Revised date: 8/1/25

2025 Summer National Meeting
Minneapolis, Minnesota

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Wednesday, August 13, 2025
10:45 a.m. – 12:00 p.m.
Minneapolis Convention Center—101—Level 1

ROLL CALL

Glen Mulready, Chair	Oklahoma	Alice T. Kane	New Mexico
Ann Gillespie, Co-Vice Chair	Illinois	TK Keen	Oregon
Grace Arnold, Co-Vice Chair	Minnesota	Alexander S. Adams Vega	Puerto Rico
John F. King	Georgia	Jon Pike	Utah
Dean L. Cameron	Idaho	Kaj Samsom	Vermont
Marie Grant	Maryland	Patty Kuderer	Washington
Anita G. Fox	Michigan	Allan L. McVey	West Virginia
D.J. Bettencourt	New Hampshire		

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer Cook

AGENDA

1. Consider Adoption of its Spring National Meeting Minutes
   —*Commissioner Glen Mulready (OK)*

2. Consider Adoption of the Reports of its Working Groups and Task Forces
   —*Commissioner Glen Mulready (OK)*
   A. Consumer Information (B) Working Group—*David Buono (PA)*
   B. Health Innovations (B) Working Group
      —*Commissioner Marie Grant (MD)*
   C. Health Actuarial (B) Task Force—*Director Anita G. Fox (MI) and Kevin Dyke (MI)*
   D. Regulatory Framework (B) Task Force
      —*Commissioner Grace Arnold (MN)*
   E. Senior Issues (B) Task Force—*Acting Commissioner Ned Gaines (NV)*

3. Hear an Update on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) and Possibly Consider Adoption—*Fred Andersen (MN) and Kevin Dyke (MI)*

4. Hear a Discussion on 2025 State Legislative Activity of Interest to the Committee—*Christina Haas (DE), George McNab (OH), and Acting Director Heather Carpenter (AK)*

5. Hear a Presentation on Supporting Medicaid Members and Patients: Eligibility Redeterminations and Learnings—*Pahoua Hoffman (Health Partners)*

6. Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Peter Nelson (CCIIO)*

7. Discuss Any Other Matters Brought Before the Task Force —*Commissioner Glen Mulready (OK)*

8. Adjournment

Agenda Item #1

Consider Adoption of its Spring National Meeting Minutes
—Commissioner Glen Mulready (OK)

Draft Pending Adoption

Draft: 4/2/25

Health Insurance and Managed Care (B) Committee
Indianapolis, Indiana
March 26, 2025

The Health Insurance and Managed Care (B) Committee met in Indianapolis, IN, March 26, 2025. The following Committee members participated: Glen Mulready, Chair (OK); Ann Gillespie Co-Vice Chair (IL); Grace Arnold, Co-Vice Chair, and Fred Andersen (MN); Dean L. Cameron (ID); Marie Grant (MD); Anita G. Fox (MI); D.J. Bettencourt (NH); Alice T. Kane represented by Alejandro Amparan (NM); Jon Pike (UT); Sandy Bigglestone (VT); Patty Kuderer (WA); and Allan L. McVey (WV). Also participating were: Paul Lombardo (CT); Andria Seip (IA); Michael T. Caljouw (MA); Angela L. Nelson (MO); Michael Humphreys (PA); Jill Kruger (SD); and Rebecca Rebholz (WI).

1. Adopted its Feb. 28, 2025, and 2024 Fall National Meeting Minutes

The Committee met Feb. 28, 2025. During this meeting, the Committee and the Regulatory Framework (B) Task Force jointly adopted a motion to rename the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group to the Prescription Drug Coverage (B) Working Group.

Commissioner McVey made a motion, seconded by Commissioner Arnold, to adopt the Committee's Feb. 28, 2025 (Attachment One) and Nov. 19, 2024 (*see NAIC Proceedings – Fall 2024, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

2. Adopted the Regulatory Framework (B) Task Force's Revised 2025 Charges for the Prescription Drug Coverage (B) Working Group

Commissioner Arnold said that based on direction from NAIC leadership and the Committee in February, the Regulatory Framework (B) Task Force developed revised 2025 charges for the renamed Prescription Drug Coverage (B) Working Group. She said the revised charges reflect the Working Group's new name and its focus on prescription drug coverage issues. She said the recently established Pharmacy Benefit Management (D) Working Group, under the Market Regulation and Consumer Affairs (D) Committee, will focus on pharmacy benefit manager (PBM) enforcement. She said the Task Force adopted the revised charges during its March 10 meeting.

Commissioner Arnold made a motion, seconded by Commissioner Pike, to adopt the Regulatory Framework (B) Task Force's revised 2025 charges for the Prescription Drug Coverage (B) Working Group *(see NAIC Proceedings – Spring 2025, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

3. Received an Update on the Regulatory Framework (B) Task Force's 2025 Work on the PA White Paper

Commissioner Arnold updated the Committee on the Regulatory Framework (B) Task Force's work on a white paper on prior authorization (PA) arrangements, which it has been tasked with developing. Based on this, the Task Force decided to jump-start that work by focusing its Spring National Meeting session on the PA issue. Commissioner Arnold said that as described in the Task Force's meeting summary in the Committee's meeting materials, the Task Force heard a summary of state PA laws from the NAIC Legal Division. It also heard presentations on the issue from the provider, consumer and patient, and industry perspectives. She said the Task Force plans to form a drafting group to develop an initial draft of the white paper. The drafting group hopes to have an initial draft of the white paper completed prior to the Summer National Meeting and forward it to the Task Force for discussion and review. Commissioner Arnold said the Task Force hopes to complete its discussion

and review and adopt the white paper prior to the Fall National Meeting and forward it to the Committee for its consideration before or at the Fall National Meeting.

4. Adopted its Working Group and Task Force Reports

Acting Director Gillespie made a motion, seconded by Director Fox, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its Feb. 6 minutes (Attachment Two); 2) Health Innovations (B) Working Group; 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force; and 5) Senior Issues (B) Task Force. The motion passed unanimously.

5. Adopted the Former Long-Term Care Insurance (B) Task Force's Dec. 18, 2024, Minutes

Commissioner Mulready said that before the Committee could hear an update on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework), it needed to adopt the Dec. 18, 2024, minutes of the disbanded Long-Term Care Insurance (B) Task Force. He said that the Task Force adopted a revised version of the LTCI MSA Framework during that meeting. However, by adopting the minutes, the Committee will not be adopting the LTCI MSA Framework because the Committee would like to have additional time for review and because one of its components, the cost-sharing piece, is not included.

Acting Director Gillespie made a motion, seconded by Commissioner Arnold, to adopt the disbanded Long-Term Care Insurance (B) Task Force's Dec. 18, 2024, minutes (Attachment Three) without adopting the LTCI MSA Framework. The motion passed unanimously.

6. Heard an Update on the LTCI MSA Framework

Andersen updated the Committee on the LTCI MSA Framework. He said that around six years ago, the NAIC members established an Executive (EX) Committee-level task force to develop a process to attempt to increase the consistency of LTCI rate increase reviews between the states. The process developed involves companies voluntarily offering up blocks of their LTCI business to be reviewed by a multistate actuarial (MSA) reviewing team.

Andersen explained that the team reviews one of the rate filings and makes a draft recommendation, which is then discussed in an all-state webinar. He said comments from the states are then considered, and a final recommendation is made to the states on an approvable rate increase amount. The company then makes a rate review filing individually for each state. Andersen said the hope is that, using this process, as many states as possible approve rate increases in line with the MSA team's rate review recommendation.

Andersen said the MSA team reviewed nine of these filings. He said he thought the process worked pretty well, which led to the pilot program being turned into the formal LTCI MSA Framework adopted by the full NAIC membership a few years ago. He explained that one of the reasons the process worked "pretty well" instead of "very well" is because the framework, at the time, contained multiple actuarial approaches, which made things confusing for the MSA reviewing team, the company making the filing, and the states. He said that over the past year, the Long-Term Care Actuarial (B) Working Group has been working to streamline the process, which includes two parts: the methodology and the cost-sharing formula. As already stated, the Long-Term Care Actuarial (B) Working Group revised the LTCI MSA Framework to include a single multistate methodology, which the former Long-Term Care Insurance (B) Task Force adopted late last year.

Andersen said the second part, the cost-sharing formula, is taking a little longer to reach consensus. He explained that the cost-sharing formula is a way to increase the cost-sharing burden for the company as the cumulative rate increases over time. He said that one concern the Long-Term Care Actuarial (B) Working Group has identified with the current cost-sharing formula is that it allows rate increases that are too high when there are very high

cumulative rate increases, which tended to occur for people aged 85 and older who have held on to their policies for 25 or more years. Given this, there is agreement among the Working Group members that the cost-sharing burden for companies needs to increase in these cases. He said, however, that at this point in the discussion, the Working Group has not been able to reach a consensus on the extent to which these cost-sharing factors should be increased.

Andersen said the most recent proposal would increase the company cost-sharing burden from 50% to 85%, but this has not yet been adopted. He said the Working Group's current proposal, which it recently voted to expose for a public comment period ending May 12, would be a 95% company cost-sharing burden after a certain cumulative amount. Andersen said that following the end of the public comment period, the Working Group plans to discuss the comments received and, hopefully, reach a consensus on the cost-sharing formula to forward to the Health Actuarial (B) Task Force and the Committee for consideration before the Summer National Meeting.

7. Heard a Presentation on the Impact of the ACA Enhanced Premium Tax Credits

Jessica Altman (Covered California) discussed the impact of the federal Affordable Care Act (ACA) enhanced premium tax credits. She provided a marketplace overview explaining how the ACA expanded affordable health insurance coverage through the creation of health insurance marketplaces for individuals who do not have other sources of affordable coverage to purchase such coverage on their own, including those losing Medicaid, the self-employed, or early retirees not eligible for Medicare. She provided statistics illustrating the growth of enrollment in these health insurance marketplaces over the years.

Altman discussed how the enhanced premium tax credits, included in the federal American Rescue Plan Act enacted in 2021, have dramatically increased affordability for health insurance marketplace enrollees, leading to more enrollment growth. She explained that the enhanced premium tax credits were set to expire at the end of 2022, but given their significant impact, the federal Inflation Reduction Act (IRA) of 2022 extended them through 2025.

Altman said that the enhanced premium tax credits reduced premium payments by an average of 44% per enrollee. As such, congressional inaction allowing these enhanced premium tax credits to expire would impact the affordability of coverage for low-income and middle-income families. She highlighted how the enhanced premium tax credits have resulted in substantial growth in marketplace enrollment, particularly among middle-income consumers.

Altman said that, based only on California data, if the enhanced premium tax credits are allowed to expire, older health insurance marketplace enrollees could pay more than a quarter of their household income in premium payments. Premiums are expected to double for enrollees ages 55–64 earning over $60,240 annually, costing as much as $1,193 per month in California. For some enrollees, this could consume as much as 29% of their annual income. Altman discussed how, based on California data, premium increases could vary significantly by region in California. She noted that communities of color could face some of the largest increases in premium. She also noted that ending the enhanced premium tax credits will increase the number of uninsured, explaining that the 10 states that did not expand Medicaid could see larger increases in their uninsured population. Altman highlighted a recently released Commonwealth Fund issue brief, "The Cost of Eliminating the Enhanced Premium Tax Credits: Economic, Employment, and Tax Consequences," which described how ending the enhanced premium tax credits would cause broad impacts.

Altman discussed timing considerations for the 2026 open enrollment period and how Congress needs to act as soon as possible if the enhanced premium tax credits are to be extended. She discussed what state insurance regulators should keep in mind if the enhanced premium tax credits are not extended or Congress acts to extend them at the last minute, including: 1) individual market instability; 2) plan and rate filing approaches, given

uncertainty; 3) interplay with other state initiatives, such as ACA Section 1332 waivers and state affordability programs; and 4) coordination with state-based health insurance marketplaces. Altman concluded her presentation with these three takeaways: 1) if the enhanced premium tax credits expire, premiums will rise on average by 93% for health insurance marketplace enrollees, while middle-income enrollees (i.e., those making more than $60,240 annually) will lose eligibility for premium tax credits entirely; 2) an estimated 4 million consumers will lost health insurance coverage entirely; and 3) timely action to extend the premium tax credits would prevent premium spikes and guard against market instability.

Commissioner Mulready asked if there were questions for Altman. Andersen asked if Altman has any suggestions or thoughts regarding whether those states with reinsurance programs should consider restructuring it for vulnerable groups to account for the loss of the enhanced premium tax credits. Altman said each state's situation is unique, but if a state has a reinsurance program or if there is any discussion about an affordability program, whether it is a cost-sharing wrap, a premium tax credit wrap, or a waiver, the state should be thinking about who is going to be impacted and where state dollars can best be used to assist its vulnerable population.

Commissioner Humphreys asked Altman if she had any suggestions regarding when a state should send notices to health insurance marketplace enrollees and consumers about the potential loss of the enhanced premium tax credits and the potential increase in premium as a result. Alman said that is tricky, as there is no conclusive answer. She noted that Covered California is struggling with the same issue of not wanting to send such notices too early because there is still uncertainty or sending them just a few weeks before open enrollment and shocking enrollees with the increased premium cost. Commissioner Mulready said he sent a letter to the governor of Oklahoma, the Speaker of the Oklahoma House Representatives, the Senate Pro Tempore of the Oklahoma Senate, and the head of Oklahoma's Medicaid agency outlining the potential ramifications to Oklahomans if the enhanced premium tax credits expire.

Director Cameron asked Altman if she had any information on how many of those who qualify for the enhanced tax credit are on silver and gold plans and what the potential is for shifting to a bronze plan as consumers deal with the loss of the enhanced tax credit. Altman said she did not include this information in her presentation but would be happy to follow up with the Committee and provide that information. She noted, however, that this dynamic will vary somewhat by state due to the enhanced tax credits, silver loading, and other factors. She said that due to these different things, there has been a significant migration into silver and gold plans from bronze plans. Altman said she thinks that in addition to the 4 million consumers losing health insurance coverage entirely and leaving the market altogether, consumers will feel the need to buy back down to the bronze level to lower premium costs but, as a result, will have higher cost-sharing because they will be giving up their access to the cost-sharing reductions only available for silver plans.

8. Heard an Update on the Braidwood Case

Sabrina Corlette (Georgetown University Center on Health Insurance Reforms [CHIR]) provided an update on the legal status of the *Kennedy v. Braidwood Management Inc.* (Braidwood) case in a presentation titled "Uncertainty for the Affordable Care Act's Preventive Services Benefit: A Roadmap for States to Protect Consumers." She explained that the CHIR is part of the Georgetown McCourt School of Public Policy. In addition to legal and policy research, analysis, and publications, the CHIR also provides technical assistance to state and federal officials as well as to other organizations. Corlette noted that the Robert Wood Johnson Foundation's (RWJF's) State Health and Value Strategies Project provided support for her presentation to the Committee. She said that any views she expresses do not necessarily reflect the views of the RWJF.

Corlette provided an overview of the requirements under Section 2713 of the ACA for group health plans and issuers to provide without cost-sharing: 1) preventive services recommended with an "A" or "B" rating by the United States Preventative Services Task Force (USPSTF); 2) vaccines recommended by the Advisory Committee

on Immunization Practices (ACIP); and 3) women's and children's preventive services recommended by the Health Resource and Services Administration (HRSA). She explained that the issue in the Braidwood case is whether the structure of the USPSTF violates the Appointments Clause of the U.S. Constitution. If so, then the USPSTF's preventive services recommendations are vacated and cannot be enforced, which would result in the loss of preventive services coverage without cost-sharing to consumers. She said the oral arguments in the case will be presented April 21. The Supreme Court of the United States' (SCOTUS') decision in the case is expected in June or July 2025. She said the Trump Administration continues to defend the provisions of Section 2713, but in its filing with SCOTUS, the Trump administration noted that the reason it is defending the case is because the secretary of the U.S. Department of Health and Human Services (HHS) can remove and appoint new members of these advisory bodies at will, which creates an administrative risk because the secretary would be responsible for final decisions on recommended items and services.

Corlette said that because the states are the primary enforcers and oversee protections for consumers in state-regulated plans, there are several actions the states can take in response to these potential threats to preventive services: one is legislative, and the other is administrative. She said that legislatively, states can codify the provisions of Section 2713 into state law. Fifteen states have already done so. She said states can also consider a state fallback if the federal recommendation process is halted or weakened. Corlette discussed administrative options the states could take to preserve access to preventive services, including: 1) reviewing their essential health benefit (EHB) benchmark plan to ensure the inclusion of recommended items and services; 2) leveraging standardized plans; and 3) enhancing marketplace oversight and communication.

Commissioner Arnold asked Corlette if she had any recommendations for the states incorporating the standards adopted under Section 2713 into state law. Corlette noted that each state is going to be different, but under the State Health and Value Strategies project, the CHIR can provide technical assistance to states to help them think about changes to their state law and, if needed, incorporate the standards. She said some states have simply added cross-references in their state law to the USPSTF, ACIP, and HRSA recommendations going forward, assuming past recommendations are protected. Acting Director Gillespie asked if, apart from vaccines, there are certain preventive services that might be at risk. Corlette said one of the arguments the plaintiffs have made in the Braidwood case is that, on religious grounds, they do not want to cover pre-exposure prophylaxis (PrEP), which is a medication regimen that can help prevent HIV infection in people who are at high risk of exposure to the virus. She noted, however, that this particular issue is not before SCOTUS, but it could still be considered. Corlette said that if SCOTUS sides with the plaintiffs on the Appointments Clause issue, then she believes insurers will examine and consider imposing cost-sharing for preventive services with higher costs, such as colonoscopies.

9. Heard an Update from the CCIIO on its Recent Activities

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest and priorities. He focused his remarks on the CCIIO's recently released 2025 Marketplace Integrity and Affordability Proposed Rule. Nelson said the focus of the proposed rule is to address issues of fraud by: 1) proposing additional safeguards to protect consumers from improper enrollments and changes to their health care coverage and establishing standards to ensure the integrity of the health insurance marketplaces; 2) strengthening income verification processes; 3) modifying eligibility redetermination procedures; and 4) adopting pre-enrollment verification for special enrollment periods (SEPs) aimed at reducing improper enrollments and improving the risk pool. He said that additionally, the rule proposes to adopt in regulation the evidentiary standard the federal Centers for Medicare & Medicaid Services (CMS) uses to assess whether to terminate an agent's, broker's, or web-broker's marketplace agreements for cause. He encouraged the NAIC and the states to submit comments on the proposed rule.

Nelson touched on CCIIO's work on price transparency and its plans to improve implementation by: 1) standardizing the files and making them comparable; 2) requiring the reporting of actual costs, not estimates; and

3) enhancing enforcement. He also highlighted the recently issued executive order aimed at addressing concerns and issues with the rule. Nelson said the CCIIO is also evaluating ways to make the federal No Surprises Act (NSA) work better, particularly in regard to the independent dispute resolution process. Nelson said that to assist in setting rates, as discussed during the Health Actuarial (B) Task Force's March 23 meeting, CMS just released a 2026 revised Actuarial Value Calculator (AV Calculator), user guide, and methodology.

Director Fox asked why CMS rescinded the suspension and termination of agents and brokers involved in illegal plan switching. Nelson said the CCIIO felt the agents and brokers may not have received adequate due process. He said the provision in the 2025 Marketplace Integrity and Affordability Proposed Rule addresses this concern by proposing a stronger evidentiary standard that must be met for such suspensions and terminations. Director Cameron said he has concerns similar to those of Director Fox regarding the new CMS policy on agent and broker suspensions and terminations. He asked Nelson if he could share data with the states on this issue so the states can better understand the scope of the issue. Nelson said the CCIIO wants to give the states the information but also wants to treat the agents and brokers fairly.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2025 Spring National Meeting/Final Minutes/03-Bmin.docx

Agenda Item #2

Consider Adoption of its Working Group and Task Force Reports
—Commissioner Glen Mulready (OK)

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meetings

CONSUMER INFORMATION (B) WORKING GROUP
June 26, 2025 / April 14, 2025

Summary Report

The Consumer Information (B) Working Group met June 26 and April 14, 2025. During these meetings, the Working Group:

1. Adopted its April 14 minutes.

2. Discussed a Consumer Guide on Selecting a Health Plan and Avoiding Improper Marketing Practices.

Draft: 7/23/25

Consumer Information (B) Working Group
Virtual Meeting
June 26, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met June 26, 2025. The following Working Group members participated: David Buono, Chair (PA); Anthony L. Williams (AL); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Amy Hoyt and Jeana Thomas (MO); Monica Snowden (NM); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Martin Swanson (NE); and Victoria Fowler (NH).

1. Adopted its April 14 Minutes

The Working Group met April 14 to discuss plans for a consumer guide for purchasing health insurance and avoiding improper marketing.

Wiseman made a motion, seconded by Hoyt, to adopt the Working Group's April 14 minutes (Attachment 1). The motion passed unanimously.

2. Discussed a Consumer Guide on Selecting a Health Plan and Avoiding Improper Marketing Practices

Buono said the draft consumer guide (Attachment 2) is intended for state departments of insurance (DOIs) to use and adapt as they see fit. He said the guide is intended to provide consumers with basic education, help them ask the right questions, and warn them about improper marketing they might encounter. He said the drafting group considered creating multiple guides for different plan types but decided on a single guide with links to additional information on specific plan types.

Buono said the draft attempts to strike a balance between providing accurate information and keeping the text readable. Buono described the initial sections of the document, including an introduction, a reference to public and employer coverage, and definitions. Brenda J. Cude (University of Georgia) asked whether definitions were taken from existing documents, such as the Summary of Benefits and Coverage (SBC). Buono responded that the drafting group borrowed liberally from other sources. However, it did make adjustments to some definitions. The Working Group discussed adding the definitions of out-of-network and network types, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The Working Group decided that the variety of network types would add too much complexity for the purposes of the guide, but that a future document could provide more information on networks.

Buono said the guide describes different plan types and provides a table at the end that offers a more complete list of plan types. Cude suggested linking to more information about essential health benefits (EHBs). Cude and J.P. Wieske (Horizon Government Affairs) suggested adding a drafting note to advise states that the federal three-month limit for short-term, limited-duration (STLD) plans may change. Swanson encouraged the inclusion of language directing consumers to check that agents are not only licensed by the state but also appointed by the appropriate insurer to sell the plans they are marketing.

Buono highlighted the sections of the guide that warn consumers about red flags and suggest tips for them to follow. The Working Group discussed plan marketing that offers free meals or cash bonuses and concluded that the guide appropriately warns about free offers. Snowden suggested that language warning consumers not to rely

on verbal promises be more prominent. The Working Group discussed whether written documentation is accessible and reviewed by consumers. It decided to include: 1) a warning not to rely on verbal promises; 2) a tip to get written documentation; and 3) and a recommendation to keep records. The Working Group discussed keeping a tip for consumers to take their time and adding advice to be aware of legitimate deadlines, like the end of enrollment periods.

The Working Group discussed recommended questions for consumers to ask. Participants discussed the importance of consumers understanding whether plans marketed to them are insurance and whether they are major medical plans. Working Group members observed that some non-insurance discount plans are marketed to consumers seeking comprehensive coverage and that other misleading marketing obscures the difference between plan types. The Working Group decided to add a question intended to clarify whether a plan provides comprehensive health coverage.

The Working Group discussed adding the term "producer" where agents and brokers are referenced. Some Working Group members mentioned that "producer" is used in state regulation but may not be a familiar term to consumers. The Working Group decided to add "producer" to the document.

Buono asked the Working Group whether the draft should be updated with the relatively minor edits discussed in the meeting and reviewed for readability by Dr. Cude. The Working Group agreed on these as the next steps for the document.

Buono mentioned that the Working Group would soon consider updates to *Frequently Asked Questions About Health Care Reform*. He said the document may need a few more updates this year due to recent changes to federal rules as well as new legislation.

Having no further business, the Consumer Information (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/Consumer Information/Consumer Info Minutes 6.26

A CONSUMER'S GUIDE FOR PEOPLE
BUYING HEALTH INSURANCE ON THEIR OWN

Buying health insurance can feel overwhelming, especially with the wide range of plans and companies out there. If you are interested in buying insurance for yourself or your family, this guide provides some tips to help you understand how to proceed.

Government-Sponsored and Employer-Based Coverage

Before you buy health insurance on your own, it's worthwhile to check whether you are eligible for coverage through a government program or an employer.

- Medicare: If you are 65 or older, have received Social Security Disability Insurance benefits for at least 24 months, or have End Stage Renal Disease or Lou Gehrig's Disease (ALS), then you are likely to qualify for Medicare. To find out more, contact [the name of your state's SHIP program] at [your state's SHIP program phone number] or an insurance broker or agent who is approved to sell Medicare-related plans.
- Medicaid: Medicaid serves people who qualify by income. It pays for comprehensive services at little or no cost. If you feel you might qualify for this program, call [name of state Medicaid agency] at [state Medicaid phone number] to learn more. People who qualify for Medicaid and Medicare can receive benefits from both programs.
- Employer-Sponsored Coverage: Many employers offer health coverage as a benefit to employees, their spouses, and dependents. Check with your or your spouse's employer to find out details and costs.

1. Know Key Terms Before You Shop

- **Premium:** What you pay each month for your health plan's coverage.
- **Deductible:** The amount you pay out-of-pocket before insurance starts paying.
- **Copayment (Copay):** Fixed fee per doctor visit, hospital day or stay, or prescription. For example, $20 for a doctor's visit or $30 to see a specialist.
- **Coinsurance:** The percentage of costs you pay. For example, 30% of hospital charges.
- **Out-of-pocket maximum:** The most you'll pay per year before insurance covers 100%. Not all plans have an out-of-pocket maximum.
- **Annual or lifetime maximum benefit:** The most a health plan will pay each year, or as long as you have a policy, toward your health costs. After that amount is reached, the plan will not pay any more toward your health costs. Health plans that are subject to the Affordable Care Act do not have these limits.
- **Provider:** An individual or facility that provides health care services.

- **Network:** The facilities, providers and suppliers your health insurer has contracted with to provide health care services. If your health plan uses a provider network, then you will pay less if you see a provider in the network.
- **Pre-existing condition:** A health problem like asthma, diabetes, or cancer you had before your health insurance went into effect. Some health plans do not cover services to treat pre-existing conditions.

2. Find Which Type of Health Plan Is Right for You

- **Marketplace Plans [If applicable, replace with name of Marketplace plans in your state]:** If you are under age 65, you should look into these plans because you may qualify for financial help. These plans are required by law to ensure individuals have access to a comprehensive range of services, also called the 10 "essential health benefits," which include:
    - Outpatient care
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services
    - Preventive and wellness services
    - Pediatric oral and vision care

  Marketplace plans must cover services to treat pre-existing conditions. Under these plans, you may qualify for financial assistance that reduces monthly premiums or out-of-pocket costs when you get care. To find out more, contact [phone number for Marketplace plans in your state], an insurance broker, agent, or health insurance navigator. **[Add link to Marketplace or navigator resources.]**

- **Short-Term, Limited Duration Plans:** These plans offer coverage for up to 3 months. They are not required to cover comprehensive services and they can exclude services to treat pre-existing conditions.

- **Other Types of Health Insurance:** There are other types of health insurance plans you can buy on your own. Insurers may offer insurance coverage outside of the **[insert State Marketplace name]** that may or may not cover the essential health benefits listed above. Financial help is only available for coverage purchased on the **[Name of Marketplace]**. Other types of insurance plans may cover fewer services, only cover specific conditions, or pay you directly a fixed amount that is not related to services rendered. See more on other types of coverage. **[Link to Types of Health Coverage Table]**

- **Other Types of Coverage that are Not Insurance**

    - **Health Care Sharing Ministry Plans:** These plans are sponsored by faith-based organizations. They are not insurance plans. The plans use a portion of plan member contributions to pay health benefits. They do not guarantee how much they will pay for services they cover.

    - **[Include if applicable] Farm Bureau Plans:** Individuals and families may qualify for coverage through the Farm Bureau, a private company. This coverage is not insurance and may not include the consumer protections provided by Marketplace plans.

- **Discount plans:** Under a discount plan, you pay upfront in order to receive a reduced fee when you receive services from a participating provider. These plans are not insurance and they do not cap the amount you may owe for healthcare services.

Compare Types of Health Coverage **[Link to Types of Health Coverage Table]**

3. Watch Out for Red Flags

- **Be aware of the source of information or marketing.** Unsolicited calls, texts, or emails from unknown sources should be approached with caution. Legitimate agents and brokers can be verified with your state insurance department.
- **If something sounds too good to be true, it probably is.** Ads that offer comprehensive coverage for $50 per month are often misleading.
- **Beware of offers of up-front payments to you.** Ads that offer a gift or a government subsidy card you can use on groceries, bills, or medical needs for signing up may be deceptive and illegal.
- **Look out for added fees.** Fees in addition to the health plan premium could mean you're signing up to join an association. Know what you're paying for.
- **Avoid pushy sales tactics:** If someone pressures you to sign today or says, "this offer is expiring now," be cautious.
- **Clarify vague plan details:** Walk away if a sales person can't provide you a Summary of Benefits and Coverage or an official plan document.
- **Don't rely on verbal promises:** Get written documentation of:
  - What's covered
  - What's not covered
  - Costs (including premiums, deductibles, copays)

4. Tips to Follow

- **Take your time:** Don't rush your decision.
- **Compare multiple plans:** Ask a trusted friend, family member, or local health navigator to review plans with you if you're unsure.
- **Review documents carefully before signing.** Check provider networks and Summaries of Benefits and Coverage.

5. Ask the Right Questions

- **Is the plan an insurance plan?** If not, you will not have government protections that require the plan to pay its stated benefits.
- **Which services are covered and not covered?** Does the plan cover hospital services, primary care and specialty physician services, other medical services like lab and imaging, prescriptions, mental health services?
- **Are your preferred providers in the network?** Check whether physicians, hospitals or other providers you want to continue to use are in the network and any limitations that apply.
- **Does the plan cover treatment for pre-existing conditions?**
- **Does the plan have an annual or lifetime limit on the amount it will pay for your care?**
- **Is there an out-of-pocket maximum that limits your total cost for deductibles, co-insurance, and co-pays?**
- **Are preventive services required to be covered at no cost to you?**

- **Are your prescription drugs covered, and how much will you pay for those drugs under the plan?**
- **If you are dealing with a broker or agent, is s/he licensed in your state?** Licensed insurance brokers and agents are required to meet state specific qualifications. If the person is licensed, ask for their state insurance license number. With that number, you can check that person's credentials at **[state DOI webpage for licensed producers]**. Later, if you have a complaint or suspect fraud, you can report that person to **[relevant state insurance department's phone number]**.

By following this guide, you'll be in a stronger position to get the coverage you need — and avoid falling for scams or misleading sales pitches.

Types of Health Coverage

Plan Type	What is Covered?	What is Not Covered?	Usually Pays You or Pays Your Provider Bill	Is This a Marketplace Plan?
Hospital Indemnity Policy: Pays a set dollar amount per hospitalization	Any covered hospital visit	Any services other than hospitalization	Usually pays you a set amount regardless of the amount of your hospital bill	No
Other Fixed Indemnity Policy: Pays a set dollar amount per service	Any covered service	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount of your provider bills	No
Critical Illness Policy: Pays a set dollar amount per diagnosis	Any covered specific diagnosis, such as cancer	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount of your provider bills	No
Disability Income Protection: Pays a set dollar amount per period if you become disabled	Any covered disability	Services for pre-existing conditions, maternity, routine physicals	Usually pays you a set amount regardless of the amount of your provider bills	No
Accident Only Policy: Pays a set dollar amount for covered accidents	Any covered accident	Services for pre-existing conditions, maternity, routine physicals	Usually pays you a set amount regardless of the amount of your provider bills	No
Limited Benefit Policy: Pays a set dollar amount for each service	Often doctor visits, lab services, some hospital services	Services for pre-existing conditions, maternity, infertility, mental health conditions	May pay you or your provider, but the amount may not be related to the amount of the provider bill	No
Vision or Dental (Limited Scope) Policy: Pays for a specific set of services within the scope of the policy	Limited services for coverage type	Services outside the scope of coverage and for pre-existing conditions, maternity, ambulance	Usually pays your provider	No
Short Term, Limited Duration Insurance: Depending on your state, may only be available for months	Limited medical services	Usually services for pre-existing conditions, maternity, infertility, mental health conditions, ambulance	Usually pays your provider	No

Draft: 5/2/25

Consumer Information (B) Working Group
Virtual Meeting
April 14, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 14, 2025. The following Working Group members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Debra Judy (CO); Randy Pipal (ID); Michelle Baldock (IL); Alex Peck (IN); Patricia Dorn (MD); Jeana Thomas (MO); Hadiya Swann (NC); Elouisa Macias (NM); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Jennette (DE); and Martin Swanson (NE).

1. Discussed a Consumer Advisory on Health Insurance

Buono explained an oversight related to the Working Group's Feb. 6 meeting. He said the calendar appointment was not sent to interested parties, so very few non-regulators were able to join the call. He apologized and said the Working Group values input from interested parties. He said the Feb. 6 meeting minutes are included in the Health Insurance and Managed Care (B) Committee's Spring National Meeting materials and are also available by request from NAIC support staff.

The Working Group discussed developing a consumer advisory to help consumers choose a suitable health plan and warn them about misleading marketing practices. Buono said improper marketing takes many different forms, so the Working Group could work on a series of guides on different plan types. He explained that a small drafting group discussed the idea and concluded that consumers do not necessarily understand the different plan types in the market or seek out information on plan types. He said the small group recommended drafting a document that provides consumers with the questions they should ask when shopping for health insurance. He said the guide or advisory document could point out why the questions matter and provide warnings for plans that may be unsuitable for certain consumers. Buono said the Working Group could use guides it previously developed and guides or advisory documents already in use by state departments of insurance as references.

Keeley suggested including information on improper marketing in the set of questions. She said consumers might better understand the products they purchase if they are armed with the right questions. Harry Ting (Health Care Consumer Advocate) asked when consumers would consult the advisory. Buono said the goal would be to get the information to consumers when they are shopping during an enrollment period, either during the annual open enrollment period or after a life change. Patton said the Working Group provides information on Affordable Care Act (ACA) plans each year, but it has not put out as much material on other plan types.

Jennette said a plain guide will not be appealing to consumers. Dorn said Maryland's consumer warnings are paired with information on ACA plan premiums. Buono said Maryland's materials are of high quality.

Wayne Turner (National Health Law Program—NHeLP) said the Working Group should educate consumers on the differences between ACA-compliant plans and other plan types. He said a consumer advisory should go further and guide consumers on how to find important plan information, like summaries of benefits and coverage and denial rates. He said the information is not readily available but is findable. He added that consumers should be educated on the difference between assisters funded by grants and producers who may be influenced by commissions.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) asked how a consumer guide differs from a consumer advisory or other document types. She asked how information can be most easily available to consumers when they need it. Buono said not all states have existing materials. He said the NAIC should work to get any materials developed by the Working Group to the states. He said states can shape the material into different forms once they have access to it, so it could be made into a guide, warning, or something different depending on state needs. Patton said there are trade-offs in different forms. He said guides focused on one plan type can be concise, but they are limited in scope. He said the Working Group will have to decide how to balance different needs. Culp said that even experts cannot always tell what plan type marketers are selling.

Claire Heyison (Center on Budget and Policy Priorities—CBPP) said that one document with questions may be better because consumers do not know the difference between plan types, and many questions would be the same across plan types. She said two important questions, regardless of plan type, are: "Does the plan cover pre-existing conditions?" and "Can I see plan documents?"

Swanson said the Improper Marketing of Health Insurance (D) Working Group is willing to help with the document. He said consumers want to ask the right question to either get off the phone with a producer or get confidence that the plan is legitimate. He suggested questions about whether the marketer is licensed, who they represent or sell for, and where they are located.

Brenda J. Cude (University of Georgia) said the NAIC shoppers' guides on home insurance and auto insurance may offer useful formatting ideas. She said the Working Group should consider whether it wants to create content for anyone who finds it to use, suggest ways to use the content, or format the content into final products that do not require editing. She said the Working Group should pursue the first two options to encourage flexibility in the use of the materials. She said materials focused on states rather than consumers would have more drafting notes. Buono said the NAIC is best positioned to distribute the advisory or guide, but states should feel free to use bits and pieces from it, or the whole document if they would like.

Dr. Ting said a guide should help consumers find a credible producer to work with.

Buono asked states to send any related materials they already use, including alerts or warnings to consumers.

Patton said the Working Group should seek to accomplish three goals with the project: 1) provide a concise description of plan types; 2) provide consumers with useful questions to ask; and 3) offer examples of problematic marketing practices. A potential fourth consideration is how to consolidate or separate this information. Culp said some of the work done in the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) on definitions would be helpful for the first goal.

Having no further business, the Consumer Information (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/Consumer Information/Consumer Info Minutes 4.14.docx

2025 Summer National Meeting
Minneapolis, Minnesota

HEALTH ACTUARIAL (B) TASK FORCE
Sunday, August 10, 2025
3:30 – 5:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met Aug. 10, 2025. During this meeting, the Task Force:

1. Adopted its July 14 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its Spring National Meeting minutes.
   B. Heard a presentation on the: 1) history and recent activity associated with multistate actuarial (MSA) reviews; and 2) proposed changes to the cost-sharing formula used in the single long-term care insurance (LTCI) MSA rate review approach methodology found in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework).
   C. Adopted the alternative proposal changes to the cost-sharing formula used in the single LTCI MSA rate review approach methodology found in the LTCI MSA Framework.

2. Adopted the Long-Term Care Actuarial Working Group's July 21 and June 2 minutes. During its July 21 meeting, the Working Group took the following action:
   A. Adopted its June 2 minutes, which included the following action:
      i. Discussed comments received on the exposure of alternative and Missouri proposal modifications to the single LTCI MSA rate review approach cost-sharing formula.
      ii. Agreed to recommend the alternative proposal to the Health Actuarial (B) Task Force as a modification to the cost-sharing factors to be used in the LTCI MSA Framework.

3. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on 2026 Affordable Care Act (ACA) rate filing deadlines and procedures, including provisions for filing amended rates given the uncertainty around the extension of the enhanced advanced premium tax credits (e-APTCs) and funding of cost-sharing reductions (CSRs).

4. Heard an update on Society of Actuaries (SOA) Research Institute activities.

5. Heard an American Academy of Actuaries (Academy) professionalism update.

6. Heard an update from the Academy Health Practice Council on recent and upcoming activities, publications, and webinars.

7. Heard an Academy presentation on 2026 ACA premium rate drivers.

2025 Summer National Meeting
Minneapolis, Minnesota

HEALTH INNOVATIONS (B) WORKING GROUP
Tuesday, August 12, 2025
11:00 a.m. – 12:00 p.m.

Meeting Summary Report

The Health Innovations (B) Working Group met Aug. 12, 2025. During this meeting, the Working Group:

1. During this meeting, the Working Group took the following action:
   A. Adopted its June 20 minutes. During this meeting, the Working Group took the following action:
      i. Adopted its April 24 minutes. During this meeting, the Working Group took the following action:
         1. Heard presentations on three sections of the Affordable Care Act (ACA) that provide flexibility to the states.
      ii. Heard a presentation from the Center for Consumer Information and Insurance Oversight (CCIIO) on health care choice compacts under Section 1333 of the ACA.
      iii. Heard presentations on state experiences with flexibility under Sections 1331 and 1332 of the ACA.
2. Discussed a request from the federal Centers for Medicare & Medicaid Services (CMS) for consultation on health care choice compacts.

3. Heard stakeholder comments on an outline for a white paper on state flexibility under the Affordable Care Act (ACA).

2025 Summer National Meeting
Minneapolis, Minnesota

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, August 12, 2025
12:00 – 1:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Aug. 12, 2025. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes.

2. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which met Aug. 12. During this meeting, the Working Group took the following action:
   A. Heard an update on ERISA preemption of pharmacy benefit manager (PBM) laws.
   B. Heard a presentation from the National Association of Benefits and Insurance Professionals (NABIP) on level-funded plans.

3. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group. The Working Group met July 2 and May 27 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:
   A. Discussed the decision by federal agencies not to enforce the 2024 revisions to the final rule on mental health parity. Working Group members generally agreed that state activity related to parity review and enforcement would continue.

4. Adopted the report of the Prescription Drug Coverage (B) Working Group, which met Aug. 11. During this meeting, the Working Group took the following action:
   A. Adopted its Spring National Meeting minutes.
   B. Adopted its May 19 minutes. During this meeting, the Working Group took the following action:
      i. Heard presentations on copay accumulators.
   C. Heard presentations from the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Cystic Fibrosis Foundation (CFF) on alternative funding programs.

5. Heard an update from AHIP and the BlueCross BlueShield Association (BCBSA) on health plans' commitment to streamlining and simplifying prior authorization (PA).

6. Heard a discussion from Katie Keith (Center for Health Policy and the Law at the O'Neill Institute) and Brian Blase (Paragon Health Institute) on the federal deregulation initiative.

7. Heard an update on the Task Force's work to develop a PA framework white paper. The Task Force has distributed a draft of the white paper on July 18 for a public comment period ending Aug. 29.

2025 Summer National Meeting
Minneapolis, Minnesota

SENIOR ISSUES (B) TASK FORCE
Tuesday, August 12, 2025
8:15 – 9:45 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met Aug. 12, 2025. During this meeting, the Task Force:

1. Adopted its June 10 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its Spring National Meeting minutes.
   B. Discussed long-term care (LTC) riders on life insurance products and variable plans.
   C. Discussed state initiatives on LTC financing.

2. Discussed the Medicare Advantage (MA)/Medicare Supplement Insurance (Medigap)/Special Enrollment Period (SEP) issue.

3. Discussed LTC riders on life insurance products and variable plans.

4. Heard a presentation from Minnesota on recently passed legislation to reduce barriers for innovative LTC product ideas.

Agenda Item #3

Hear an Update on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) and Possibly Consider Adoption—*Fred Andersen (MN) and Kevin Dyke (MI)*

Long-Term Care
Multi-state Actuarial Framework Changes

Fred Andersen, Minnesota Department of Commerce

8/13/2025

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Multi-state LTC rate reviews – Background

- Revisions to Multi-state actuarial (MSA) Framework
  - MSA Framework was adopted in 2022
  - Company option to file a rate increase initially with the MSA team
  - MSA team reviews and issues a recommended rate increase amount
    - Webinar, including feedback from states, before recommendation is finalized
  - Company then files with each state
    - Hope is that the state approves increases in line with the MSA recommendation
  - MSA Framework only applies to these company-initiated MSA filings
    - Although a goal is for more consistency between states on rate increase approvals

Multi-state LTC rate reviews – Recent NAIC activity

- In reaction to first 8 MSA reviews, a couple concerns:
  - Confusion resulting from having 2 methodologies
  - Extent of further rate increases for older policyholders with older policies and high past cumulative rate increases

- 2024 – 2025:
  - LTC Actuarial Working Group (LTCAWG) and LTC / Health Actuarial Task Forces adopted Framework changes to address concerns

- Preview was provided to B Committee at March NAIC national meeting

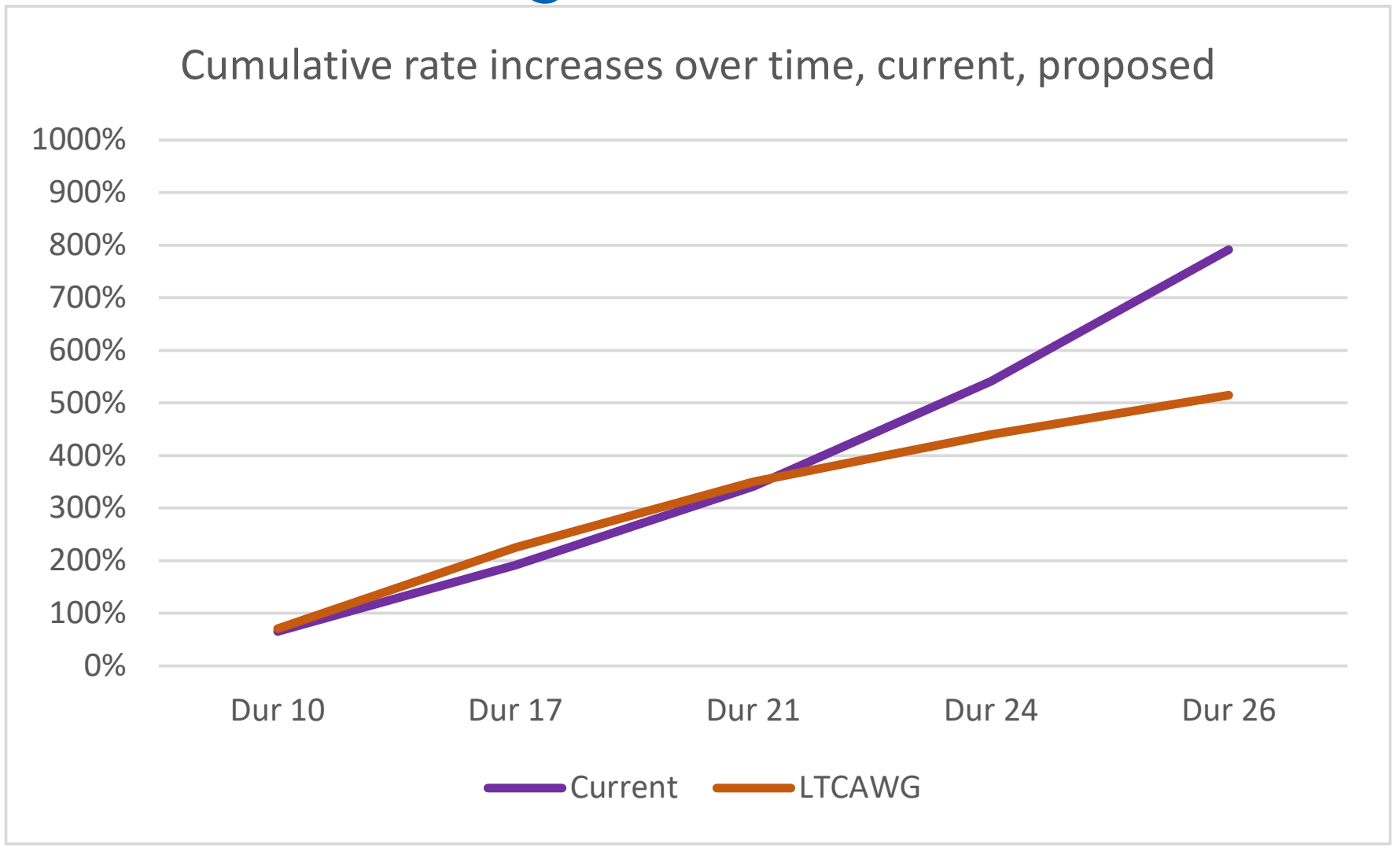
Multi-state LTC rate reviews – Recent NAIC activity

- Result: single methodology with revised cost-sharing
  - Methodology:
    - Will now be known as the “MSA methodology”
    - Similar to “blended / if-knew” Minnesota approach
      - In place in MSA pilot and framework reviews for 5 years and vetted at NAIC groups for 9 years
      - Helps ensure policyholders get appropriate expected value of benefits even after rate increases
  - Cost sharing:
    - Revised cost-sharing factors reduce rate increases for those who have faced past high cumulative rate increases
    - These past high cumulative rate increases tend to have occurred for older policyholders with older policies

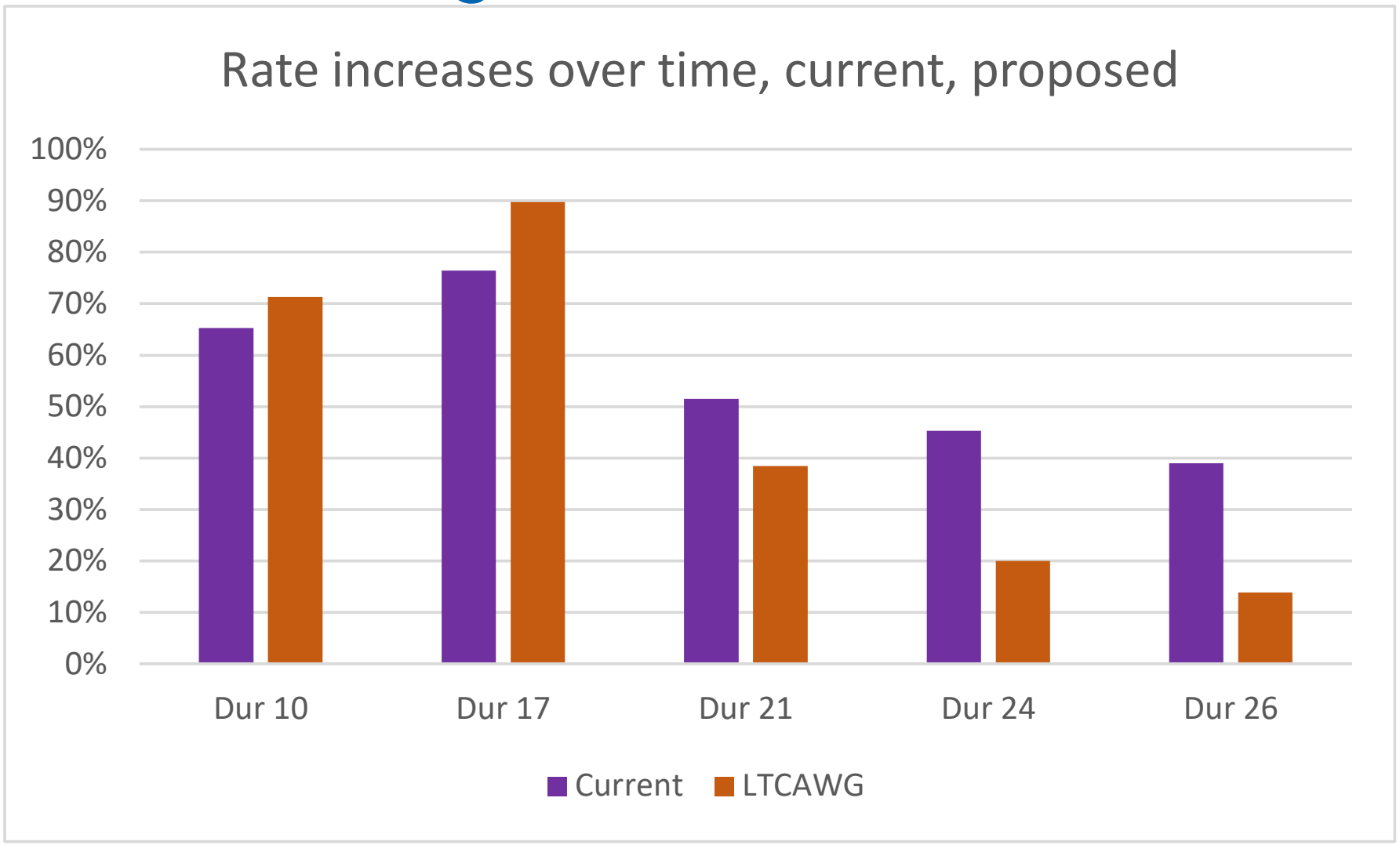
LTCAWG (& HATF) -adopted cost-sharing factors

Blended range		Current PH Share	LTCAWG PH Share
0%	100%	**84%**	**95%**
100%	400%	**57%**	**65%**
400%	800%	**50%**	**30%**
800%		**50%**	**15%**

Revised cost-sharing factors



Revised cost-sharing factors



B Committee consideration of adoption

- LTC TF MSA methodology and HATF cost-sharing formula

- If adopted by B committee and exec / plenary, would only apply to MSA recommendations on MSA-filed rate increases
  - States can still decide on their own re: rate increase approvals for their states' policyholders
  - Goal is more consistency between states

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Commissioner Glen Mulready, Chair of the Health Insurance and Managed Care (B) Committee

FROM: Kevin Dyke, Chair of the Health Actuarial (B) Task Force
Fred Andersen, Chair of the Long-Term Care Actuarial (B) Working Group

DATE: July 23, 2025

RE: Amendments to the LTCI MSA Framework

Please find attached an amended version of the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) for consideration by the Health Insurance and Managed Care (B) Committee. The key amendments are: 1) a change from two actuarial rate review methodologies to a single rate review methodology; 2) a revised cost-sharing formula; and 3) moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options, to the Senior Issues (B) Task Force.

The amendments described above were discussed in open session multiple times. All amendments were exposed for public comment by the Long-Term Care Actuarial (B) Working Group, and/or the former Long-Term Care Insurance (B) Task Force. Comments received were discussed and addressed. Amendments described in #1 and #3 above were adopted by the Long-Term Care Insurance (B) Task Force on December 18, 2024, and amendments described in #2 above were adopted by the Health Actuarial (B) Task Force on July 14, 2025.

The revisions to the LTCI MSA Framework are recommended for adoption by the Committee.

If you have any questions about the amendments, please contact NAIC staff, Eric King or Jane Koenigsman.

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PREFACE

Background

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 Dec. 12, 2021, and the NAIC Executive Committee and Plenary on April 8, 2022.

2025 Amendments

Amendments to the LTCI MSA Framework were adopted by the Long-Term Care Insurance (B) Task Force on December 18, 2024, the Health Actuarial (B) Task Force on July 14, 2025, and the NAIC Executive Committee and Plenary on [date]. The key amendments are 1) a change from two actuarial rate review methodologies to a single rate review methodology; 2) a revised cost-sharing formula; and 3) moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options, to the Senior Issues (B) Task Force.

Table of Contents

I. INTRODUCTION

A. Purpose

In 2019, 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 proposal[1] 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 Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee, or an appointed subgroup, and be revised as directed by the Health Actuarial (B) 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.

[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.

- "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 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 or impacted 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 a single approach ("MSA approach") to calculate recommended, approvable rate increases. While aspects of the MSA approach 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 approach falls 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

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 Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee

The Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee will oversee the MSA Review process, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Health Actuarial (B) 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 Health Actuarial (B) Task Force may create or appoint one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Health Actuarial (B) 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 Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee, or an 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 Health Actuarial (B) 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 participate as a member of the Long-Term Care Actuarial (B) Working Group (or an equivalent 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 Health Actuarial (B) Task Force or its appointed Subgroup, or the former Long-term Care insurance (B) Task Force

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 when rate reviews are in progress (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 Health Actuarial (B) 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 Health Actuarial (B) 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 MSA approach.
- 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

<u>Authority of the MSA Team</u>

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.

<u>Disclosures and Confidentiality Obligations, as Applicable</u>

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 Health Actuarial (B) 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 or Impacted 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 will notify participating or impacted states 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 regularly to assign MSA Team member responsibilities, discuss the review, determine any needed correspondence with the insurer and establish timelines. NAIC staff will assist in facilitating MSA Team member meetings and communications. 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 Health Actuarial (B) 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 to be determined by the Insurer – Individual rate increase filings submitted to each state insurance department.
- Date to be determined 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 Health Actuarial (B) 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 Health Actuarial (B) 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 MSA approach ensures 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 MSA approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied.

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 the MSA approach 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. The recommendation may be the result of MSA approach or may also use professional judgement, where the MSA Team may recommend a rate increase outside of this approach. 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.

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 MSA approach 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 MSA approach, it would produce the recommended rate increase.

C. MSA Approach

Key aspects of the MSA 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 2019[3] 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 MSA 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 MSA approach, all factors impacting the business are considered.

[3] NAIC Proceedings including meeting minutes are available from the NAIC Library, https://naic.soutronglobal.net/portal/Public/en-US/Search/SimpleSearch.

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. RBOs

In 2020, the former 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, 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 Senior Issues (B) Task Force, or its appointed Subgroup and/or the Health Actuarial (B) Task Force, will encourage collective consideration of 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.

E. Non-Actuarial Considerations

The Health Actuarial (B) Task Force or its appointed Subgroup and/or the Senior Issues (B) Task Force, will continue 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 Health Actuarial (B) Task Force, or its appointed Subgroup, and/or the Senior Issues (B) Task Force, will encourage collective consideration of 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 MSA approach 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*[4] (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

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"[5] 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.

[4] https://content.naic.org/sites/default/files/inline-files/committees_b_senior_issues_exposure_ltc_guide_manual.docx

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

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.

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

MSA Approach

Details on the key aspects of the MSA 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 (claims) / original LLR] - PV (past premium)} / PV (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 (claims) / PV (premiums)] / 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. 5% haircut for the first 100%.
   ii. 35% for the portion of cumulative rate increase between 100% and 400%.
   iii. 70% for the portion of cumulative rate increase between 400% and 800%.
   iv. 85% for the portion of cumulative rate increase in excess of 800%.

   Reviewers note: The cost-sharing formula (Step 6) was revised in 2025to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations.

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 $30,000.
      iii. If-knew premium is $1,500.
      iv. 46% of policyholders remain.
      v. Past rate increases are 405%:
      vi. Blended amount is:
         1. $30,000 / $1,000 * 0.46 +
         2. $1,500 / $1,000 * 0.54
         3. – 1 =
         4. 1380% + 81% – 1 = 1461% – 1 = 1361%
      vii. Reduced cumulative approval after cost-sharing is:
         1. 95% * 1.00 +
         2. 65% * 3.00 +
         3. 30% * 4.00 +
         4. 15% * 5.61 =
         5. 494%, reflecting cost-sharing of (1-4.94/13.61) = 64%
      viii. Deduction for past rate increases results in:
         1. (1 + 4.94) / (1 + 4.05) – 1 =
         2. Approvable rate increase of 18%

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

In 2020, the former 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 Senior Issues (B) Task Force, or its appointed Subgroup and/or the Health Actuarial (B) Task Force, or an appropriate NAIC actuarial committee or group, will encourage collective consideration of 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 former 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

<u>Filing Rate Action Letters</u>

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.

<u>Readability and Accessibility</u>

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 REPORT[6]

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

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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 MSA approach. 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 in developing and implementing 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].

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 MSA Review process 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

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

Actuarial Review

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. The MSA Team applied the MSA approach to calculate the recommended, approvable rate increases. Aspects of the MSA 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.

The MSA approach 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 MSA 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 MSA Team's recommendation, in consideration of the MSA approach, 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.

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 NAIC.

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 MSA 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 MSA formula (see Appendix 3): 11%
- Recommended cumulative rate increase since issue: 109%
  - = (1 - 0.11) * 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 MSA 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.

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	20xx Recommended Rate Increase
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:

- 5% haircut for the first 100%.
- 35% for the portion of cumulative rate increase between 100% and 400%.
- 70% for the portion of cumulative rate increase between 400% and 800%.
-
- 85% for the portion of cumulative rate increase in excess of 800%.

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.

August 8, 2025

Commissioner Glen Mulready,
Chair of NAIC Health Insurance and Managed Care (B) Committee
Director Ann Gillespie,
Co-Vice Chair of NAIC Health Insurance and Managed Care (B) Committee

Dear Commissioner Mulready and Director Gillespie:

As indicated in the agenda of the NAIC Health Insurance and Managed Care (B) Committee, scheduled for Wednesday, August 13, 2025, the committee plans to "Hear an Update on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) and possibly Consider Adoption". While there was not a formal request for comments, we are sharing the following input ahead of the upcoming meeting. Given the significance of the proposal and its potential impact, we believe it is important to provide our perspective for the record.

- The MSRR framework has not met its intended goal. The framework was developed in response to the NAIC Long-Term Care (EX) Task Force's charge to create a consistent and transparent national approach for reviewing LTC rates that results in rates that are grounded in sound actuarial principles. This proposal moves away from those core values and introduces arbitrary adjustments, bringing back the very challenges the MSRR was originally designed to address.

- The process leading to the development of the MSRR framework has generally lacked clarity, transparency, and coordination. The extent to which states will adopt and consistently apply the framework remains uncertain and continues to raise important questions about its effectiveness.

- Over the past 5 years, ACLI and AHIP have offered alternatives, raised concerns, and asked questions, most of which have not been fully addressed. Even among regulators, the votes show a lack of consensus on various aspects of the MSSR framework.

- Adding cost-sharing may sound reasonable on the surface, but it's not backed by actuarial principles. It amounts to a cap on rate increases, which undermines the very purpose of MSRR.

- We have seen similar debates play out more than a decade ago. Efforts to cap rate increases at that time contributed to outcomes resulting from one major insolvency, where thousands of policyholders lost coverage.

- Protecting consumers isn't about keeping premiums low in the short term. It's about making sure the coverage they've paid for is there when they need it. If companies can't collect the rates needed to support claims, policyholders could end up with reduced benefits or none at all.

We appreciate the considerable time and effort that has gone into developing this proposal. We offer our comments in the spirit of continued constructive engagement.

Sincerely,

Jan Graeber
Senior Actuary, ACLI

Amanda Herrington
Executive Director, AHIP

cc: Ray Nelson, AHIP's Consulting Actuary

Agenda Item #4

Hear a Discussion on 2025 State Legislative Activity of Interest to the Committee—*Christina Haas (DE), George McNab (OH), and Acting Director Heather Carpenter (AK)*

Agenda Item #5

Hear a Presentation on Supporting Medicaid Members and Patients: Eligibility Redeterminations and Learnings—*Pahoua Hoffman (Health Partners)*

Supporting Medicaid Members & Patients: Eligibility Redeterminations & Learnings

August 2025

Pahoua Yang Hoffman, Senior Vice President, Government & Community Relations

HealthPartners®

About HealthPartners

A nonprofit integrated health system headquartered in Bloomington, Minnesota

Health plan

1.7 million medical and dental plan members

Care system

More than 1.3 million medical and dental patients

Research & education

HealthPartners Institute conducts hundreds of research studies each year and shares its findings worldwide. It also provides education, training and support for medical students and clinicians.

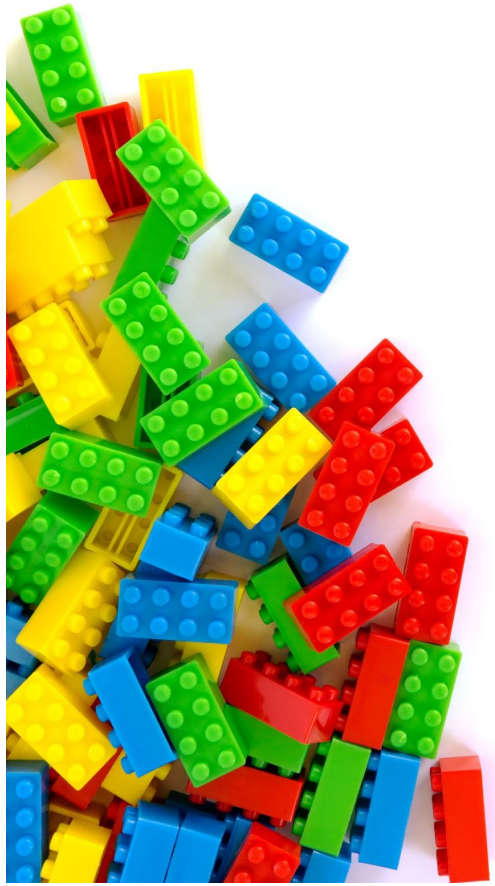
About Minnesota's process for Medicaid eligibility determinations

- Medicaid is formally named Medical Assistance (MA) with the state
  - Often creates member confusion from federal naming convention (we call it Medicaid)
- Counties are responsible for the application and eligibility determinations for Medicaid
  - 87 Counties in Minnesota
  - 12 Counties in HealthPartners service area
  - All counties have variability in workflows, staffing, and turn-around times
- Minnesota's systems are paper-based and rely on US Mail for renewal notification
  - Some electronic capability to accept forms, but there is not an on-line application or re-enrollment option
- Health Plans can educate and direct members to navigators or counties, but cannot physically help members submit eligibility paperwork

Challenges to navigate

- **Online tools not available** specific to Medicaid redetermination/eligibility renewal applications
- Renewal & **application status not easily available to** enrollees nor stakeholders
- **Resources were not adequate** for the high volume of work for counties & tribal nations - entities authorized to handle Minnesota Medicaid eligibility applications and determinations
- **Complex systems and rules** to navigate

Critical building blocks needed



- **Public-private partnership**
  - Stakeholders working together: state agencies, counties, tribal nations, community organizations, health plans and providers
  - Shared core messaging
- **Important role of community organizations** in connecting with members and patients
- **Multi-channel communication** to reach as many people as possible

HealthPartners partnership contribution

- **Value of integration at HealthPartners**
  - Care & coverage
  - Community health needs assessment
  - Role of language interpreters

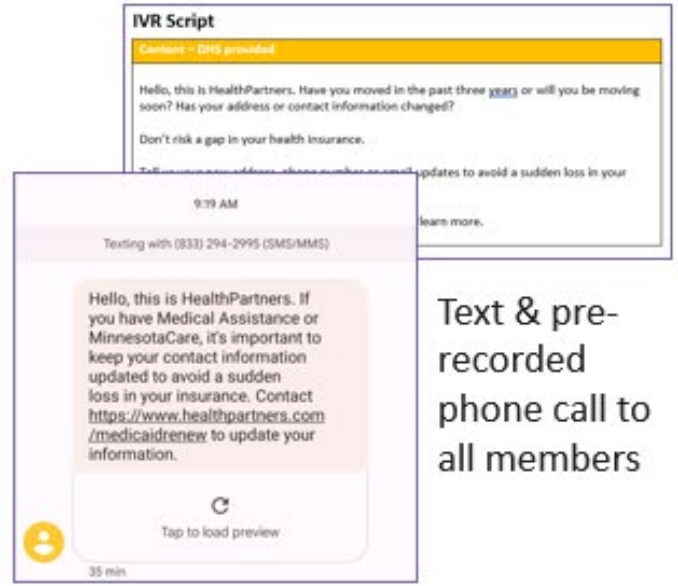
- **Objective:** Retain eligible Medicaid members and ensure minimal disruption and gaps in coverage and access to care

- **Strategy:**
  - Educate members and patients about the restart of the re-enrollment process, how to re-enroll and resources to support them
  - Guide members who no longer qualify for Medicaid to other health coverage options

Pre-Redetermination

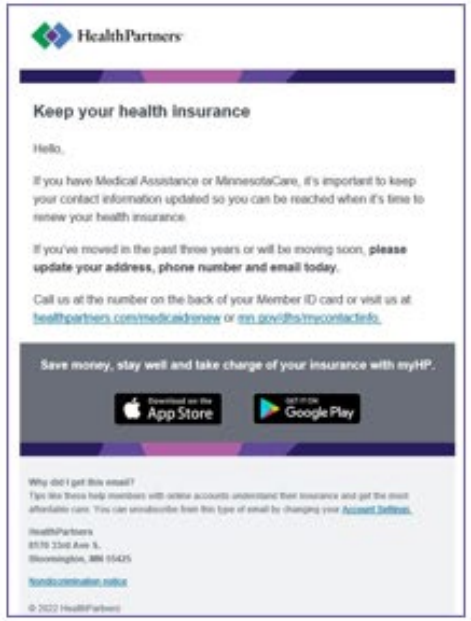
Fall and Winter 2022

Postcard to all members, six languages

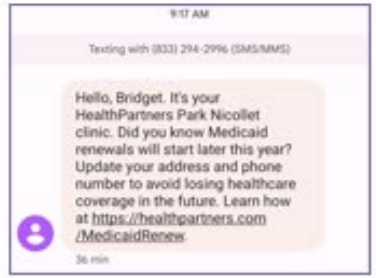


Text & pre-recorded phone call to all members

Clinic brochure, six languages



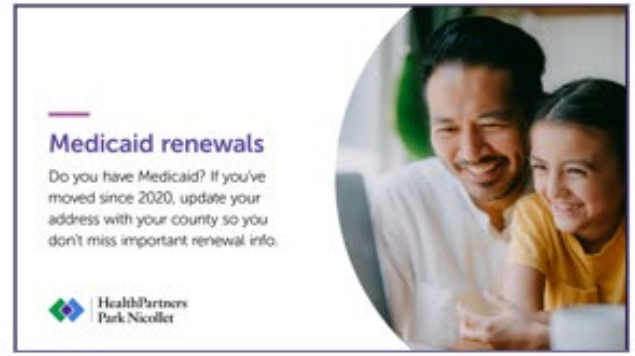
Email to members with online accounts



Text to patients with Medicaid payment history

Facebook ads, English & Spanish

In-Clinic monitor – clinics & hospitals



Pre-redetermination outreach impact

- 459,600 direct-to-consumer messages sent to members and patients
  - Direct mail – 11% undeliverable / returned
  - Email – 59% opened, 6% clicked through
  - Text – 74% delivered
  - Pre-recorded call – 94% delivered

- 1.586 million Facebook ad impressions within service area
  - Drove 10,015 clicks to webpage (0.64%)
  - More interaction from ads in Spanish

During Redetermination

- March 2023 to Present

Applied key learnings

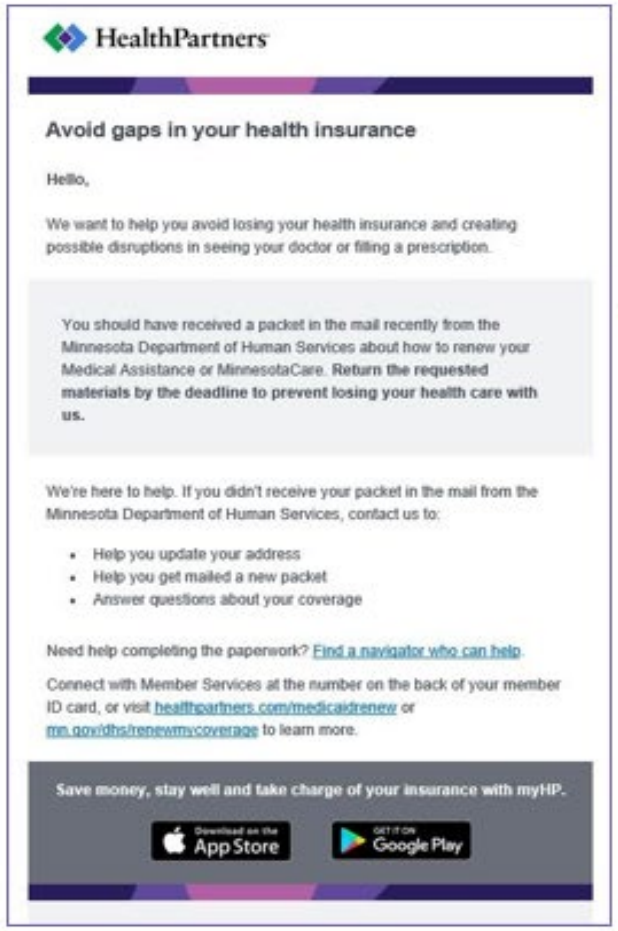
Pre-recorded phone calls have most expansive reach of all direct-to-member channels – Especially when recorded in multiple languages

Social media was a good way to reach a larger audience, but we had opportunities to share more than one message

Google search volumes gradually increased during campaign, indicating Search Engine Optimization should be further leveraged

Direct-to-Member Campaign

- ✓ Email
- ✓ HP app push notification
- ✓ Authenticated web notification
- ✓ Text
- ✓ Pre-recorded phone call (8 languages)
- ✓ Member Services active talking points


HealthPartners

Avoid gaps in your health insurance

Hello,

We want to help you avoid losing your health insurance and creating possible disruptions in seeing your doctor or filling a prescription.

You should have received a packet in the mail recently from the Minnesota Department of Human Services about how to renew your Medical Assistance or MinnesotaCare. **Return the requested materials by the deadline to prevent losing your health care with us.**

We're here to help. If you didn't receive your packet in the mail from the Minnesota Department of Human Services, contact us to:

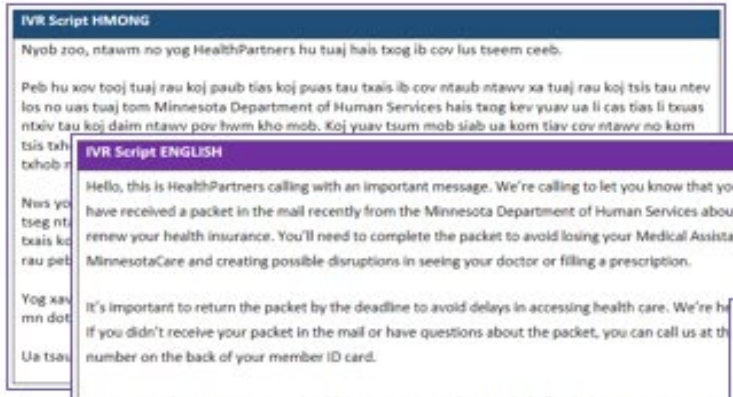
- Help you update your address
- Help you get mailed a new packet
- Answer questions about your coverage

Need help completing the paperwork? Find a navigator who can help.

Connect with Member Services at the number on the back of your member ID card, or visit healthpartners.com/medicaidrenew or mn.gov/dhs/renewmycoverage to learn more.

Save money, stay well and take charge of your insurance with myHP.

App Store Google Play


IVR Script HMONG

Nyob zoo, ntawm no yog HealthPartners hu tuaj hais txog ib cov lus tseem ceeb.

Peb hu xov tooj tuaj rau koj paub tias koj puas tau txais ib cov ntaub ntawv xa tuaj rau koj tsis tau ntev los no uas tuaj tom Minnesota Department of Human Services hais txog kev yuav ua li cas tias li txuas ntxiv tau koj daim ntawv pov hwm kho mob. Koj yuav tsum mob siab ua kom tiav cov ntawv no kom

IVR Script ENGLISH

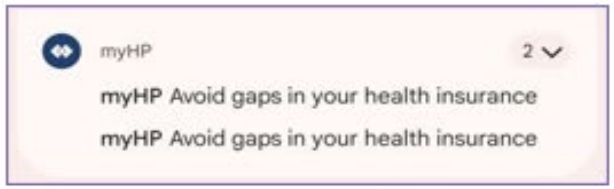
Hello, this is HealthPartners calling with an important message. We're calling to let you know that you should have received a packet in the mail recently from the Minnesota Department of Human Services about how to renew your health insurance. You'll need to complete the packet to avoid losing your Medical Assistance or MinnesotaCare and creating possible disruptions in seeing your doctor or filling a prescription.

It's important to return the packet by the deadline to avoid delays in accessing health care. We're h

If you didn't receive your packet in the mail or have questions about the packet, you can call us at th number on the back of your member ID card.

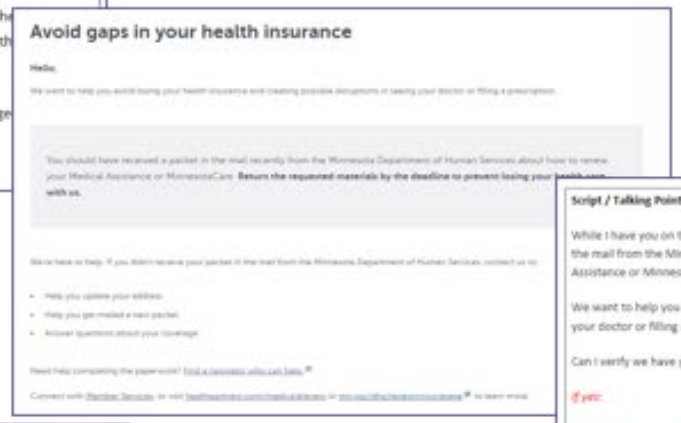
Learn more about renewing your health insurance at mn dot gov slash dhs slash renew my coverage

Thank you for being a part of HealthPartners.


myHP 2

myHP Avoid gaps in your health insurance

myHP Avoid gaps in your health insurance


Avoid gaps in your health insurance

Hello,

We want to help you avoid losing your health insurance and creating possible disruptions in seeing your doctor or filling a prescription.

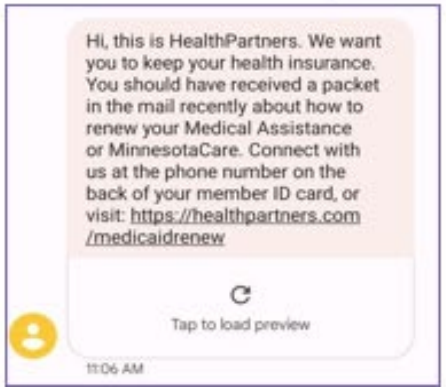
You should have received a packet in the mail recently from the Minnesota Department of Human Services about how to renew your Medical Assistance or MinnesotaCare. **Return the requested materials by the deadline to prevent losing your health care with us.**

We're here to help. If you didn't receive your packet in the mail from the Minnesota Department of Human Services, contact us to:

- Help you update your address
- Help you get mailed a new packet
- Answer questions about your coverage

Need help completing the paperwork? Find a navigator who can help.

Connect with Member Services at the number on the back of your member ID card, or visit healthpartners.com/medicaidrenew or mn.gov/dhs/renewmycoverage to learn more.


Hi, this is HealthPartners. We want you to keep your health insurance. You should have received a packet in the mail recently about how to renew your Medical Assistance or MinnesotaCare. Connect with us at the phone number on the back of your member ID card, or visit: https://healthpartners.com/medicaidrenew

Tap to load preview

11:06 AM


Script / Talking Points:

While I have you on the phone, I want to make sure you know that you will soon receive a packet in the mail from the Minnesota Department of Human Services about how to renew your Medical Assistance or Minnesota Care.

We want to help you avoid losing your health insurance and creating possible disruptions in seeing your doctor or filling a prescription.

Can I verify we have your correct address on file to ensure you get your packet in the mail?

If yes:

[Read address listed in HCSS]

If no:

No problem. Keep an eye on your mail for that important information and return it as quickly as you can! Thank you!

If yes and address is incorrect:

[Once available, complete the MCO Change in Member Address form.]

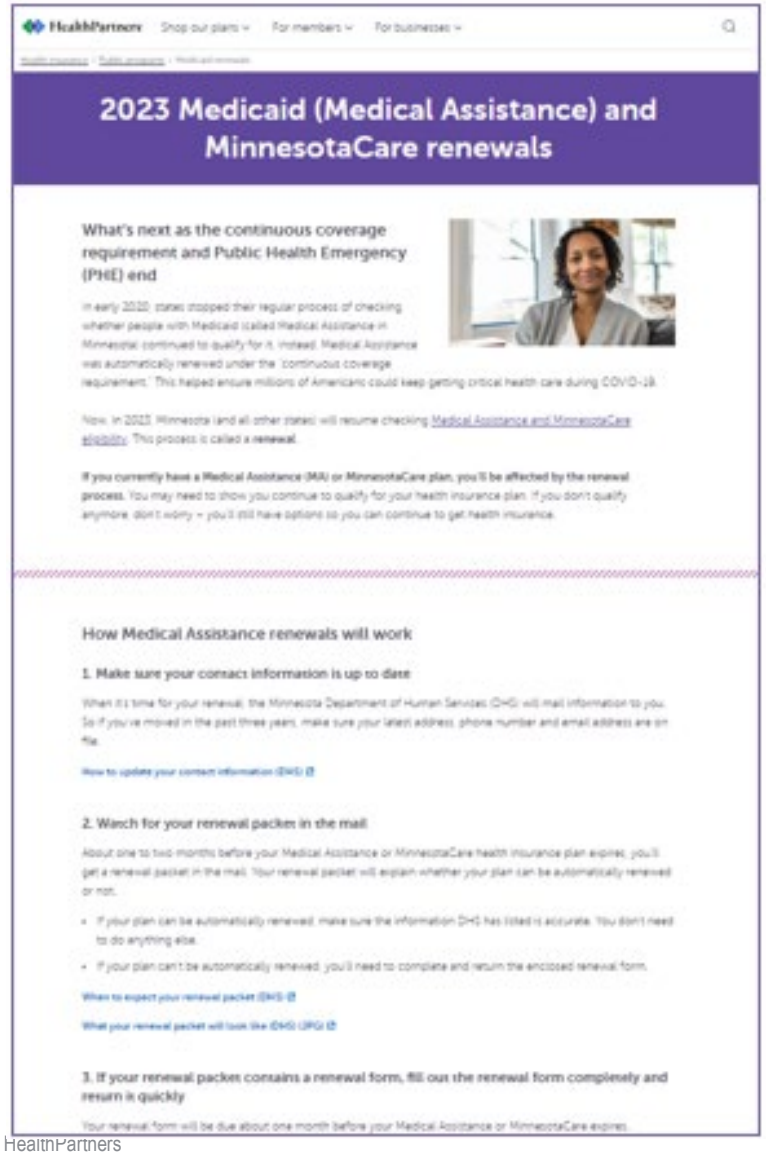
[If not yet available, help enrollees identify whom to call to update their information:

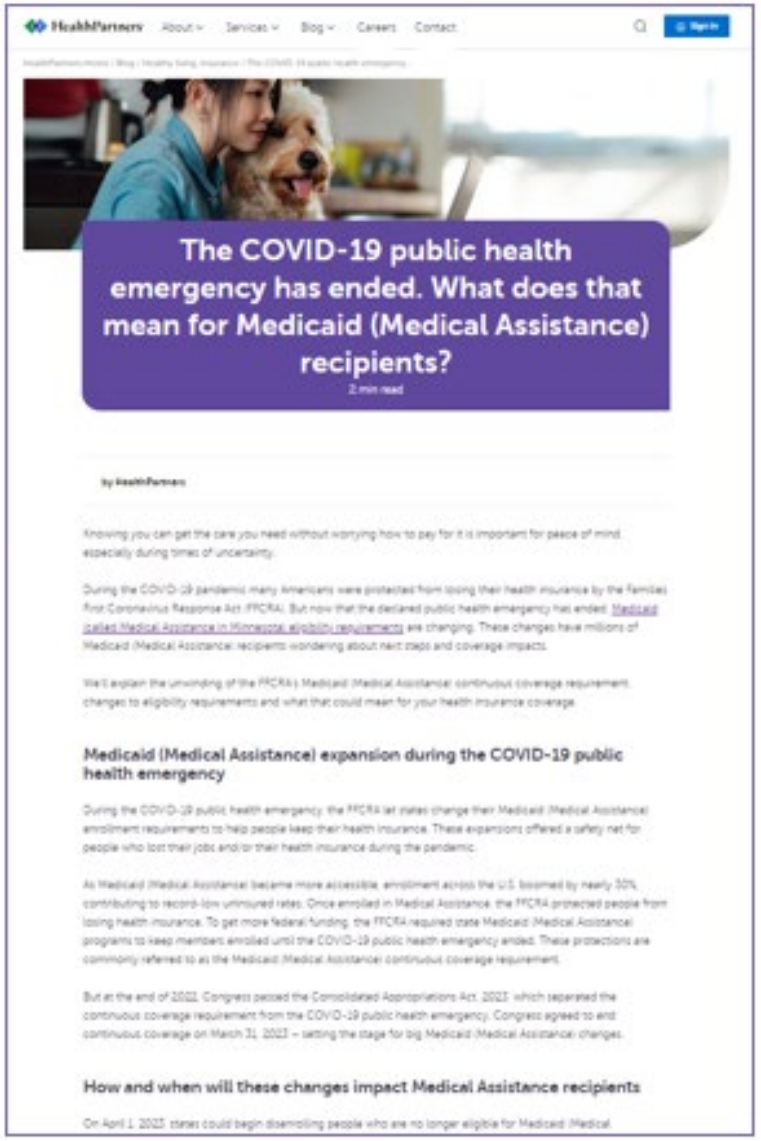
- You need to contact your county to update your information, or your tribe if you belong to Red Lake Nation or White Earth Nation.
- What county do you live in?

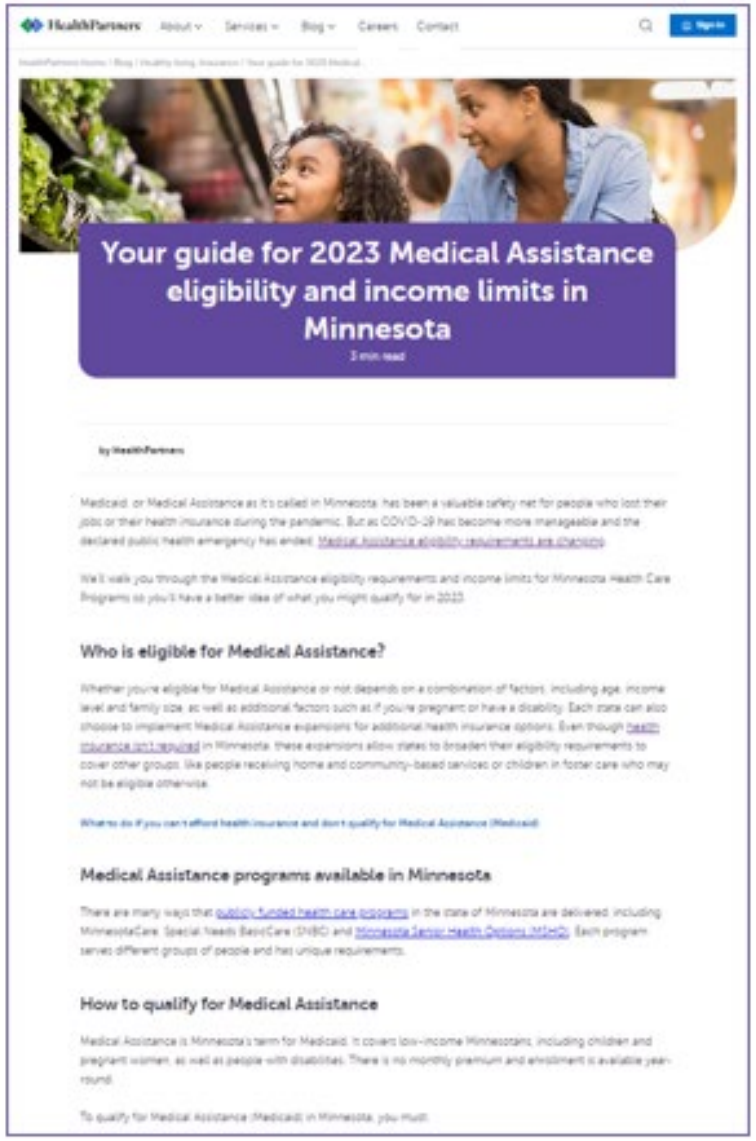
[Use this link to look up county and provide appropriate contact information:
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/contact-us/county-tribal-offices.jsp]

- If you have MinnesotaCare, you can also call Health Care Consumer Support at 800-657-3672.]

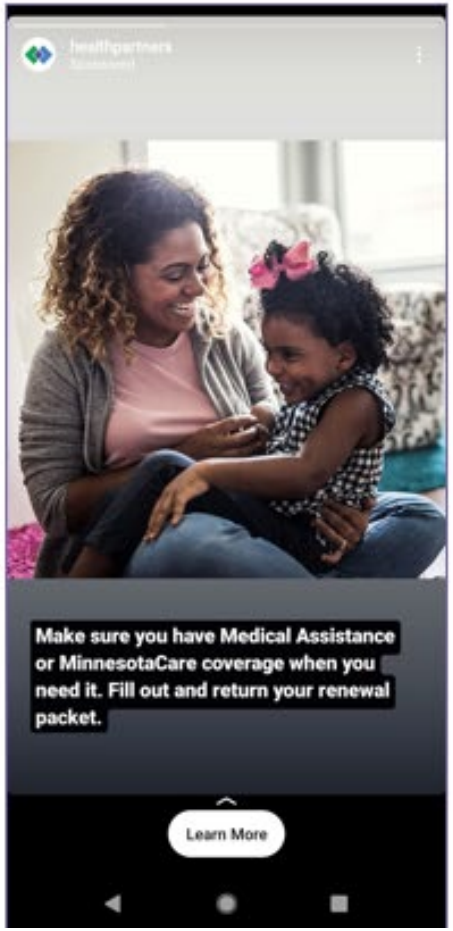
Enhanced Web Landing Page + Blogs

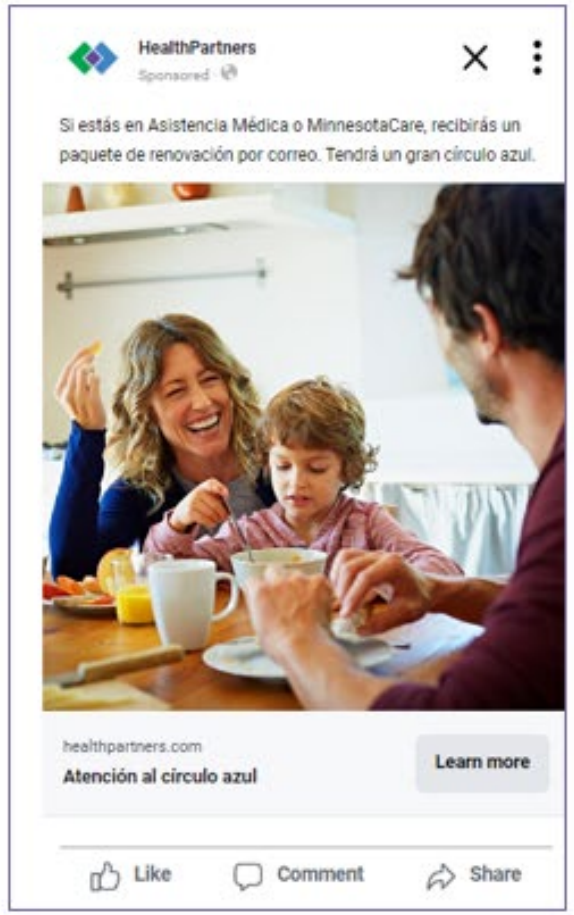






Paid Media – Facebook and Instagram



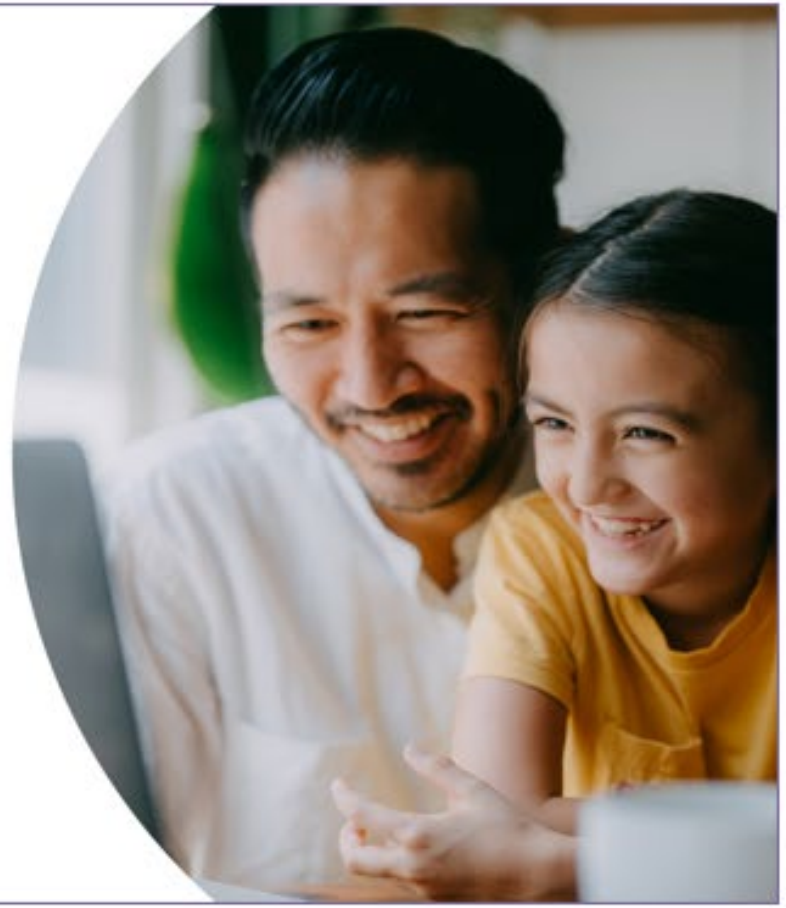


Inside HealthPartners Hospitals & Clinics

Medicaid renewals

If you or a family member has Medicaid, watch your mailbox for important renewal paperwork over the next year.

healthpartners.com/medicaidrenew



Get ready for Medicaid renewals

Update your contact info now.

Are you covered by Medical Assistance or MinnesotaCare? If so, it's important to update your contact information to avoid losing your health insurance.

If your address or phone number has changed in the last three years, contact your county or tribal agency to update your contact information so you don't miss important renewal information from the MN Department of Human Services (DHS).

Visit **mn.gov/dhs/mycontactinfo** or **healthpartners.com/medicaidrenew** to learn how to update your contact information.

HealthPartners Park Nicollet

Spanish

Mantenga actualizados su dirección, número telefónico y correo electrónico para evitar perder su seguro de salud Visite mn.gov/dhs/mycontactinfo para aprender cómo mantener su información de contacto actualizada.

Somali

Ha jihaadio cwaanka, taleefoonka iyo iimaylkaaga mid sax ah si aad iskaga ilaaliso in aad lumiso caymiskaaga caafimaad. Booqo mn.gov/dhs/mycontactinfo si aad u barato sida macluumaadkaaga xirirka aad uga dhigto mid sax ah.

Hmong

Hloov kho koj qhov chaw nyob, tus naib npawb xov tooj thiab tus emial kom tshiab tas li kom zam tau kev plam koj li kev tuav pov hwm them nqi kho mob cov txheej txheem pab cuam ntawm. Mus saib mn.gov/dhs/mycontactinfo txhawm rau kawm paub txog txoj hauv kev hloov kho koj cov ntaub ntawv tiv tauj kom tshiab tas li tau li cas.

Vietnamese

Nhớ cập nhật địa chỉ, số điện thoại và email của quý vị để tránh bị mất bảo hiểm sức khỏe. Vào trang mạng mn.gov/dhs/mycontactinfo để tìm hiểu cách cập nhật thông tin liên lạc của quý vị.

Russian

Регулярно обновляйте свой почтовый адрес, номер телефона и адрес электронной почты, чтобы избежать потери медицинской страховки. Зайдите на сайт mn.gov/dhs/mycontactinfo to чтобы узнать, как поддерживать свою контактную информацию в актуальном состоянии.

Medicaid renewals coming soon

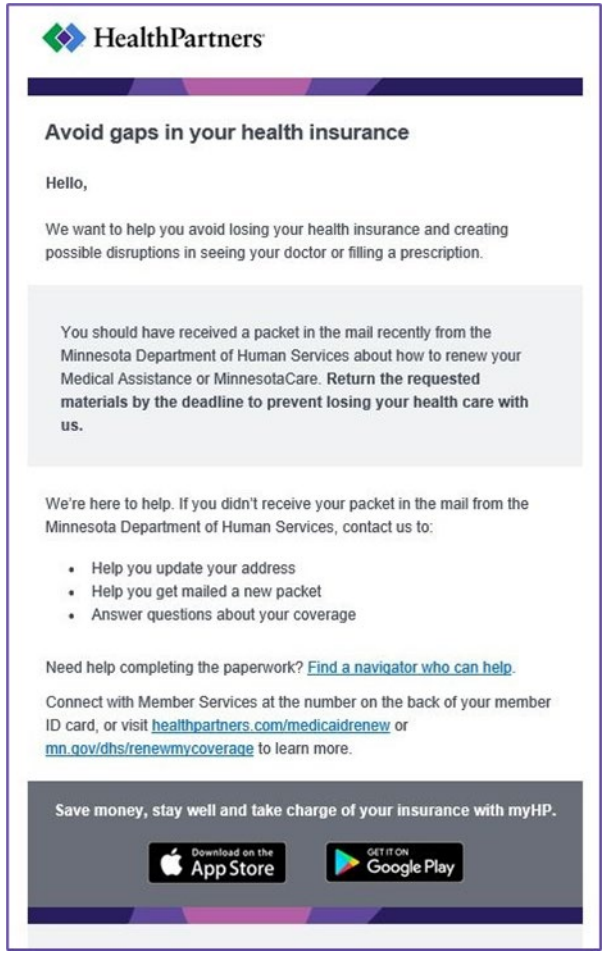
If you are covered by Medical Assistance or MinnesotaCare and your address or phone number has changed in last three years, you need to update your contact information with your county or tribal office. Visit **mn.gov/dhs/mycontactinfo** or **healthpartners.com/medicaidrenew** to learn how to update your contact information.

HealthPartners Park Nicollet

Results

Direct to Member Campaign Results
Notification of Renewal

- 546,301 touches
  - Higher than subsequent phases due in part to DHS required outreach reruns
- Email: 56% open, 7% click through
  - Click throughs to DHS or HP web pages with more detail
- Text: 80% delivered
- Pre-recorded phone calls:
  - English 94% delivered
  - Other languages 89-95% delivered (lowest Oromo, highest Amharic)



HealthPartners

Avoid gaps in your health insurance

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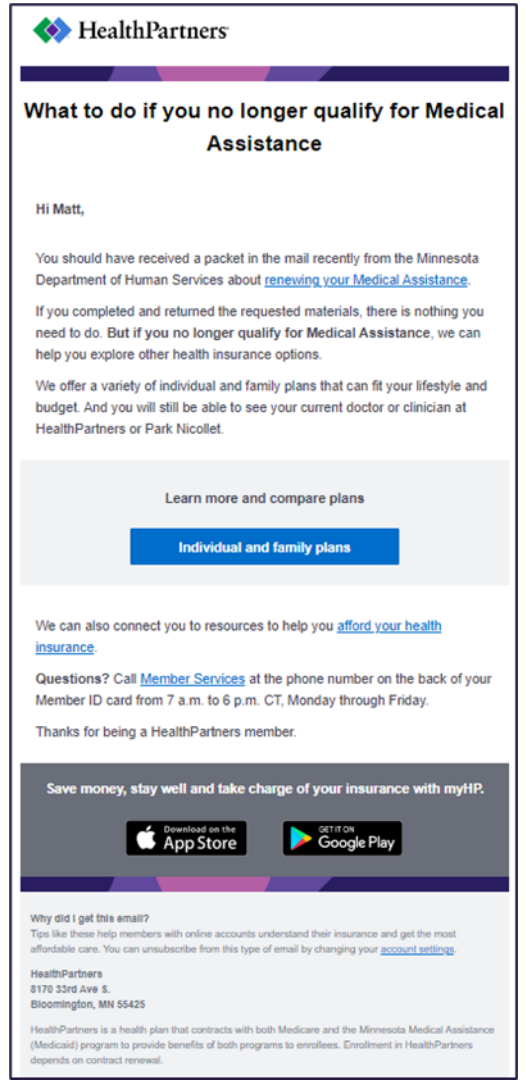
Save money, stay well and take charge of your insurance with myHP.

Download on the App Store | GET IT ON Google Play

Direct to Member Campaign Results

Offering Options When Not Medicaid Eligible

- 289,591 touches
- Email: 55% open, 10% click through
  - Click through +3% than Renewal message (above average)
  - Click through to Individual / Family or Medicare plan detail web pages
- Text: 81% delivered
- Pre-recorded phone calls: 93% delivered



HealthPartners

What to do if you no longer qualify for Medical Assistance

Hi Matt,

You should have received a packet in the mail recently from the Minnesota Department of Human Services about renewing your Medical Assistance.

If you completed and returned the requested materials, there is nothing you need to do. **But if you no longer qualify for Medical Assistance**, we can help you explore other health insurance options.

We offer a variety of individual and family plans that can fit your lifestyle and budget. And you will still be able to see your current doctor or clinician at HealthPartners or Park Nicollet.

Learn more and compare plans

Individual and family plans

We can also connect you to resources to help you afford your health insurance.

Questions? Call Member Services at the phone number on the back of your Member ID card from 7 a.m. to 6 p.m. CT, Monday through Friday.

Thanks for being a HealthPartners member.

Save money, stay well and take charge of your insurance with myHP.

Download on the App Store | GET IT ON Google Play

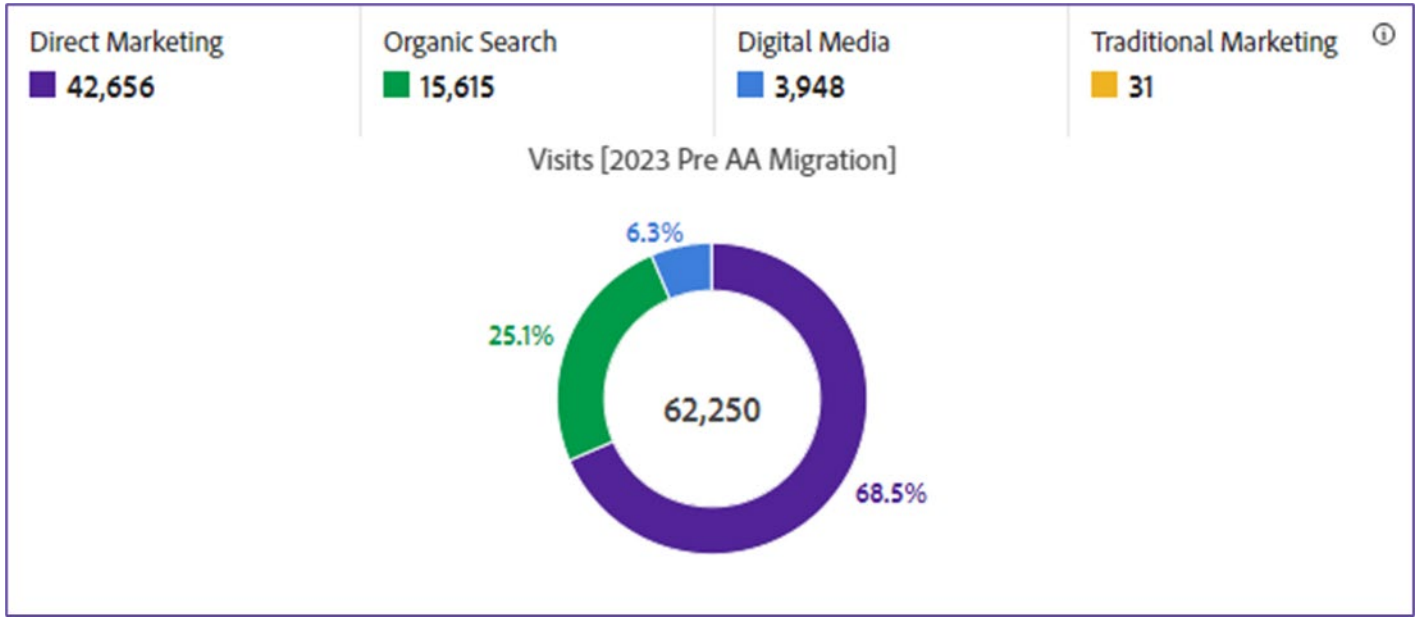
Why did I get this email?
Tips like these help members with online accounts understand their insurance and get the most affordable care. You can unsubscribe from this type of email by changing your account settings.

HealthPartners
8170 33rd Ave S.
Bloomington, MN 55425

HealthPartners is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in HealthPartners depends on contract renewal.

Web Landing Page + Blogs

- Web visits:
  - 70% driven by direct-to-member outreach
  - 25% by organic search
  - 6% by paid social media on Facebook and Instagram

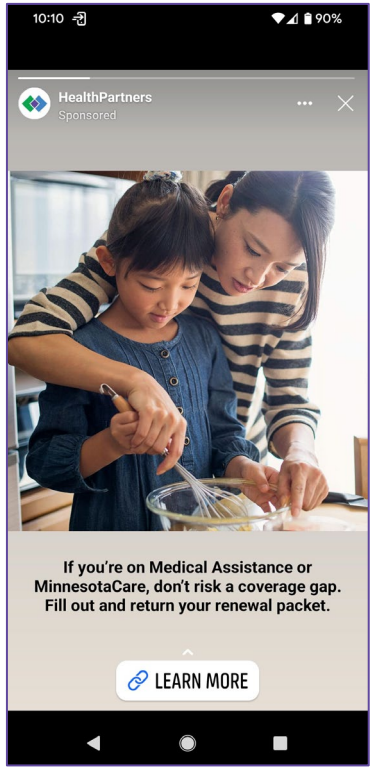


Organic search

- 25% of total web visits from organic search
- Top visited was “What to do if you can’t afford health insurance and don’t qualify for Medicaid”
  - Showed up in more than 110,000 search results in first 90 days
  - 7.1% of people clicked through for more than 8,700 visits
- Notable increase in search-related visits during Nov/Dec 2023

Paid Social Media

- 9.4 million impressions across 812,000 unique individuals (11-12 per person)
- Drove 5,500 clicks to Medicaid Renewal webpage
- Of four messages, “Don’t risk a gap in your coverage” performed the best
  - Seen by 81% of people (661K)
  - Generated 70% of click throughs



Key takeaways from redetermination

- **Public-private partnership with strong community presence** was critical
- **Multi-channel and frequent outreach** strategies have increased member engagement
- **Voice messaging, particularly in multiple languages**, yields the highest reach rate
- **Social Media** methods yield higher interaction rates
- **Continuous messaging and support remains crucial** for Medicaid members to maintain eligibility

Agenda Item #6

Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Peter Nelson (CCIIO)*

Agenda Item #7

Discuss Any Other Matters Brought Before the Committee
—Commissioner Glen Mulready (OK)