved health, and lower LTC costs can give that assurance.		Added a comment to the "process" section
71	ACLI/AHIP	Guiding principles are vital.		Agree with comments
72	ACLI/AHIP	Encourage clear and concise notice about the collection, use, and disclosure of personal information.		Updated 8c2
73	ACLI/AHIP	Support the ability for consumers to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information.		Added section to 8c.
Misc comments - Fred lead			Edit doc in response?	Where / How Addressed in Framework
74	Other comment	Key is to offer the benefits (home modification, caregiver training, care management) when there's an initial need, not when it's too late		
75	Other comment	Pre-claim (pre-2 ADL) access to caregiver training and home modifications can delay the need for formal care and may provide fairly reliable claim cost savings.		
76	Other comment	If the initiative is age- or condition-based, it should be offered consistently.		
77	Other comment	Health plans already offer caregiver training, home modifications, or wellness programs without tax consequences – what's different about LTC?		
78	Other comment	If the initiative is one of early support, broad communication and outreach is key.		



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Vermont Comments

LTC (EX) Multi-state Actuarial Rate Review Framework

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

Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:

- *Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach.*

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

Consider this example:

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

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

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

Draft: 10/8/21

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

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

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

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

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

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

[11 09-27-21 LTCI RBO min.docx](#)

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.

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- Reads in a clear, logical, not overly complex manner.
- Identifies ~~if~~ the options are ~~presented~~^{[A3][A4]} ~~fairly~~ and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

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- 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^[A7]^[A8]^[A9]^[A10] Subgroup? **RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt use the checklist ^[A11]^[A12] when reviewing filed Long-Term Care Insurance RBO Communications.

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

Checklist for Premium Increase Communications

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

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all <u>required</u> materials to including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (<u>screenshots may be requested expected</u> if communication refers policyholder to website for more information ^{[A13][A14]})? ^{[A15][A16]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will <u>notice of</u> ^{[A17][A18]} the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)? ^{[A19][A20][A21][A22]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all <u>new innovative</u> ^{[A23][A24]} <u>RBO</u> options presented in the communication been <u>mentioned prominently as part of clearly explained in</u> ^{[A25][A26]} the filing? Have they been vetted by policy and actuarial staff? ^{[A27][A28][A29]}	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. <u>Are there sample policyholder communications with a statement of variability?</u> ^{[A30][A31][A32][A33][A34]} <u>Do reviewers understand any variable information that appears in the lettercommunication?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Are there insurer rules ^[A35] <u>and training</u> ^[A36] for customer service interactions regarding RBOs? ^{[A37][A38][A39][A40][A41][A42]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>45-60Y-days</u> before effective date. PA posts filed rate increase details on their website. ^{[A43][A44][A45]}	
Yes	No	N/A	READABILITY AND ACCESSIBILITY ^{[A46][A47]}	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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)? <u>Is the primary message of the communication presented first and clearly worded?</u> ^{[A48][A49][A50][A51]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all <u>technical</u> insurance technical ^{[A52][A53]} terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is the communication in an easily readable font? <u>For example: Is the type in</u> at least <u>{11-point}</u> type? ^{[A54][A55]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Does the communication use headings to help the reader find information easily?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are tables, charts, and other graphics, <u>easy to read and understand</u> ^{[A56][A57][A58][A59]} ? <u>(See question 18 for reference).</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are the grade level and reading ease scores appropriate <u>according to state readability standards? -D</u> ^{[A60][A61][A62][A63][A64][A65][A66][A67][A68]} <u>(8th grade) or lower; Flesch reading ease score</u> ^{[A60][A61][A62][A63][A64][A65][A66][A67][A68]} <u> 60 or higher)?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Are there side-by-side illustrations of options compared with current benefits? Are <u>reduced benefit options</u> they clear and not misleading? ^{[A69][A70]} <u>For example: Are there side-by-side illustrations of options compared with current benefits?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. If FAQs are included, are they succinct and easy to understand?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? ^{[A71][A72]} For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or <u>macular degeneration</u> ^{[A73][A74]} <u>low vision</u> ^{[A73][A74]} , deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language? ^{[A75][A76]}	
Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Does the communication answer what is happening?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Does the communication answer why the consumer is receiving a rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Does the communication reflect negatively ^[A77] ^[A78] on the Department of Insurance? ^[A79] ^[A80]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Does the communication indicate when the rate increase will be effective?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Does the communication clearly indicate they <u>policyholder</u> has <u>options</u> ? ^[A81] ^[A82] ^[A83] ^[A84] ^[A85]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Does the communication clearly indicate how <u>the consumer may to</u> elect an option? Does the election documentation <u>allow the consumer</u> consumer <u>to</u> clearly indicate <u>his or her choice</u> ? <u>For example, when check boxes are used to indicate a choice there may should be some way to verify that choice on the form returned to the insurer to avoid mistakes. the consumer's choice?</u> ^[A86] ^[A87] ^[A88] ^[A89] ^[A90] ^[A91]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. <u>Does the communication clearly explain that the consumer is not being singled out for the increase?"</u> <u>26. Does the communication clearly describe "class basis"?</u> <u>Are consumers being singled out for the increase?</u> <u>Suggested text: "Overall experience of all ^[A92]^[A93] in your class..."</u>	
Yes	No	N/A	COMMUNICATION TOUCH AND TONE	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication remind consumers to reflect ^[A94] ^[A95] ^[A96] ^[A97] on <u>why they may have purchased the original reason they bought</u> ^[A98] ^[A99] the policy?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Does the communication express <u>empathy and understanding of the difficulty of evaluating choices</u> ^{[A100][A101]} ?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are the options represented fairly? ^{[A102][A103][A104]} <u>Options are not presented fairly</u> ^{[A105][A106][A107]} Ifs one option <u>is</u> emphasized, mentioned multiple times or bolded when re the others <u>options</u> are not? ^{[A105][A106][A107]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Are <u>the</u> ^[A108] words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider <u>demonstrating immediacy by using the word "now," instead of and avoiding words like "must"</u> ^{[A109][A110][A111][A112]} . Consider <u>"mitigation options"</u> ^{[A113][A114][A115]} , <u>"offset premium impact"</u> ^{[A116][A117][A118][A119]} , or "manage an increase" instead of "avoid an increase."	
Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Is the insurer's consumer service <u>number</u> ^{[A120][A121][A122][A123]} easy to find? Is it clear what hours and days consumer service is open ^{[A124][A125][A126][A127][A128]} <u>Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times rather than a phone tree</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Are website links <u>and phone numbers</u> accurate and functional? ^{[A129][A130]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial <u>planner</u> ^[A131] <u>advisor</u> , producer, <u>state SHIP program (-where applicable)</u> ^{[A132][A133][A134]} <u>with the state-specific name of the program</u> , or	

			trusted family member ^{[A135][A136][A137]} ? <u>Is that information communicated clearly</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the Insurer encourage consumers to consult the Department of Insurance? <u>Does it specify the Departments^{[A138][A139][A140]} can only give general information?^{[A141][A142][A143][A144]}</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>of^{[A145][A146]} Partnership status?^{[A147][A148]}</u>	
Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Are the number of options presented reasonable <u>^{[A149][A150][A151][A152][A153][A154]} but no more than 5-7 options^{[A155][A156][A157]}? <u>If there are less than 3, but more than 5, engage with insurer to understand what is being presented.</u></u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is the <u>Right to Reduce Coverage at Any Time at any time of a policyholder's choosing^{[A158][A159]} clear^{[A160][A161]}?^{[A162][A163]} <u>Are the instructions about how to do that clear?^{[A164][A165]}</u></u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>choose</u> ^[A166] ^[A167] an option?	
Yes	No	N/A	UNDERSTANDING OPTIONS – PAST RATE ACTIONS	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a statement that premiums may increase in the future? <u>Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear? 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?</u> ^[A168] ^[A169]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms? ^[A170] ^[A171] ^[A172] ^[A173] ^[A174] ^[A175] <u>(if not in the model for policy increases, okay to remove)</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication disclose the policy is guaranteed renewal <u>renewable and clearly explain guaranteed renewable</u> ^[A176] ^[A177] ? ^[A178] ^[A179]	
Yes	No	N/A	UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. Does the communication indicate what the reader must do <u>to elect an option and provide a</u> and the deadline to do it? ^[A180] ^[A181]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. For <u>if</u> options that are only available during the decision window, is that limitation clear to consumers? ^[A182] ^[A183]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication ^[A184] ^[A185] <u>answer/indicate address</u> what happens if <u>the policyholder does not send payment</u> no payment is sent ? <u>For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?</u> For example, if	

			no payment is received within 120 days, does the communication explain that it advise Contingent Non-Forfeiture will apply and what that means? [A186][A187]	
Yes	No	N/A	UNDERSTANDING OPTIONS – CURRENT BENEFITS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. Does the communication [A188][A189][A190] include all relevant the following applicable information? Current policy [A191][A192] benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form ?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. If current benefits [A193][A194][A195][A196] have an inflation option, does the communication [A197][A198] include the [A199][A200] lifetime maximum benefit in dollars illustrated both five and fifteen years into the future? [A201][A202]	
Yes	No	N/A	UNDERSTANDING OPTIONS – PERSONAL DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown sent options that are not available to them)? Are the [A203][A204] options presented available [A205][A206] to the policyholder?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Does the communication [A207][A208] contain descriptions of the consumer's options (including changes in the [A209][A210] daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)? [A211][A212][A213][A214]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Does the communication [A215][A216][A217] prompt the policyholder to consider their personal situation, such as: current age, health	

			conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of for institutionalized care?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. Do options clearly indicate value for consumers? Does Do Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in available LTC benefits? value (benefit period)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Do the options reflect the impact of removing or reducing the inflation option in terms of on the growth or reduction if the option is to remove or reduce inflation of future benefits?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59. For phased-in increases ^{[A240][A241][A242][A243][A244]} : Is there a table with all phase-in dates and premium amounts <u>if no RBO is selected? Does the communication clearly state if RBO are limited to the first rate increase or will be available during each phase of the rate increase?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60. For phased-in increases ^{[A245][A246][A247]} , are there communications sent 45- 60 days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61. Does the communication ^{[A248][A249][A250]} disclose that not all reduction options <u>are require careful consideration and are not of equal in</u> value? ^{[A251][A252]}	

DRAFT

Draft: 9/8/21

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

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

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[12 08-23-21 LTCI RBO min.docx](#)

Comments as of 7-21-21 Noted

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[The LTC Task Force? The RBO^{[A7][A8][A9][A10]} Subgroup?] **RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt use the checklist^{[A11][A12]} when reviewing filed Long-Term Care Insurance RBO Communications.

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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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all <u>required</u> materials to including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (<u>screenshots may be requested expected</u> if communication refers policyholder to website for more information ^{[A13][A14]})? ^{[A15][A16]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will <u>notice of</u> ^{[A17][A18]} the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)? ^{[A19][A20][A21][A22]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all <u>new innovative</u> ^{[A23][A24]} <u>RBO</u> options presented in the communication been <u>mentioned prominently as part of clearly explained in</u> ^{[A25][A26]} the filing? Have they been vetted by policy and actuarial staff? ^{[A27][A28][A29]}	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. <u>Are there sample policyholder communications with a statement of variability?</u> ^{[A30][A31][A32][A33][A34]} <u>Do reviewers understand any variable information that appears in the lettercommunication?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Are there insurer rules ^[A35] <u>and training</u> ^[A36] for customer service interactions regarding RBOs? ^{[A37][A38][A39][A40][A41][A42]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>45-60Y-days</u> before effective date. PA posts filed rate increase details on their website. ^{[A43][A44][A45]}	
Yes	No	N/A	READABILITY AND ACCESSIBILITY ^{[A46][A47]}	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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)? ^{[A48][A49]} <u>s the primary message of the communication presented first and clearly worded?</u> ^{[A50][A51]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all <u>technical</u> insurance technical ^{[A52][A53]} terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is the communication in an easily readable font? <u>For example: Is the type in</u> at least <u>{11-point}</u> type? ^{[A54][A55]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Does the communication use headings to help the reader find information easily?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are tables, charts, and other graphics, <u>easy to read and understand</u> ^{[A56][A57][A58][A59]} ? <u>(See question 18 for reference).</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are the grade level and reading ease scores appropriate <u>according to state readability standards? -D</u> ^{[A60][A61][A62][A63][A64][A65][A66][A67][A68]} <u>([8th grade] or lower; Flesch reading ease score [60] or higher)?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Are there side-by-side illustrations of options compared with current benefits? Are <u>reduced benefit options</u> they clear and not misleading? ^{[A69][A70]} <u>For example: Are there side-by-side illustrations of options compared with current benefits?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. If FAQs are included, are they succinct and easy to understand?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? ^{[A71][A72]} For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or <u>macular degeneration</u> <u>low vision</u> ^{[A73][A74]} , deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language? ^{[A75][A76]}	
Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Does the communication answer what is happening?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Does the communication answer why the consumer is receiving a rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Does the communication reflect negatively ^[A77] _[A78] on the Department of Insurance? ^[A79] _[A80]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Does the communication indicate when the rate increase will be effective?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Does the communication clearly indicate they <u>policyholder</u> has <u>options</u> ? ^[A81] _[A82] ^[A83] _[A84] ^[A85]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Does the communication clearly indicate how <u>the consumer may to</u> elect an option? Does the election documentation <u>allow the consumer</u> consumer <u>to</u> clearly indicate <u>his or her choice</u> ? <u>For example, when check boxes are used to indicate a choice there may should be some way to verify that choice on the form returned to the insurer to avoid mistakes. the consumer's choice?</u> ^[A86] _[A87] ^[A88] _[A89] ^[A90] _[A91]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. <u>Does the communication clearly explain that the consumer is not being singled out for the increase?"</u> <u>26. Does the communication clearly describe "class basis"?</u> <u>Are consumers being singled out for the increase?</u> <u>Suggested text: "Overall experience of all ^[A92]_[A93] in your class..."</u>	
Yes	No	N/A	COMMUNICATION TOUCH AND TONE	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication remind consumers to reflect ^[A94] _[A95] ^[A96] _[A97] on <u>why they may have purchased the original reason they bought</u> ^[A98] _[A99] the policy?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Does the communication express <u>empathy and understanding of the difficulty of evaluating choices</u> ^{[A100][A101]} ?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are the options represented fairly? ^{[A102][A103][A104]} <u>Options are not presented fairly</u> ^{[A105][A106][A107]} Ifs one option <u>is</u> emphasized, mentioned multiple times or bolded when re the others <u>options</u> are not? ^{[A105][A106][A107]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Are <u>the</u> ^[A108] words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider <u>demonstrating immediacy by using the word "now," instead of and avoiding words like "must"</u> ^{[A109][A110][A111][A112]} . Consider <u>"mitigation options"</u> ^{[A113][A114][A115]} , <u>"offset premium impact"</u> ^{[A116][A117][A118][A119]} , or "manage an increase" instead of "avoid an increase."	
Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Is the insurer's consumer service <u>number</u> ^{[A120][A121][A122][A123]} easy to find? Is it clear what hours and days consumer service is open ^{[A124][A125][A126][A127][A128]} <u>Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times rather than a phone tree</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Are website links <u>and phone numbers</u> accurate and functional? ^{[A129][A130]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial <u>planner</u> ^[A131] <u>advisor</u> , producer, <u>state SHIP program (-where applicable)</u> ^{[A132][A133][A134]} <u>with the state-specific name of the program</u> , or	

			trusted family member ^{[A135][A136][A137]} ? <u>Is that information communicated clearly</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the Insurer encourage consumers to consult the Department of Insurance? <u>Does it specify the Departments^{[A138][A139][A140]} can only give general information?^{[A141][A142][A143][A144]}</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>of^{[A145][A146]} Partnership status?^{[A147][A148]}</u>	
Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Are the number of options presented reasonable ^{[A149][A150][A151][A152][A153][A154]} <u>but no more than 5-7 options^{[A155][A156][A157]}?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is the <u>Rright to Rreduce Ccoverage at Aany Ttime at any time of a policyholder's choosing^{[A158][A159]} clear^{[A160][A161]}?^{[A162][A163]} <u>Are the instructions about how to do that clear?^{[A164][A165]}</u></u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <u>decide on^{[A166][A167]} choose</u> an option?	

Yes	No	N/A	UNDERSTANDING OPTIONS – PAST RATE ACTIONS	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a statement that premiums may increase in the future? <u>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?</u> ^{[A168][A169]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication include a 10-year nationwide rate increase history for this and similar forms? ^{[A170][A171][A172][A173][A174][A175]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication disclose the policy is guaranteed renewal <u>renewable and clearly explain guaranteed renewable</u> ^{[A176][A177]} ? ^{[A178][A179]}	
Yes	No	N/A	UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. Does the communication indicate what the reader must do and the deadline to do it? ^{[A180][A181]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. For <u>if</u> options that are only available during the decision window, is that limitation clear to consumers? ^{[A182][A183]}	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication ^{[A184][A185]} answer <u>indicate</u> address what happens if <u>the policyholder does not send payment</u> no payment is sent ? <u>For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?</u> For example, if no payment is received within 120 days, does the communication explain that it advise Contingent Non-Forfeiture will apply and what that means? ^{[A186][A187]}	

Yes	No	N/A	UNDERSTANDING OPTIONS – CURRENT BENEFITS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. Does the communication [A188][A189][A190] include all the following information? Current <u>policy</u> [A191][A192] benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) <u>in list form</u> ?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. If current benefits [A193][A194][A195] have an inflation option, <u>does the communication</u> [A196][A197] include <u>the</u> [A198][A199] lifetime maximum benefit in dollars illustrated both five and fifteen years into the future? [A200][A201]	
Yes	No	N/A	UNDERSTANDING OPTIONS – PERSONAL DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. <u>Can the insurer confirm policyholders will see only those options that are available to them (and not be shown sent options that are not available to them)? Are the</u> [A202][A203] <u>options presented available</u> [A204][A205] <u>to the policyholder?</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. <u>Does the communication</u> [A206][A207] <u>contain descriptions of the consumer's options (including changes in the</u> [A208][A209] <u>daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</u> [A210][A211][A212][A213]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Does the communication [A214][A215] 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?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. Does the communication [A216][A217][A218] 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. Do options clearly [A219][A220][A221] indicate value for consumers? Does Do [A222][A223] Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in available LTC benefits? value (benefit period)? [A224]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options [A225][A226], or help understand their options? [A227][A228][A229]	
Yes	No	N/A	UNDERSTANDING OPTIONS – IMPACT OF DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Is there a prominent statement telling policyholders they can maintain their [A230][A231] current benefits by paying the increased premium?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Do the options reflect the impact of removing or reducing the inflation option in terms of on the growth or reduction if the option is to remove or reduce inflation of future benefits? [A232][A233]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed? [A234][A235][A236]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59. For phased-in increases [A237][A238][A239][A240][A241]: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO are limited to the first rate increase or will be available during each phase of the rate increase?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60. For phased-in increases ^{[A242][A243][A244]} , are there communications sent 45- 60 days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61. Does the communication ^{[A245][A246][A247]} disclose that not all reduction options <u>are require careful consideration and are not of equal in</u> value? ^{[A248][A249]}	

DRAFT

Issues related to LTC wellness benefits

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

Objective:

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

Background:

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

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

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

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

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

Details:

1. Analysis of effectiveness

- a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
 - i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
 1. Expenses vary - in many cases are upfront and significant.
 2. The financial impact on claims cost is typically unknown and down the road.
 - ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
 - iii. Some companies are concerned about regulatory reaction to these changes.
- b. Current observations
 - i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
 - ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow, and it is difficult to implement control trials.
 1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
 - iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.
 - iv. Effectiveness may increase or decrease if targeting certain policyholders.
 - v. Development of experience showing effectiveness will be a work in progress.
- c. Addressing of Issues
 - i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
 - ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
 - iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.

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

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

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

- b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program's overarching goals?
 - c. May classification be made by product form?
 - ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
 - 1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
 - a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
 - b. Initial selection of participants may be the most important for antidiscrimination. That selection for pilots should consider including, but not limited to, a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected, as appropriate to the wellness initiative.
 - 2. Would a random selection of policyholders be unfair?
 - 3. Should policyholders be given the option to participate in a wellness initiative?
 - a. Must *all* policyholders be given the option to participate?
 - 4. How much time/data is needed to prove the initiative is valuable?
 - 5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.
 - a. Even if benefits are available to all those who utilize, the initiatives may be limited in application depending on a policyholder's specific circumstances.
 - iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
 - 1. Does it limit who can participate based on the medium and cost of the equipment or technology? For example:
 - a. Does it require access to a computer or internet for online participation?
 - b. Does it require access to a smart phone, texting minutes, etc., to use an app?
 - c. Does it require access to roads, pools, sidewalks?
 - d. Does it require technical skills to use software or hardware?
 - e. Will insurers utilize different communication methods, such as phone, text, e-mail, or mail?
 - 2. Does any such limitation require alternatives for those unable to participate in the initiative?
 - iv. Uniformity: If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?
 - 1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
 - 2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.

- a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.
3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?
- d. Dependencies
 - i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
 1. Analyzing Effectiveness
 2. Actuarial Impacts
 3. Rebate Standards and Limitations
 - a. What if an insurer offers the service at a cost (full or portion) for the policyholder(s) after the pilot?
 4. Regulatory Evaluation
- e. Next steps
 - i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

3. Consumer confusion

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

- ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.
- iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont's sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.
- iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.
- v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: <https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html>) . This builds trust through human contact with medical professionals.
 - 1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.

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

4. Rebating

- a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).
- b. Addressing issues:
 - i. NAIC Model Law. The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.
 - ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins, or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state's rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:
 - a. **Alaska:** Statutorily excludes "a reward under a wellness program established under a health care plan that favors an individual" from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.
 - b. **Maine:** Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.
2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction's rebating law and if there are any state specific requirements for offering such an initiative.
- iii. Trends in State Law. Notwithstanding the variation in individual state's laws and if and how they have been amended or interpreted, there does appear to be a general trend that "services are not prohibited if they are directly related to the insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner." J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.
- iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, where the initiatives do not begin at the moment the policy is issued, and where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer's share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.

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

5. Tax considerations

- a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
- b. Current observations
 - i. In order for a contract to be a “qualified long-term care insurance contract” (QLTCI) as defined in 26 USC 7702B, it must satisfy a number of definitional requirements, including that such a contract must provide insurance coverage only of qualified long-term care services and it generally cannot provide a cash value. There may be adverse tax consequences for consumers if a contract provided benefits that are inconsistent with the definitional requirements.
- c. Addressing issues:
 - i. If a QLTCI contract meets the statutory definition, it is treated as an accident and health insurance contract. See 26 USC 7702B(a)(1). The NAIC is addressing the addition of wellness benefits to QLTCI contracts, and it is understood that insurers would only offer such benefits where this could be done without forfeiting the contract’s tax qualified status. Wellness benefits may include provision of home assessments to identify risks which could lead to a chronic illness such as tripping hazards, installation of ramps and railings, caregiver training for family members and sharing information regarding local LTC providers to those in need or anticipating assistance.
 - ii. While not exactly on point, two interpretive letters* from the Internal Revenue Service responded to questions from a taxpayer regarding the inclusion of riders to QLTCI that 1) “allow access to information pertaining to health, wellness and long term care that promotes and encourages a healthy lifestyle,” and 2) allow participation in voluntary incentive programs that are based on periodic health assessments and other medical criteria evidencing health living and could result in premium discounts or increases in benefits.

- iii. The interpretive letters observe that 26 USC 7702B was enacted to provide incentive for individuals to take financial responsibility for their long-term needs and therefore generally provides favorable tax treatment with respect to QLTCI and qualified long-term care services meeting the statutory requirements. The Code defines “qualified long-term care services” as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services which are required by a chronically ill individuals and are pursuant to a plan of care prescribed by a licensed health care practitioner. The IRS further observed that, in essence, the rider allows the contract to be implemented based on the risk profile of the insured. The IRS held that the inclusion of the rider in a QLTCI contract will not cause the contract to be treated as providing insurance coverage other than of qualified long-term care services.
* The guidance contained in the interpretive letters is directed only to the requesting taxpayer(s) and may not be used or cited as precedent.

d. Next steps:

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

6. Regulatory role in approving or evaluating LTC wellness approaches

- a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
- b. Current observations:
 - i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
- c. Addressing issues
 - i. Idea:
 - 1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
 - a. These issues include company plans to accumulate data on programs’ effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.

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

7. Actuarial considerations

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

8. Data privacy

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

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

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

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

9. Other considerations

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

10. Miscellaneous topics

- a. How will insurers report on issues and learnings?
- b. This document will likely need to be updated with new learnings or issues.

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

Checklist for Premium Increase Communications

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

AUTHORITY

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

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

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

INTRODUCTION

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

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

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

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

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

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

Checklist for Premium Increase Communications

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

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all required materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all new innovative RBO options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Do reviewers understand any variable information that appears in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Were state-specific or contract-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification Y before effective date. PA posts filed rate increase details on their website.	
Yes	No	N/A	READABILITY AND ACCESSIBILITY	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Are all technical insurance terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Is the communication in an easily readable font? For example: Is the type at least 11-pointtype?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Does the communication use headings to help the reader find information easily?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Are tables, charts, and other graphics, easy to read and understand? (See question 18 for reference).	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>14. Are the grade level and reading ease scores appropriate according to state readability standards?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>15. Are reduced benefit options clear and not misleading? For example: Are there side-by-side illustrations of options compared with current benefits?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>16. Does the communication include diminished contrast features that may make it harder to read? Examples include:</p> <ul style="list-style-type: none"> • Use of Italics • Narrow margins (top and bottom less than 1.5 inches) • All caps (all bold is acceptable) • Difficult to read text (fonts other than Sans Serif or Courier) • Different colors throughout • Small font <p>Reviewers should aim to review these communications in the size and contrast in which a consumer would see them; a print test may be beneficial.</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>17. If FAQs are included, are they succinct and easy to understand?</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>18. Does the communication include notice that policyholders with disabilities and policyholders for whom English is not a first language can request ongoing accommodations that will enable them to read online and written materials and notices?</p> <p>For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration deafness and hearing loss, learning disabilities,</p>	

			cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.	
Yes	No	N/A	IDENTIFICATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the communication answer what is happening?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Does the communication answer why the consumer is receiving a rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Does the communication reflect negatively on the Department of Insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Does the communication indicate when the rate increase will be effective?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Does the communication clearly indicate the policyholder has options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Does the communication clearly explain that the consumer is not being singled out for the increase?	
Yes	No	N/A	COMMUNICATION TOUCH AND TONE	Page Reference and Filing Notes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Does the communication remind consumers to reflect on the original reason they bought the policy?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication express an understanding of the difficulty of evaluating choices?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Are the options represented fairly? Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded when the other options are not.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider demonstrating immediacy by using the word "now and avoiding words like "must." Consider "manage an increase" instead of "avoid an increase."	
Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Are website links accurate and functional?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial advisor, producer, state SHIP program (where applicable) with the state-specific name of the program or trusted family member?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the Insurer encourage consumers to consult the Department of Insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?	
Yes	No	N/A	UNDERSTANDING OPTIONS - PRESENTATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the number of options presented reasonable? If there are more than 5, engage with insurer to understand what is being presented	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Is the right to reduce coverage at any time of a policyholder's choosing clear? Are the instructions about how to do that clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?	
Yes	No	N/A	UNDERSTANDING OPTIONS – PAST RATE ACTIONS	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?	
Yes	No	N/A	UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication indicate what the reader must do to elect an option and provide a deadline to do it?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. If options are only available during the decision window, is that limitation clear to consumers?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. Does the communication indicate what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?	
Yes	No	N/A	UNDERSTANDING OPTIONS – CURRENT BENEFITS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication include all the following applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. If current benefits have an inflation option, does the communication clearly explain the impact that changes to this inflation option may have on benefits now and in the future?	
Yes	No	N/A	UNDERSTANDING OPTIONS – PERSONAL DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown options that are not available to them)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of care?	
Yes	No	N/A	UNDERSTANDING OPTIONS – VALUE OF OPTIONS	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Is the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options clear that there is a reduction in the current policy's LTC benefits? The narrative does not have to include the dollar value for CNF.	
Yes	No	N/A	UNDERSTANDING OPTIONS – IMPACT OF DECISION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. If dropping inflation protection results in the loss of accumulated benefit amount, is that clearly explained?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55. For phased-in increases: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first rate increase or will be available during each phase of the rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. For phased-in increases, are there communications sent at least 45 days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Does the communication disclose that all reduction options require careful consideration and may not be equal in value?	