Draft date: 3/6/25

2025 Spring National Meeting
Indianapolis, Indiana

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Wednesday, March 26, 2025
10:30 – 11:45 a.m.
JW Marriott Indianapolis—JW White River F–J—Level 1

ROLL CALL

Glen Mulready, Chair	Oklahoma	Alice T. Kane	New Mexico
Ann Gillespie, Co-Vice Chair	Illinois	Andrew R. Stolfi	Oregon
Grace Arnold, Co-Vice Chair	Minnesota	Alexander S. Adams Vega	Puerto Rico
John F. King	Georgia	Jon Pike	Utah
Dean L. Cameron	Idaho	Sandy Bigglestone	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 Feb. 28, 2025, and 2024 Fall National Meeting Minutes—*Commissioner Glen Mulready (OK)* — Attachment One

2. Consider Adoption of the Regulatory Framework (B) Task Force's 2025 Revised Charges—*Commissioner Grace Arnold (MN)*

3. Consider Adoption of its Working Group and Task Force Reports —*Commissioner Glen Mulready (OK)*
   A. Consumer Information (B) Working Group—*David Buono (PA)*
   B. Health Innovations (B) Working Group —*Acting 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—*Commissioner Scott Kipper (NV)*

4. Hear an Update on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework)
   —*Fred Andersen (MN)*

5. Hear a Discussion on the Enhanced Federal Affordable Care Act (ACA) Premium Subsidies Issue—*Jessica Altman (Covered California)*

6. Hear a Status Update on the *Braidwood Management Inc. v. Becerra* Case—*Sabrina Corlette (Georgetown University Center on Health Insurance Reforms [CHIR])*

7. Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Peter Nelson (CCIIO)*

8. Hear a Discussion on Next Steps for Transitioning the Special (EX) Committee on Race and Insurance's Health Workstream's Work to the Committee—*Commissioner Grace Arnold (MN)*

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

10. Adjournment

Agenda Item #1

Consider Adoption of its Feb. 28, 2025, and 2024 Fall National Meeting Minutes
—Commissioner Glen Mulready (OK)

Draft: 3/6/25

Health Insurance and Managed Care (B) Committee
and Regulatory Framework (B) Task Force
E-Vote
February 28, 2025

The Health Insurance and Managed Care (B) Committee and the Regulatory Framework (B) Task Force conducted a joint e-vote that concluded Feb. 28, 2025. The following Committee members participated: Glen Mulready, Chair, represented by Mike Rhoads (OK); Ann Gillespie, Co-Vice Chair (IL); Grace Arnold, Co-Vice Chair (MN); John F. King represented by Steve Manders (GA); Dean L. Cameron (ID); Marie Grant (MD); Anita G. Fox (MI); D.J. Bettencourt (NH); Andrew R. Stolfi represented by TK Keen (OR); Jon Pike represented by Tanji Northrup (UT); Patty Kuderer represented by John Kelcher and Alissa Julius (WA); and Allan L. McVey represented by Joylynn Fix (WV). The following Regulatory Framework (B) Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Lori K. Wing-Heier represented by Sarah Bailey, (AK); Peter M. Fuimaono (AS); Barbara D. Richardson (AZ); Michael Conway represented by Debra Judy (CO); Michael Yaworsky represented by Sheryl Parker and Stephanie Avello (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Robert L. Carey represented by Robert Wake (ME); Mick Campbell (MO); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); D.J. Bettencourt (NH); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by John Kelcher and Alissa Julius (WA); and Nathan Houdek (WI).

1. Adopted a Revised Name for Pharmaceutical Benefit Management Regulatory Issues (B) Working Group

The Committee and the Task Force conducted a joint e-vote to change the name of the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group to the Prescription Drug Coverage (B) Working Group. The motion passed with American Samoa voting “no” and Idaho and Nebraska abstaining.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2025 Spring National Meeting/B Cmte and RFTF 2-28-25 E-Vote MtgMin.docx

Draft Pending Adoption

Draft: 12/2/24

Health Insurance and Managed Care (B) Committee
Denver, Colorado
November 19, 2024

The Health Insurance and Managed Care (B) Committee met in Denver, CO, Nov. 19, 2024. The following Committee members participated: Anita G. Fox, Chair (MI); Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair, and Andrew Schallhorn (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron and Shannon Hohl (ID); Marie Grant (MD); D.J. Bettencourt (NH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating were: Paul Lombardo (CT); Ann Gillespie (IL); Vicki Schmidt (KS); Robert Wake (ME); Mike Chaney (MS); Chrystal Bartuska (ND); Maggie Reinert (NE); Scott Kipper (NV); and Michael Wise (SC).

1. Adopted its Summer National Meeting Minutes

Commissioner McVey made a motion, seconded by Commissioner Mulready, to adopt the Committee's Aug. 15 (*see NAIC Proceedings – Summer 2024, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

3. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Arnold made a motion, seconded by Commissioner Navarro, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its Oct. 18 (Attachment One) minutes; 2) the Health Innovations (B) Working Group, including its Oct. 15 (Attachment Two) minutes; 3) the Health Actuarial (B) Task Force; 4) the Long-Term Care Insurance (B) Task Force; 5) the Regulatory Framework (B) Task Force; and 6) the Senior Issues (B) Task Force. The motion passed unanimously.

4. Adopted its 2025 Proposed Charges and its Task Forces' 2025 Proposed Charges

Director Fox said that prior to this meeting, NAIC staff distributed for comment and posted on the NAIC website the Committee's 2025 proposed charges (Attachment Three). She said the only substantive changes from its 2024 charges are the deletion of the charge related to the Long-Term Care Insurance (B) Task Force and the renaming of the Consumer Information (B) Subgroup to the Consumer Information (B) Working Group. Director Fox explained that as provided in its memorandum to the Committee, the Long-Term Care Insurance (B) Task Force recommends disbanding and moving its work to the Health Actuarial (B) Task Force and the Senior Issues (B) Task Force. Those changes are reflected in their 2025 proposed charges.

Director Fox said: 1) the Health Actuarial (B) Task Force adopted its 2025 proposed charges on Oct. 1; 2) the Regulatory Framework (B) Task Force adopted its 2025 proposed charges on Nov. 4; and 3) the Senior Issues (B) Task Force adopted its 2025 proposed charges on Oct. 21.

Commissioner McVey made a motion, seconded by Director Cameron, to adopt the Committee's 2025 proposed charges, the Health Actuarial (B) Task Force's 2025 proposed charges, the Regulatory Framework (B) Task Force's 2025 proposed charges, and the Senior Issues (B) Task Force's 2025 proposed charges. The motion passed unanimously.

5. Adopted the Revisions to the Model #171

Schallhorn said the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), were identified in 2014 as needing to be revised because of the federal Affordable Care Act (ACA). He said the Regulatory Framework (B) Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup in 2016 to revise Model #170 and Model #171. The Subgroup completed its work on Model #170 in late 2018. The full NAIC membership adopted the Model #170 revisions in February 2019.

Schallhorn said Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA, leaving only those products considered excepted benefits and therefore, not subject to the ACA's requirements. He explained that excepted benefit products, such as accident-only plans and specified disease plans, are medically underwritten and subject to preexisting condition exclusions. He said the Subgroup also added short-term, limited-duration (STLD) plans to Model #170 because there was no other vehicle available to add those products, and the Subgroup did not want to create a new NAIC model for them.

Schallhorn said the revisions to Model #171 were revised for consistency with the revised Model #170. He said the revisions also add standards for STLD plans. He added that because the Subgroup did not want to dictate what benefits and coverages these plans must include, the standards specify that STLD must provide the benefits and coverages required by the state. He said the revisions also clarify provisions on consumer disclosure and outline of coverage requirements making them much more understandable for consumers, including requiring specific language stating that these plans are supplemental and are not intended to be major medical coverage.

Schallhorn said the Accident and Sickness Insurance Minimum Standards (B) Subgroup adopted the revisions on Oct. 17, and the Regulatory Framework (B) Task Force adopted the revisions on Nov. 4. He said that prior to adopting the Model #171 revisions, the Task Force discussed a provision in the model permitting health carriers to exclude mental health and substance use benefits from coverage. He explained that during this discussion, Task Force members and others emphasized that these are excepted benefit products, not major medical coverage and that this provision is optional. As such, he said the states can require such coverage if they feel it is appropriate. In addition, as already noted, for STLD plans, the benefits and coverages for these plans are tied to the state's requirements. If a state requires these plans to include mental health and substance use benefits, then the plan must include the coverage.

Director Fox said that prior to this meeting, NAIC staff distributed proposed revisions to drafting notes in Model #171 (Attachment Four) to address concerns expressed with the optional provision in Section 7D—Prohibited Policy Provisions. She said this language is a compromise and makes it clear that states should carefully consider whether to permit mental health and substance use coverage exclusions for STLD plans and disability income protection policies given the importance of such coverage. She noted, however, that these are excepted benefits products, not comprehensive, major medical coverage. She said the proposed revisions also add similar language to a drafting note in Section 8H—Short-Term, Limited-Duration Health Insurance Coverage.

Commissioner Humphreys said he appreciates the Subgroup's work on the Model #171 revisions, which include many good consumer protections. He also appreciates the suggested proposed revisions to the drafting notes. He said Pennsylvania is challenged particularly by the idea that STLD plans can exclude mental health coverage. Given this, he plans to abstain when voting.

Commissioner Mulready noted the Accident and Sickness Insurance Minimum Standards (B) Subgroup's painstaking work over the past six-plus years in crafting the revisions and the dedication, collaboration, and

compromise among the stakeholders—state insurance regulators, industry, and consumers—to end up with a consensus product. He also noted that these are excepted benefit products, which are medically underwritten, not comprehensive, major-medical coverage. He also noted that the model establishes minimum standards meaning this is a floor. States can and have gone further. Commissioner Mulready said he would be voting in favor of adopting the proposed revisions.

Acting Commissioner Grant said she shares Commissioner Humphreys' concerns, but she plans to vote in favor of adopting the proposed revisions because the model sets minimum standards, and the proposed revisions to the drafting notes emphasize the flexibility the states have to go further. She said Maryland already has gone further than the existing model. She also expressed appreciation for the work that has gone on over the years. Commissioner McVey expressed support for the proposed revisions. He acknowledged the Accident and Sickness Insurance Minimum Standards (B) Subgroup's painstaking work over the past six years. He also noted that the model sets minimum standards and states can go further.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) expressed appreciation for the Accident and Sickness Insurance Minimum Standards (B) Subgroup's work over the past six years. She urged Committee members to vote in favor of adopting the proposed revisions because the proposed revisions include many important consumer protections and, overall, improve the existing model. She said that as states consider adopting the revised model, the NAIC consumer representatives look forward to working with each state to remove the permitted exclusions as the state considers appropriate. Culp said the NAIC consumer representatives support the proposed revisions to the drafting notes as a compromise to alert the states to carefully consider and think through what is appropriate for their market with respect to these permitted exclusions.

Commissioner Kreidler made a motion, seconded by Commissioner Mulready, to adopt the revisions to Model #171, including the suggested revisions to Section 7D and Section 8H (Attachment Five). The motion passed with the following states voting in favor of the motion: Delaware, Georgia, Idaho, Maryland, Michigan, Minnesota, New Hampshire, Oklahoma, Oregon, Utah, Washington, and West Virginia. Pennsylvania abstained.

6. Heard a Presentation on the Use of AI to Conduct Utilization Management Research

Culp and Lauren Seno (NORC at the University of Chicago—NORC) provided an overview of a report prepared by NORC in collaboration with the NAIC consumer representatives focused on health. Culp noted the Committee's previous discussions on prior authorization. She said that, given these discussions, the NAIC consumer representatives believe it is important to look at how artificial intelligence (AI) is being used by health insurance companies in utilization management (UM) decision-making.

Before discussing the report's key findings, Seno first defined the terms used as the foundation of the report—AI, which is the catch-all term referring to technologies that enable computers and machines the ability to mirror human learning and decision-making, and natural language processing (NLP) and machine learning (ML). She said for purposes of the report: 1) NLP is a form of AI that allows computers to understand, interpret, and generate human language, and 2) ML refers to the ability of computer systems to learn and adapt beyond their initial instructions.

Seno discussed the report's key findings: 1) health plans are leveraging the ability of AI to make UM decisions, specifically to respond to prior authorization requests; 2) stakeholders see immense opportunities in such use, but warn that proper safeguards are missing today and need to be in place to protect consumers; and 3) some states have begun to regulate the development and use of AI in health insurance, but they have not been able to keep up with the proliferation of the use of AI itself. She discussed how health plans see AI as a means potentially to: 1) reduce administrative burden, 2) allow clinical reviewers to work at the top of their license, and 3) speed

approvals. She said the research into this area focused on the three primary ways health plans are using AI in UM—administrative-only AI, decision-making AI, and AI learning model.

Seno said that as AI tools are developed and deployed to make coverage decisions, concerns arise. She said that in the absence of a comprehensive regulatory framework for the use of AI in health insurance, stakeholders have started to identify the potential risks that may adversely affect care delivery and health outcomes. Those potential risks include: 1) tools trained by biased data sets, 2) algorithms developed with misaligned incentives, and 3) ML systems developing their own processes. She said that as AI in UM develops, the state regulatory landscape has been uneven in its ability to keep up with advancements. Seno highlighted three states—California, Colorado, and Utah—that have developed their own approaches on how to best regulate this evolving environment. She also noted organizations that have developed frameworks on how AI should be used and regulated in health insurance practices, including the NAIC, the National Health Law Program (NHeLP), AHIP, and the American Medical Association (AMA).

Culp said that in looking at the report's key findings, the NAIC consumer representatives have these recommendations to address the use of AI in UM decision-making: 1) transparency, both to regulators and consumers, is a crucial component of AI oversight; 2) transparency is critical to hold health plans accountable, and when appropriate, liable for the harm caused by the integration of AI into UM activities; and 3) regulators need to ensure health insurers place humans with the appropriate clinical training and authority at the center of decisions that impact patient care. Accessible appeals processes must be considered a right for all consumers. She urged state insurance regulators to act now because the rapid expansion of AI tools in health insurance demands immediate regulatory attention to protect consumers from potential harm and discrimination.

7. Heard a Presentation from the CIPR on Small Group Market Trends

Kelly Edmiston (Center for Insurance Policy and Research—CIPR) discussed small group market trends. He discussed current insurance requirements for small businesses under the ACA. He said cost is the primary challenge for small group businesses. He said that prior to the ACA, small-group market insurance was largely risk-rated. Small businesses have smaller populations over which to pool risk and spread fixed costs. Edmiston noted, however, that there were thriving markets for small business health insurance, so the problem was not so much obtainability as cost. He said that although the ACA required insurers to accept every small employer that applies for coverage and all its employees, guaranteed issue does not guarantee affordability.

Edmiston discussed how employer-provided health insurance premiums have risen dramatically over the past few years and how the percentage of small employers offering health insurance to their employees has declined. He also discussed how the percentage share of what employees pay at small businesses has increased, particularly as compared to employees at large businesses.

Edmiston discussed small business insurance options, such as: 1) purchasing commercial health insurance or 2) self-insuring. He discussed the basics of both options, including the additional risk for small employers opting for self-funded coverage. He also highlighted firms with self-funded health insurance plans by size. Edmiston also discussed level-funded plans as a type of self-funded plan designed for small- and medium-sized businesses. He noted that small firms are taking up level-funded plans in large numbers.

Edmiston discussed additional small business health insurance options—health reimbursement arrangements (HRAs) and the ACA's Small Business Health Options Program (SHOP). He noted the increasing popularity of HRAs as either individual coverage HRAs (ICHRAs) for small businesses with 50 or more employees and qualified small employer HRAs (QSEHRAs) for small businesses with fewer than 50 employees.

Commissioner King said he would like to learn more ICHRAs and would like to discuss it with Edmiston following the meeting. He said Georgia is considering looking at using ICHRAs as an option as part of its state-based health insurance exchange. Edmiston agreed to discuss the issue in more detail later. Acting Commissioner Grant asked Edmiston if the CIPR has some of the data he presented broken down by state. Edmiston said he believes the CIPR can get this information broken down by state, particularly the premium data. Acting Commissioner Grant said she is most interested in obtaining data by state related to the take-up rate of level-funded plans and stop-loss products. Edmiston said he would pull this information together. Hohl said Idaho is interested in any information the CIPR has or could obtain on the benefits provided under these types of self-funded plans, particularly ones with stop-loss coverage.

Commissioner Kreidler asked about the impact of association health plans (AHPs). He explained that AHPs have devastated Washington's small group market to the extent that it does not have small group employers in its state-based health insurance exchange. He asked about the extent to which the CIPR has seen this issue in its research, particularly with the impact of adverse selection and AHPs in the small group market. Edmiston said it is possible there is such a problem when the AHPs cherry-pick the good risks. He said the CIPR will research the issue and get back to the Committee.

Director Fox asked about cost drivers in the small group market and small employers limiting their coverage to employee-only coverage, not family coverage. Edmiston said as far as cost drivers are concerned, the CIPR has not seen anything different in the small group market from the large group market. He said the CIPR has seen some shifts in coverage in the small group market to employee-only coverage but not in large numbers. Commissioner Mulready said he would like some information on the breakdown of prescription drug cost by premium in the small group market. Commissioner Humphreys said he agreed with Commissioner Kreidler's comments on AHPs and potential cherry-picking. He suggested that the Committee examine this more in 2025. He also suggested that the CIPR look at captive insurance. Given the number of CIPR research requests, Director Fox suggested that Committee members send their requests to her and NAIC staff. She said she would circulate the requests and have the Committee rank them to prioritize the CIPR's research. Wake volunteered the Employee Retirement Income Security Act (ERISA) (B) Working Group to assist the Committee in this research and its discussions.

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

Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest. His update included a discussion of three main areas: 1) the current 2025 open enrollment period, 2) recent regulatory activity, and 3) a new grant-funding opportunity.

Wu said the current open enrollment period for 2025 began Nov. 1 and ends Jan. 15, 2025. He said that after last year's record-breaking season, the CCIIO has continued to make changes to healthcare.gov to improve the consumer shopping experience by making it easier to understand plan options all around the country. He said the CCIIO has continued to fund large-scale outreach, advertising, and enrollment assistance. He said the CCIIO appreciates the efforts of the NAIC and state insurance regulators in assisting the CCIIO in getting the word out to consumers about their open enrollment opportunities and awareness around the availability of affordable plans. Wu noted that due to the enhanced premium subsidies, four out of five healthcare.gov customers will find health care coverage for $10 a month or less.

Wu said that in May, the federal Centers for Medicare & Medicaid (CMS) published a final rule that allows Deferred Action for Childhood Arrivals (DACA) participants to enroll for health care coverage through the health insurance exchanges or through the ACA's Basic Health Program (BHP). He said that as this year's open enrollment is occurring, there are still a few states continuing their Medicaid unwinding process. He said the CMS' priority is to ensure that those individuals who are no longer eligible for coverage under Medicaid or the federal Children's Health Insurance Program (CHIP) find access to other coverage, whether through the health insurance

marketplaces or other forms of coverage. Wu also discussed the CMS' efforts and steps taken to address the issue and consumer complaints about agents making unauthorized plan switches. He said he believes that to date, the CCIIO has remedied about 99.7% of all the complaints that it is receiving. He said the CMS is working to update its health insurance marketplace systems to prevent unauthorized switches. Wu thanked the Committee and the Improper Marketing of Health Insurance (D) Working Group for assisting the CMS and the CCIIO in addressing these issues.

Wu said the CMS recently released a funding opportunity for states on the federal health insurance marketplace interested in updating their essential health benefits (EHB) benchmarks. He said the goal of the EHB-Benchmark Plan Modernization Grant for States is to help defray some of the costs of analysis involved in undertaking the process. To be eligible for funding, the state must have a federal health insurance exchange as of Jan. 1, 2026. He said the CMS encourages states to submit a letter of intent for planning purposes, but the letter of intent is optional. States that opt to submit a signed letter of intent should do so electronically by Dec. 15. Grant applications are due Jan. 15, 2025. He said the CMS hopes to award grants in March 2025.

Wu discussed a few federal rules, such as the recently finalized mental health parity rule and the recently issued Notice of Benefit and Payment Parameters for 2026 proposed rule. He said over the past few years, there have been some issues related to accessing preventive care services and the treatments related to those services. He said the CCIIO believes part of the problem relates to coding. As such, the CCIIO recently issued guidance for health plans and health care providers on coding for preventive care services.

Director Fox thanked Wu for the update. She said to the extent it can do so, the NAIC and its members and other stakeholders would urge the CCIIO to issue as soon as possible final rules and/or guidance it has been promising this year on: 1) preventive care services; 2) co-payment accumulators; and 3) implementation of the ACA's 1557 final rules.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2024 Fall National Meeting/11-Bmin.docx

Agenda Item #2

Consider Adoption of the Regulatory Framework (B) Task Force's 2025 Revised Charges
—Commissioner Grace Arnold (MN)

Draft: 2/27/25
Adopted by the Health Insurance and Managed Care (B) Committee, TBD
Adopted by the Regulatory Framework (B) Task Force, March 10, 2025

2025 Revised Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2025.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

3. The **ERISA (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.

4. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
   A. Monitor, report, and analyze developments related to the MHPAEA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related to the MHPAEA.

D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The **Prescription Drug Coverage (B) Working Group** will:
   A. Serve as a forum to educate state insurance regulators on issues related to prescription drug coverage regulation and stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to prescription drug coverage regulation, such as pharmaceutical drug pricing and transparency, formularies, pharmacy payments, pharmacy benefit managers (PBMs), and coverage options.
   C. Maintain a current listing of all prescription drug coverage laws and regulations and case law, as fall under the purview of state-based insurance.
   D. Disseminate materials and reports via the NAIC to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   E. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding prescription drug coverage and PBMs.
   F. Provide assistance and input to the Market Regulation and Consumer Affairs (D) Committee and/or any of its groups, as necessary, on matters related to PBM enforcement.

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

Agenda Item #3

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

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

CONSUMER INFORMATION (B) WORKING GROUP
February 6, 2025

Summary Report

The Consumer Information (B) Working Group met Feb. 6, 2025. During this meeting, the Working Group:

1. Discussed potential work projects for 2025 based on the results of a Working Group member survey. The survey responses identified consumer education on improper marketing of health plans as a top priority for the Working Group's 2025 work. The next most popular priorities were mental health parity, balance billing protections under the federal No Surprises Act (NSA), network adequacy, and preventive services. The Working Group decided to reach out to the Improper Marketing of Health Insurance (D) Working Group chair to discuss potential collaboration on developing consumer-facing educational materials on the improper marketing of health plans. The Working Group then plans to convene a small group to identify the specific topics it will work to educate consumers on, using existing state materials as a starting point.

Draft: 2/26/2025

Consumer Information (B) Working Group
Virtual Meeting
February 6, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met Feb. 6, 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); Patricia Dorn (MD); Jeana Thomas (MO); Elouisa Macias (NM); Hadiya Swann (NC); Donna Dorr and Mike Rhoads (OK); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI).

1. Discussed Potential Work Projects for 2025

Buono reminded participants that the Consumer Information (B) Subgroup's name has been changed to the Consumer Information (B) Working Group.

Buono thanked those who responded to a survey in December 2024 requesting input on Working Group priorities for 2025. He said that the Working Group should consider its existing resources, capacity, potential to add value, and the survey results when selecting its next projects. He said the top priority among state insurance regulators who responded to the survey was consumer education on improper marketing of health plans. The next most popular priorities were mental health parity, balance billing protections under the No Surprises Act (NSA), network adequacy, and preventive services. He said interested parties responded with suggestions, such as a document to guide consumers to resources for help in choosing health plans or to better understand facility fees.

Working Group members supported work on improper marketing, saying that they often receive consumer complaints and that certain practices truly harm consumers. In particular, members identified unauthorized enrollments and plan transfers as improper practices that should be covered. Patton suggested that the Working Group coordinate with the Improper Marketing of Health Insurance (D) Working Group. He said Minnesota has worked to develop a one-page guide to help consumers find licensed and certified agents or assistance personnel. He said the Working Group should focus its efforts so the piece does not become too sprawling, as there are many different improper practices.

Buono discussed whether the Working Group should work on different consumer education pieces simultaneously, each focusing on a different improper practice. He suggested that a smaller group map out the issues that should be covered and bring a plan back to the Working Group's next meeting. A number of Working Group members volunteered to join a smaller group.

The Working Group discussed whether to work on a document to educate consumers about potential changes to the level of premium tax credits under the Affordable Care Act (ACA). Rhoads said an end to enhanced subsidies would have major impacts on consumers, and it may be beneficial to get ahead of it. The Working Group discussed the possibility of enhanced subsidies ending or being altered. The Working Group decided to hold on to the idea because of the uncertain timing of the decision regarding continuing the enhanced subsidies.

The Working Group discussed a variety of potentially improper marketing practices that could be included in a consumer education document, including misleading ads, misleading statements about a plan's network or

benefits, and selling a product as a major medical plan when it is not. Buono clarified that marketing limited benefit plans is not improper if consumers are made aware of the plan's limits. Patton added that it is important to frame consumer education documents carefully so that they are fair to different plan types while still giving consumers the information they need to avoid improper marketing.

Buono asked for examples of states' consumer education materials. Several Working Group members sent links or promised to follow up with materials from their states, noting that they may have useful information even if their topics differ slightly from what the Working Group plans to develop.

Buono said he would consult with the Improper Marketing of Health Insurance (D) Working Group chair and then plan to convene a small group to identify the specific topics the Working Group will work to educate consumers on, using existing state materials as a starting point.

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

SharePoint/NAIC Support Staff Hub/B CMTE/Consumer Information/Minutes 2.6

2025 Spring National Meeting
Indianapolis, Indiana

HEALTH ACTUARIAL (B) TASK FORCE
Sunday, March 23, 2025
3:30 – 5:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met March 23, 2025. During this meeting, the Task Force:

1. Adopted its 2024 Fall National Meeting minutes.

2. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met March 14. During this meeting, the Working Group took the following action:
   A. Adopted its 2024 Fall National Meeting minutes.
   B. Adopted its Feb. 21 and Jan. 13 minutes. During these meetings, the Working Group took the following action:
      i. Discussed comments received on alternate proposal modifications to the single long-term care insurance (LTCI) multistate rate review approach cost-sharing formula.
      ii. Discussed revisions to the single LTCI multistate actuarial (MSA) rate review approach cost-sharing formula.

3. Discussed next steps for the Knowledge Statements for the Appointed Actuary – Health Blank.

4. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on: 1) the federal Centers for Medicare & Medicaid Services (CMS) 2025 Marketplace Integrity and Affordability Proposed Rule; 2) procedures for dual Affordable Care Act (ACA) rate filings for plan year 2026 given uncertainty around the extension of the enhanced advanced premium tax credits (e-APTCs); and 3) key dates for plan year 2026 ACA rate filings.

5. Heard an update on Society of Actuaries (SOA) Research Institute Activities and SOA Education Redesign.

6. Heard an update from the American Academy of Actuaries (Academy) Health Practice Council on recent and upcoming activities, publications, and webinars.

7. Heard an Academy professionalism update.

2025 Spring National Meeting
Indianapolis, Indiana

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, March 25, 2025
1:00 – 2:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met March 25, 2025. During this meeting, the Task Force:

1. Adopted its 2024 Fall National Meeting minutes.

2. Adopted its March 10 and Feb. 28 minutes. During these meetings, the Task Force took the following action:
   A. Jointly adopted with the Health Insurance and Managed Care (B) Committee a motion to rename the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group to the Prescription Drug Coverage (B) Working Group.
   B. Adopted 2025 revised charges for the renamed Prescription Drug Coverage (B) Working Group reflecting the Working Group's new name and its focus on prescription drug coverage issues and the recently established Pharmacy Benefit Management (D) Working Group focusing on pharmacy benefit management enforcement.

3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group.

4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its 2024 Fall National Meeting minutes. The Working Group met March 25 and took the following action:
   A. Adopted its 2024 Fall National Meeting minutes.
   B. Heard presentations from Inseparable and the Association for Behavioral Health and Wellness (ABHW) on state legislation related to sources of clinical standards.
   C. Met in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue discussion of the opioid use disorder issue.

5. Adopted the report of the Prescription Drug Coverage (B) Working Group, which met March 24 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its 2024 Fall National Meeting minutes.
   B. Heard a presentation from the HIV+Hepatitis Policy Institute on pharmacy benefit managers (PBMs) and how they function, particularly from the consumer perspective.
   C. Heard a presentation from Segal on pharmacy benefit management.

6. Heard a presentation from the NAIC Legal Division on state prior authorization laws.

7. Heard presentations on the prior authorization issue from the provider, consumer and patient, and industry perspectives.

2025 Spring National Meeting
Indianapolis, Indiana

SENIOR ISSUES (B) TASK FORCE
Monday, March 24, 2025
7:45 – 9:00 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met March 24, 2025. During this meeting, the Task Force:

1. Adopted its Feb. 27 minutes. During this meeting, the Task Force took the following action:
   A. Discussed issues and topics for the Task Force to consider in 2025.

2. Heard an update from the Center for Insurance Policy and Research (CIPR) on its report on evaluating preferences in long-term care insurance (LTCI) reduced benefit options (RBOs).

3. Heard a presentation from the American Academy of Actuaries (Academy) on its issue brief titled *The State of Long-Term Care Insurance—2025*.

4. Heard a presentation from the Coalition Against Insurance Fraud (CAIF) on LTCI fraud.

5. Heard from NAIC consumer representatives on the importance of educating consumers about LTCI benefit options and the need for more discussion and research on disparities, including gender.

Agenda Item #4

Hear an Update on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework)—*Fred Andersen (MN)*

Draft: 1/2/25

Long-Term Care Insurance (B) Task Force
Virtual Meeting
December 18, 2024

The Long-Term Care Insurance (B) Task Force met Dec. 18, 2024. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Barbara D. Richardson (AZ); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Sean Brady and Sydney Sloan (CO); Karima M. Woods represented by Stephen Flick (DC); Gordon I. Ito represented by Kathleen Nakasone (HI); Doug Ommen represented by Klete Geren (IA); Holly W. Lambert represented by Scott Shover (IN); Sharon P. Clark represented by Angela Raley and Shaun Orme (KY); Michael T. Caljouw represented by Mary Hosford (MA); Marie Grant represented by Bradley Boban (MD); Robert L. Carey represented by Marti Hooper (ME); Chlora Lindley-Myers, Cynthia Amann, and William Leung (MO); Mike Causey represented by Tracy Biehn and Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Alice T. Kane represented by Brittany ODell (NM); Scott Kipper (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Lisa Emerson (OR); Michael Humphreys and Dave Yanick (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Bill Huddleston (TN); Cassie Brown represented by Carol Lo (TX); Jon Pike and Tomasz Serbinowski (UT); Scott A. White represented by Dan Bumpas (VA); Kevin Gaffney and Anna Van Fleet (VT); Mike Kreidler represented by John Haworth (WA); Nathan Houdek (WI); Allan L. McVey represented by Joylynn Fix (WV); and Jeff Rude represented by Tana Howard (WY).

1. Adopted its Fall National Meeting Minutes

Commissioner Kipper made a motion, seconded by Amann, to adopt the Task Force's Nov. 17 minutes (*see NAIC Proceedings – Fall 2024, Long-Term Care Insurance (B) Task Force*). The motion passed unanimously.

2. Discussed Comment Letters Received on the Proposed LTCI MSA Framework Revisions

Lombardo said that because there was no consensus among members of the Long-Term Care Actuarial (B) Working Group when the Working Group adopted the proposed cost-sharing formula on Nov. 16, he recommends the Task Force discuss the comments received, defer any vote on adjusting the cost-sharing formula, and instead send the comments to the Working Group to consider further revisions to the formula. He said to achieve the Task Force's goal to provide some level of rate relief for the older age population that has held their long-term care insurance (LTCI) policy for a long duration and has received significant rate increases (referred to as the 85/25/400 issue), he recommends trying to achieve more consensus among members before considering a vote on the cost-sharing formula revisions to the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). Commissioner Kipper, Leung, and Sloan agreed. Lombardo said that since no objection was heard from Task Force members, the comment letters will be sent to the Working Group for further work on the cost-sharing formula beginning in mid-January 2025.

A. Alabama

Lombardo summarized Alabama's comments (Attachment --), which offer an adjustment to the proposed cost-sharing formula for the 300%–400% haircut range.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if Alabama's changes in the cost-sharing haircut levels are intended to be revenue-neutral or provide additional consideration to certain groups of consumers beyond the current considerations. Lombardo said Alabama is proposing to increase the haircut between 300% and 400% versus the exposed proposal, which would put greater emphasis on the insurer and less cost sharing on the consumer between 300% and 400%. That would be for any consumer who has the policy.

Birnbaum asked if the goal is that the additional haircut for some of the higher-rate, longer-term policies be covered by less of a haircut for other types of policies or if the goal is to give more consideration to consumers generally, which will fall in the longer-term, higher-increase groups of policyholders.

Andersen said it is complicated, as there are two parts to the cost-sharing formula. The first part is blending the makeup and "if knew" premium, which helps ensure that every policyholder pays a premium in line with expected benefits and related expenses. That is how regulators can gain comfort that policyholders are not paying more than what they are expected to receive. It is established that, in general, policyholders are not paying more than the expected benefits and related expenses. It is a lot higher than everyone originally thought, and the expected costs are higher. The second part is the additional cost sharing. This current cost-sharing methodology is only for the LTCI MSA Framework and is in Minnesota and perhaps a handful of other states. The new proposal that was exposed would also only apply to the LTCI MSA Framework. He said it would be applied in Minnesota, and states could choose whether to apply it. What is being done in one state might be revenue neutral; however, it may be more or less revenue for the consumer or the company in another state where they are starting from a completely different methodology. A question to discuss is whether the goal is to be revenue-neutral or to have an impact on overall rate increases. An important thing to note is that there is no consistent starting point across all states.

Birnbaum said that when comparing the current cost-sharing formula to the proposed formula in the exposure draft, the exposed formula appears to generate more revenue for insurers. Lombardo said it depends on where the insurer is currently with respect to cumulative increases, specifically if an insurer already has cumulative increases beyond a certain point. The exposed proposal allows for greater increases earlier in the policy life of cumulative increases and lower increases beyond 400%. Birnbaum said it would be useful to look at the impact on specific rate filings companies have made.

B. Academy

Lombardo summarized the American Academy of Actuaries' (Academy's) comments (Attachment --). Lombardo recommended accepting the Academy's recommendation to delete "actuarially justified" and move a sentence in Section VII.A. of the LTCI MSA Framework. Lombardo said he did not recommend accepting the italicized text that the Academy recommended. Hearing no objection, Lombardo said the changes he recommended accepting could be made as they do not pertain to the cost-sharing formula. Andersen and Leung agreed.

C. ACLI and AHIP

Lombardo summarized the joint comment letter from the American Council of Life Insurers (ACLI) and AHIP (Attachment --). He said the two topics included in the letter are already addressed within the text of the current LTCI MSA Framework.

Jan Graeber (ACLI) said it is disappointing that no decision will be made on the cost-sharing adjustments. She said the ACLI thinks the exposed proposal strikes a balance and represents a reasonable step forward in fulfilling the 2024 charge to not only adopt a single methodology but to address large cumulative increases for older-aged policyholders. It also gives industry the predictability and transparency needed to encourage the use of the multistate rate review process. She said sending this topic back to the Working Group prolongs uncertainty,

continues the debate, and provides no resolution; meanwhile, the policyholders continue to age. She said the ACLI thinks it is important to make meaningful progress on these challenges and strongly encourages state insurance regulators to prioritize work to ensure the states are transparent about how they intend to use the multistate rate recommendation in their review process. She said the ACLI understands that the recommendation does not bind states; however, it is critical to know whether the recommendation will at least be considered in state insurance departments' reviews. Graeber said past internal state surveys conducted by state insurance regulators have not been shared with industry, which leaves companies uncertain about the value of participating in the multistate rate review process. She said companies need transparency around state intentions to promote consistency and predictability.

D. Genworth

Lombardo summarized the comments from Genworth Life Insurance Company (Genworth) (Attachment --) on the proposed cost-sharing formula. He said Genworth's letter provides an example of where it would like to see the blending, and it continues to indicate that including the "if knew" premium is non-actuarial.

E. Maryland

Lombardo summarized Maryland's comments (Attachment --), which offer a hybrid version of the current and proposed cost-sharing formulas. Boban said his comment is to keep the existing cost-sharing haircuts and add a new haircut level above 400%. To clarify a point in the comment letter, Andersen said that the cumulative increase gets up to 750% and that the proposed formula produces a lower blended increase; therefore, the pre-cost-sharing number is not something the consumers feel. Boban agreed it is not consumer-facing.

F. Missouri

Lombardo summarized Missouri's comments (Attachment --), which offer an alternative to the proposed cost-sharing formula that Missouri previously proposed. Lombardo said that, as a reminder, the 85/25/400 term was coined as an easy way to describe the cumulative rate increase issue being addressed.

G. Pennsylvania

Yanick summarized Pennylvania's comment letter (Attachment --). Yanick said Pennsylvania understands how the modifications will impact LTCI policyholders and agrees that the insurers' cost-sharing burden should increase as the cumulative rate increases. In addition to the cost-sharing adjustments, state insurance regulators should consider a cap on any aggregate rate increase request at 100%, as many policyholders may not be able to financially support such large increases in premiums. The onus should be placed on the insurers to update their prior experience, examine their future assumptions, and ultimately submit an updated rate filing for review. He said a disclosure could be included within the notification to the policyholder explaining that their rate increase was capped and that additional rate increases will be needed if the experience stays in line with the current assumptions. This would not only help policyholders prepare for future increases but also help them make informed decisions on their reduced benefit options (RBOs).

H. RRC

Lombardo summarized Risk & Regulatory Consulting LLC's (RRC's) comments (Attachment --), a few of which pertain to the proposed cost-sharing formula. Lombardo said comments on phasing-in adjustments from cost-sharing changes to the cost-sharing formula could be part of a discussion at the Working Group level.

Regarding the comments on outreach to consumer advocates, Lombardo said since the work on the LTCI MSA Framework revisions has been held in open session and consumer advocate representatives have already been participating in the process, he does not feel additional outreach is needed.

I. Texas

Lombardo summarized Texas's comments (Attachment --), which offer an alternative to the proposed cost-sharing formula.

J. Washington

Lombardo summarized Washington's comments (Attachment --). He said the Working Group originally discussed the potential for adjusting attained age rate increases so that if an insurer files a 100% rate increase, a greater amount would be shifted to younger attained ages, and a lower amount would be shifted to older attained ages. The Working Group quickly realized that this could raise discrimination issues. Related to this, the insurance pricing was based upon issue age and not attained age, so that probably would not be appropriate for the contractual capability of how rates move by classification.

Haworth said Washington has a lot of closed blocks that are getting close to age 85. Another consideration is that if the majority of the policyholders are reaching 85, state insurance regulators have to look at the company's financial stability.

Serbinowski said metrics that can be used to compare the various proposed cost-sharing formulas from commentors would help state insurance regulators better understand the impact of each proposal.

3. Adopted Proposed Revisions to the LTCI MSA Framework

Andersen recommended the following reviewer's note be included in the LTCI MSA Framework temporarily to recognize the ongoing development of a revised cost-sharing formula and to allow flexibility to address the 85/25/400 issue until the NAIC develops consensus on the cost-sharing formula:

> Appendix C, paragraph 6: "Reviewer's note: The cost-sharing formula (Step 6) was reviewed in 2024 to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. The NAIC is working to develop consensus around exact cost-sharing factors. In the meantime, there may be latitude in applying cost-sharing factors to address this issue."

Hearing no objection, Lombardo said Andersen's recommendation will be accepted.

Commissioner Gaffney made a motion, seconded by Yanick, to adopt proposed revisions to the LTCI MSA Framework, including: 1) revisions to reflect the Minnesota Approach as the single rate review methodology; 2) removing the Texas rate review methodology; 3) proposed editorial changes; 4) revisions accepted during the meeting from the Academy's comment letter; and 5) the proposed reviewer's note. All proposed revisions related to the cost-sharing formula will be excluded (Attachment --). The motion passed, with Texas and Washington objecting and Ohio abstaining.

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

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, and the NAIC Executive Committee and Plenary on [date]. The key amendment is a change from two actuarial rate review methodologies to a single rate review methodology. Other amendments include 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.

Disclosures and Confidentiality Obligations, as Applicable

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

Conflict of Interest Avoidance Procedures and Certifications

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

F. Required NAIC and Compact Resources

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected that NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the 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[4] are incorporated, including the concept that rates will not substantially rise as the block shrinks, as policyholder persistency falls over time.

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

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

Information Required for an MSA Review of a Rate Proposal

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

1. Identify all states for which the product associated with the rate proposal is or has been issued.

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
   a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.

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

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

b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

3. Rate increase history that reflects the filed increase.
   a. Provide the month, year, and percentage amount of all previous rate revisions.
   b. Provide the SERFF MSA numbers associated with all previous rate revisions.

4. Actuarial memorandum justifying the new rate schedule, which includes:
   a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
      i. The projection should be by year.
      ii. Provide the count of covered lives and count of claims incurred by year.
      iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies that should be provided.
      iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
   a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
   b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.
   c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
   d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.

6. Statement that policy design, underwriting, and claims handling practices were considered.
   a. Show how benefit features (e.g., inflation and length of benefit period) and premium features (e.g., limited pay and lifetime pay) impact requested increases.
   b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
   c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

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, <u>all</u> 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 <u>active</u> 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. No haircut for the first 15%.
      ii. 10% for the portion of cumulative rate increase between 15% and 50%.
      iii. 25% for the portion of cumulative rate increase between 50% and 100%.
      iv. 35% for the portion of cumulative rate increase between 100% and 150%.
      v. 50% for the portion of cumulative rate increase in excess of 150%.

   Reviewers note: The cost-sharing formula (Step 6) was reviewed in 2024 to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. The NAIC is working to develop consensus around exact cost-sharing factors. In the meantime, there may be latitude in applying cost-sharing factors to address this issue.

7. Reduction for past rate increase:
   a. Take 1 plus the cost-sharing-adjusted blend amount and divide by 1 plus the previous, cumulative rate increases, then subtract 1. This is the approvable rate increase.

8. Summary.
    a. Review current assumptions.
    b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
    c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
    d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
    e. Apply the cost-sharing formula to the blended amount.
    f. Deduct past rate increases.
    g. Example – if:
        i. The original premium is $1,000
        ii. Makeup premium is $3,000.
        iii. If-knew premium is $1,500.
        iv. 60% of policyholders remain.
        v. Past rate increases are 50%:
        vi. Blended amount is:
            1. $3,000 / $1,000 * 0.60 +
            2. $1,500 / $1,000 * 0.40
            3. – 1 =
            4. 180% + 60% – 1 = 240% – 1 = 140%
        vii. Cost sharing is:
            1. 100% * 1.000.15 +
            2. 90% * 0.35 +
            3. 75% * 0.5 +
            4. 65% * 90.4 =
            5. 110%
        viii. Deduction for past rate increases results in:
            1. (1 + 1.1) / (1 + 5) – 1 =
            2. 40%

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.

<u>Principles and Issues</u>

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.

<u>Widely Established RBOs in Lieu of Rate Increases</u>

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.

<u>Less Common RBOs for Potential Discussion</u>

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

Filing Rate Action Letters

Insurers should consider:

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

Readability and Accessibility

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
- Presenting the RBOs in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
- Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.

- Using illustrative tools, such as bullet points or illustrations, as appropriate, and graphs or charts enabling a side-by-side comparison.
- Including definitions of complex terms; and if a term, subject, or warning is repeated throughout the communication, consider making the language consistent throughout the document.
- Including a Q&A section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or policyholders for whom English is not a first language.

Identification

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

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

Communication Touch and Tone

Insurers should consider:

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

Consultation and Contact Information

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

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

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

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

Understanding Policy Options

Insurers should consider the presentation of the communication by:

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

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

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

Insurers should consider including disclosures regarding rate increase history by:

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

Insurers should consider advising policyholders of their current benefits:

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

Insurers should consider personal needs decision-making by:

- Only listing RBOs that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact LTC costs, such as:
  - The average cost of care for in-home care, assisted living, and nursing home care in their area.

  - The inflation rate of the cost of care for in-home and nursing home care in their area.
  - The average age and duration of an LTC claim for in-home and nursing home care.
  - Factors that influence the age, duration, and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
  - Buyout or cash-out disclosures.
    - The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

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

- Providing a series of questions to help policyholders contemplate the implications of each action, such as:

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

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

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

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT[7]

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

Executive Summary

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 34% 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]. Starting in the first half of 2020, the MSA Team accepted rate increase proposals as part of a pilot program. The MSA Review became operational on [insert date].

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

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

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

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

Workstream-Related Review Aspects

Actuarial Review

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): 12%
- Recommended cumulative rate increase since issue: 109%
  - = (1 - 0.12) * 1.23, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%
  - = (1 + 1.09) / (1 + 0.55) – 1, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
  - Minimum of calculated approval rate of 35% and insurer proposal of 60%.
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the 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**	**2021 Recommended Rate Incr**
Example: state with average past approvals	55%	0%	35%	**35%**
Example: state with lower than average past approvals	27%	22%	35%	**65%**
*The recommendation for each state is based on the actual past cumulative approved increases in that state.				

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

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

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

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

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

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

Agenda Item #5

Hear a Discussion on the Enhanced Federal Affordable Care Act (ACA) Premium Subsidies Issue—*Jessica Altman (Covered California)*

The Impact of Enhanced Tax Credits

March 2025

MARKETPLACE OVERVIEW: FILLING THE COVERAGE GAPS

Expanding Affordable Coverage: The Affordable Care Act (ACA) created health insurance marketplaces for individuals who do not have other sources of affordable coverage to purchase coverage on their own, including those losing Medicaid, self-employed individuals without employer coverage, or early retirees not yet eligible for Medicare. These marketplaces, also known as exchanges, provide a platform where individuals can shop for and purchase health insurance plans.

Marketplace Milestone: A groundbreaking achievement was reached with Marketplace enrollment soaring to a record-breaking 24.2 million people.[1] This represents an impressive growth, more than double compared to the 2021 Open Enrollment Period[1].

Widespread Impact: Nearly 1 in 7 U.S. residents have benefited from a Marketplace plan at some point[3]. As of 2024, Marketplace enrollment surpassed Medicaid expansion enrollment (21.4 million enrollees in Marketplace, compared to 21.3 million enrollees in Medicaid expansion).[2]

COVERED CALIFORNIA

Citation: 1. Centers for Medicare & Medicaid Services. (2025). Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025. https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025
2. Tolbert, J., Bell, C., Cox, C., Ortaliza, J., & Rudowitz, R. (2025). A Look at ACA Coverage through the Marketplaces and Medicaid Expansion Ahead of Potential Policy Changes. *Kaiser Family Foundation*.
3. U.S. Department of the Treasury. (2024). People Enrolled in ACA Marketplace Coverage, 2014-2024. Retrieved from https://home.treasury.gov/system/files/131/People-Enrolled-ACA-Mkt-Coverage-2014-24-09032024.pdf

EXPANDED AFFORDABILITY FROM THE ENHANCED TAX CREDITS

Passed in 2021, the American Rescue Plan Act provided enhanced tax credits, which have dramatically increased affordability for marketplace consumers by:

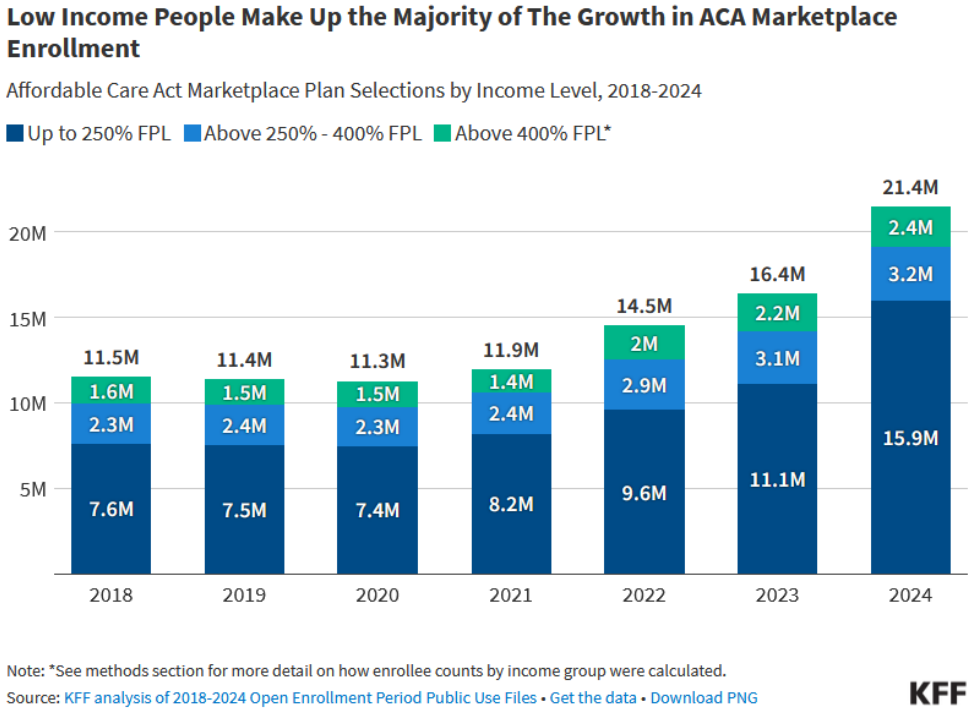
- Increasing the amount of tax credits available for low-income enrollees, e.g. individuals earning between $15,060 and $60,240
- Eliminating the “cliff” for middle-income enrollees, e.g. individuals earning $60,240 above who were previously ineligible for any tax credits

Originally set to expire at the end of 2022, the Inflation Reduction Act (IRA) of 2022 extended the enhanced tax credits through 2025, acknowledging their significant impact. The enhanced tax credits reduced premium payments by an average 44% per enrollee. Congressional inaction would take away this tax credit from low-income and middle-income families struggling to make ends meet.

Kaiser Family Foundation. (2024). Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?

ENHANCED TAX CREDITS HAVE RESULTED IN SUBSTANTIAL GROWTH IN MARKETPLACE ENROLLMENT

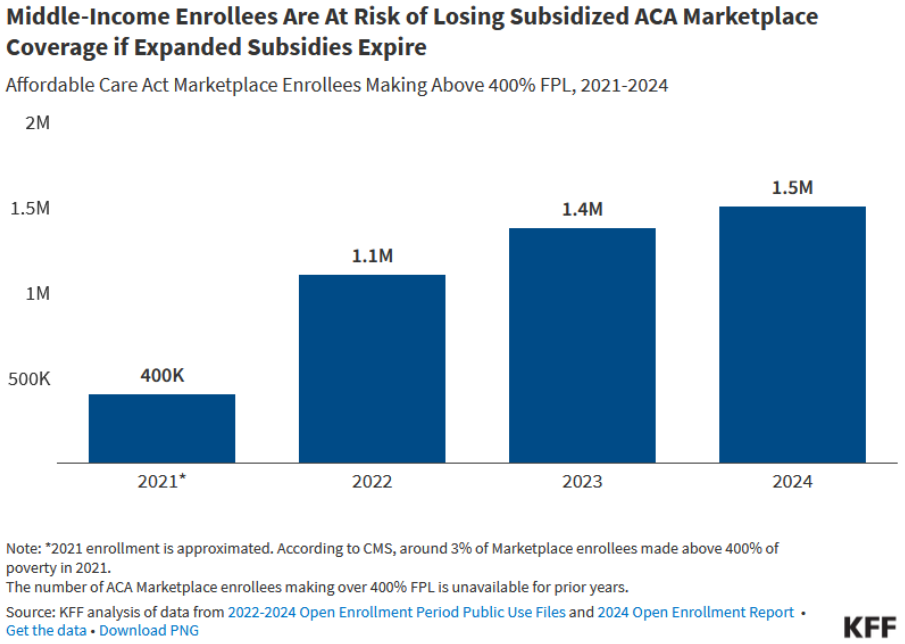
- Approaching the end of the 2025 Open Enrollment cycle, more than 24 million individuals signed up for coverage – the highest count yet for an Open Enrollment period.
- That represents a nearly 14% increase in sign-ups from 2024, without yet including the remaining weeks of Open Enrollment for many state-based marketplaces.



Plan selections counts represent 'net' plan selections, excluding consumers in a cancelled or pending status.

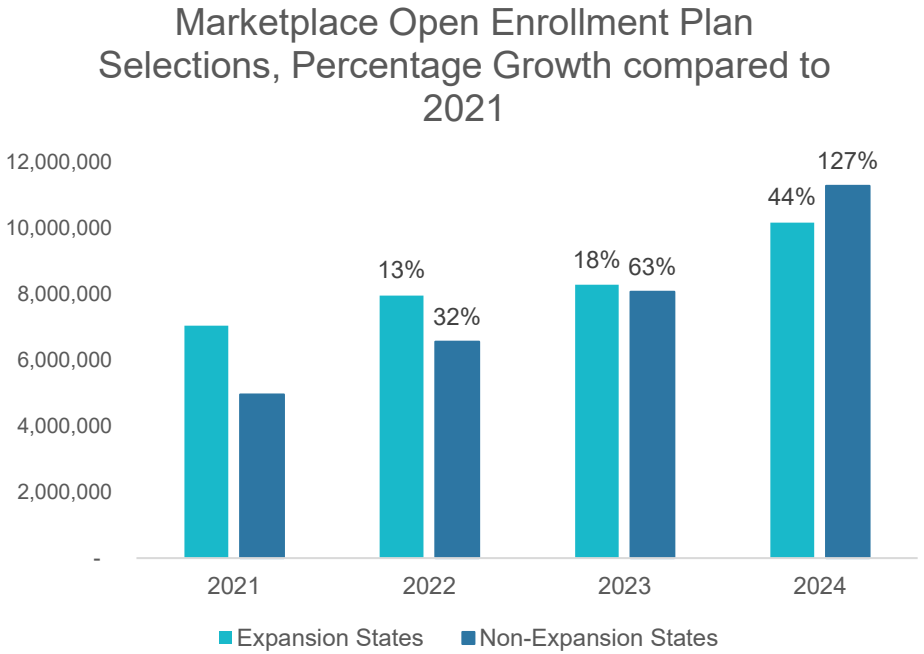
ENROLLMENT AMONG MIDDLE-INCOME CONSUMERS HAS NEARLY DOUBLED SINCE 2021

- The expansion in eligibility for tax credits to middle income consumers has resulted in substantial enrollment growth among this group.
- Since 2021, enrollment has more than tripled among those with incomes over 400% FPL (or $60,240 for an individual in 2025).



IMPACT ON ENROLLMENT FOR STATES THAT HAVE NOT EXPANDED MEDICAID

- Ten states have not expanded Medicaid eligibility to allow people with incomes below 138% of FPL to enroll in Medicaid (roughly $22,000 for an individual). Without expansion, only individuals earning over 100% of FPL ($15,060) may enroll in marketplace coverage with ACA tax credits.
- The enhanced tax credits have provided a level of affordability that has allowed many residents of these states between 100-138% FPL to enroll in the marketplace, the only coverage option available to many of them.
- Enrollment growth since implementation of the enhanced tax credits has been highest in these ten states, growing 127% since 2021.



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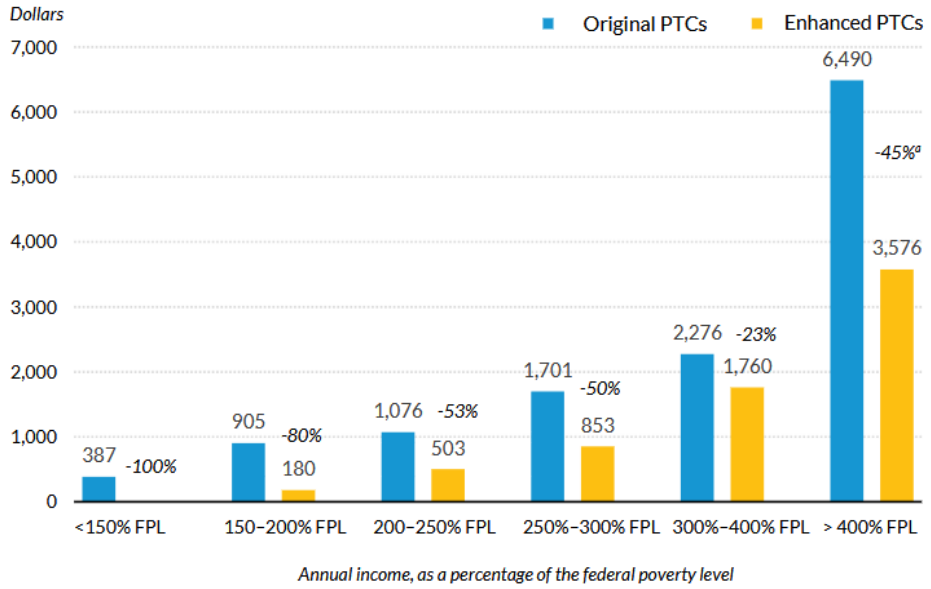
The ten states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, and Wyoming. Source for plan selections: https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf

NATIONWIDE IMPACT TO AFFORDABILITY

- If the enhanced tax credits expire, almost all ACA Marketplace enrollees will experience steep increases in premium payments in 2026, with an average increase of 93%.[1]
- Without enhanced tax credits, Marketplace participants with very low incomes (earning less than $23,000 annually) would pay an average of $387 per year in premiums; under enhanced tax credits, they would pay no premium.
- The average person with an income above $60,240 (400% FPL), who would lose eligibility for enhanced tax credits, would pay over $2,900 more in premiums if they keep Marketplace coverage.

Projected Average Annual Premiums Paid by People with Subsidized Marketplace Coverage under Original and Enhanced Premium Tax Credits, by Federal Poverty Level Category, 2025

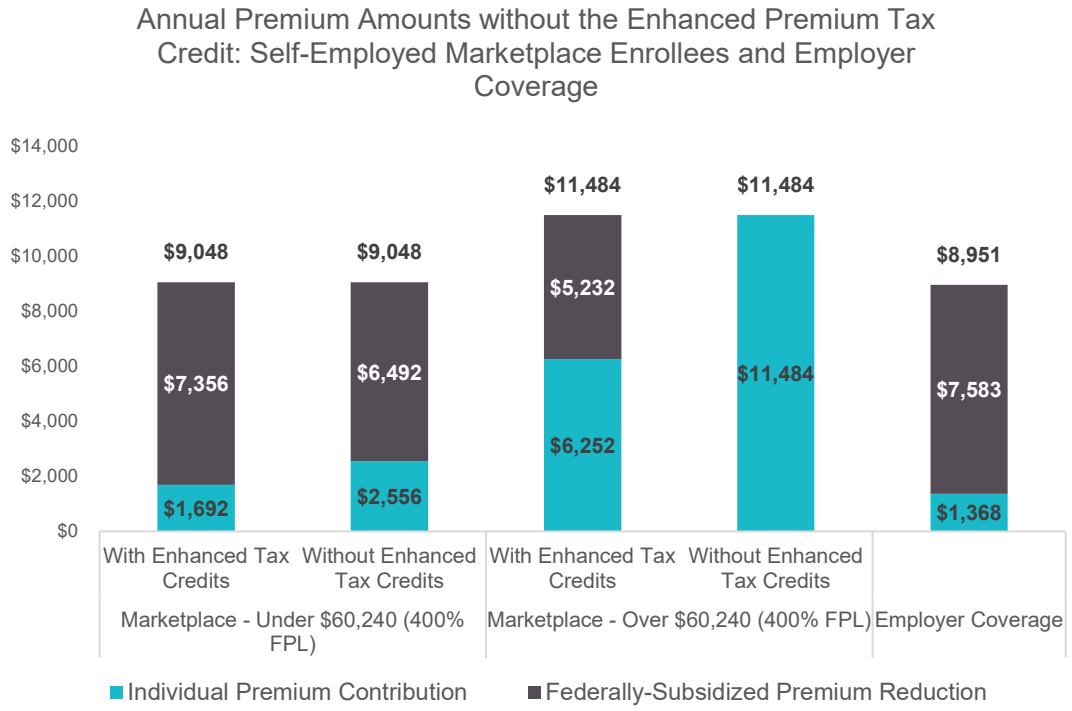


URBAN INSTITUTE

Citation: 1. Kaiser Family Foundation. (2024). Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?
2. Urban Institute. (2024). Who would Lose Coverage If Enhanced Premium Tax Credits Expire? Retrieved from: Who Would Lose Coverage If Enhanced Premium Tax Credits Expire? | Urban Institute

TAX CREDITS ENSURE AFFORDABLE COVERAGE FOR SELF-EMPLOYED CONSUMERS (CA DATA)

- More than 500,000 enrollees in California receiving tax credits are self-employed, saving an additional $106 per month on their premium costs.
- Subsidized coverage is particularly important for these consumers as they are not eligible for other sources of coverage, such as through an employer, and must rely on the individual market for coverage.
- Employed workers pay an average of $1,368 per year in premiums. Without enhanced tax credits, middle income self-employed workers in CA would be asked to pay an average of nearly $1,000 per month.

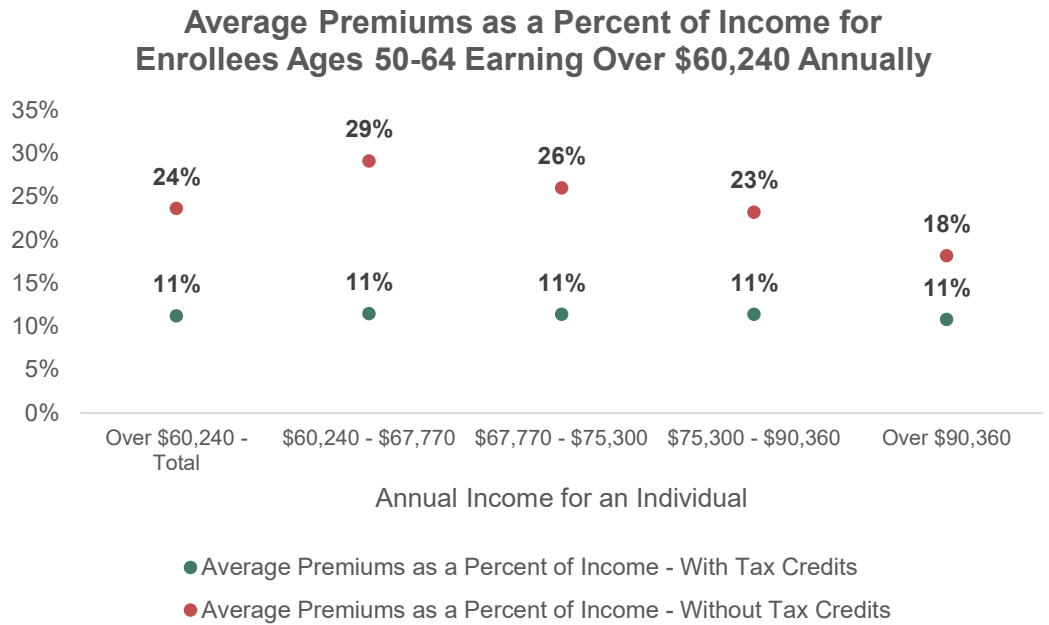


COVERED CALIFORNIA

Source: Snapshot of January 2025 Covered California among individuals receiving monthly APTC. Employer data source: 2024 Employer Health Benefits Survey. KFF 2024. https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/

OLDER ENROLLEES COULD PAY MORE THAN A QUARTER OF THEIR HOUSEHOLD INCOME (CA DATA)

- Marketplaces provide an important bridge between retirement and Medicare for enrollees ages 55-64.
- Premiums are expected to double or more for enrollees ages 55-64 earning over $60,240 annually, costing as much as $1,193 per month in California.
- For some enrollees, this can consume as much as 29% of their annual incomes.



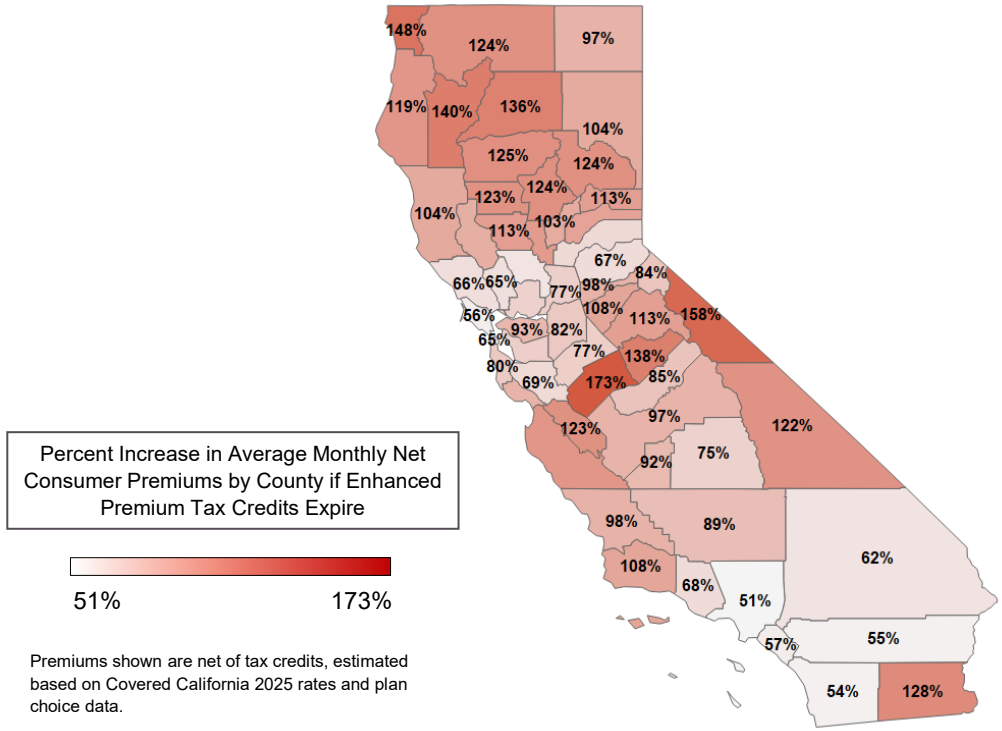
Source: Snapshot of January 2025 Covered California among individuals receiving monthly APTC.

PREMIUM INCREASES VARY SIGNIFICANTLY BY REGION (CA DATA)

- On average, Californians across the state will see their monthly premiums increase by 66%.

- However, over 96,000 individuals living in rural areas will see monthly premiums increase by an average of $133, compared to increases of $100 for individuals living in urban areas.

  - As a percent, rural consumers will see premiums increase by an average of 95%, while urban consumers will see a 65% increase.



Premiums shown are net of tax credits, estimated based on Covered California 2025 rates and plan choice data.

Source: Snapshot of January 2025 Covered California among individuals receiving monthly APTC.

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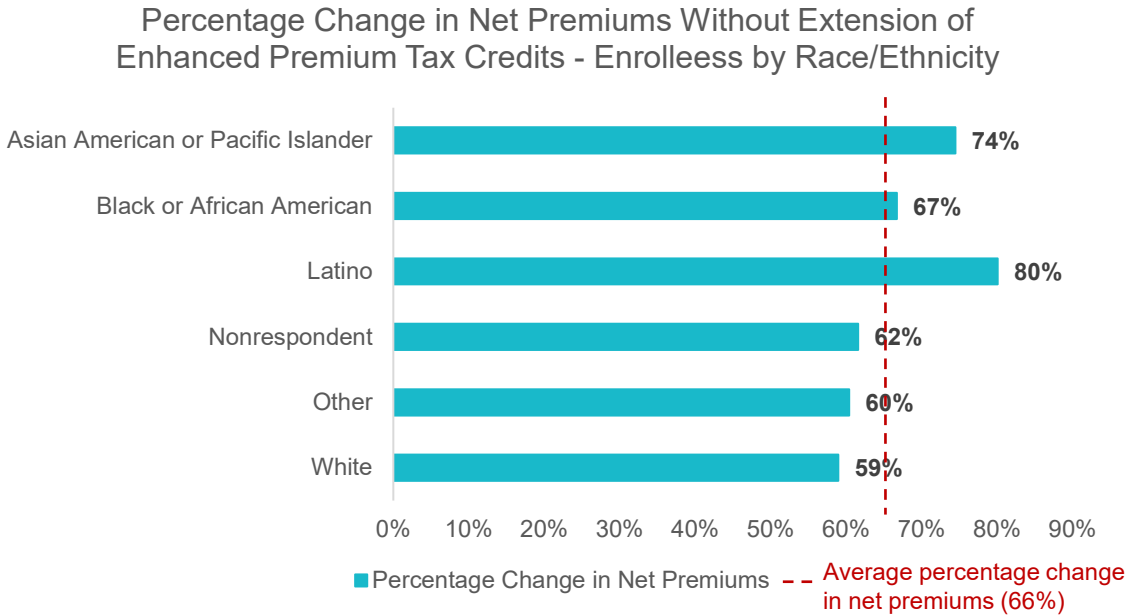
COMMUNITIES OF COLOR FACE LARGEST INCREASES IN PREMIUMS (CA DATA)

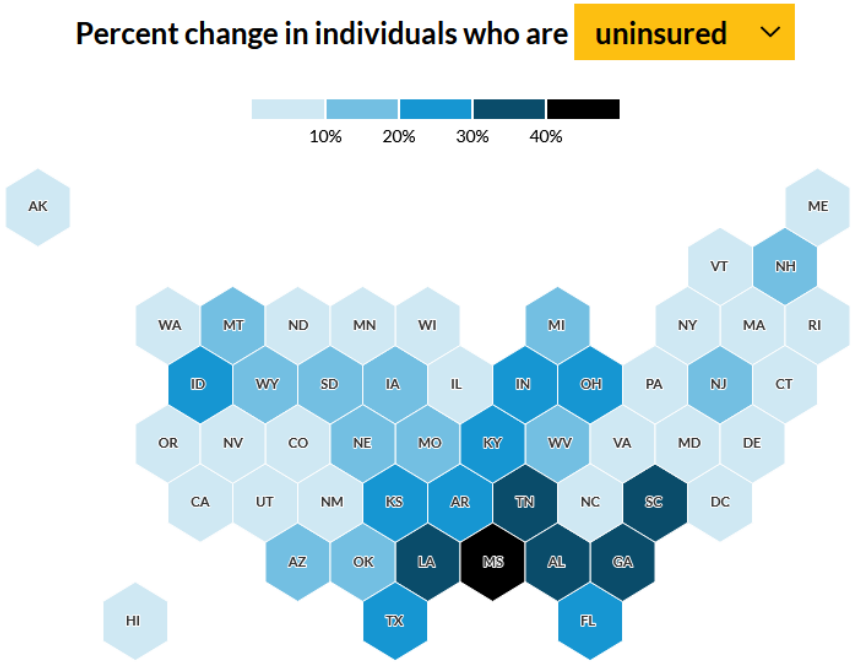
- While Covered California subsidized enrollees face an average 66% increase, premiums will increase more for communities of color.
- Communities that had some of the highest gains in enrollment since 2020 will face the greatest threats to affordable coverage without the enhanced tax credits.



Source: Snapshot of January 2025 Covered California among individuals receiving monthly APTC.

ENDING THE ENHANCED TAX CREDITS WILL INCREASE UNINSURANCE

- It is projected that 4 million individuals will lose their health insurance coverage in 2026 if enhanced tax credits are ended.[1]
- The ten states that did not expand Medicaid will see larger increases in their uninsured populations.
- Consumers expect the current level of affordability. In Covered California, the majority of current enrollees (54%) have only had marketplace coverage with the expanded affordability of the enhanced tax credits.



Citation: 1. Urban Institute. (2024). Who would Lose Coverage If Enhanced Premium Tax Credits Expire? Retrieved from: Who Would Lose Coverage If Enhanced Premium Tax Credits Expire? | Urban Institute

ENDING ENHANCED TAX CREDITS WILL HAVE BROAD IMPACTS

- Expiration of enhanced tax credits is projected to trigger a ripple effect throughout the entire health care industry.[1]

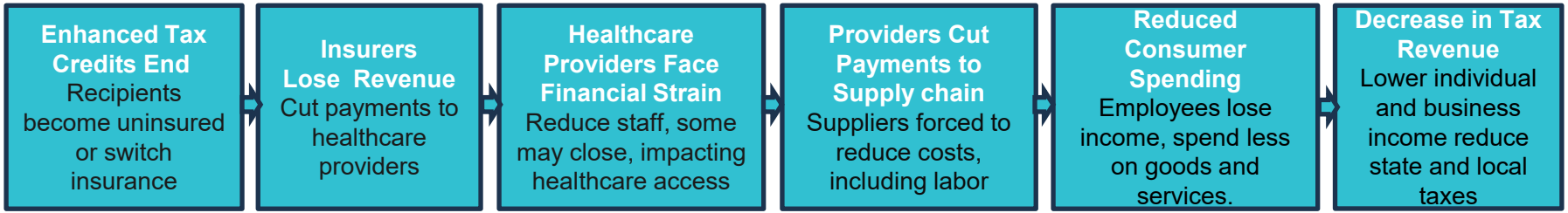


Fig. The dynamics of this ripple effect if ePTC disappear, adapted from Leighton et al. (2025)

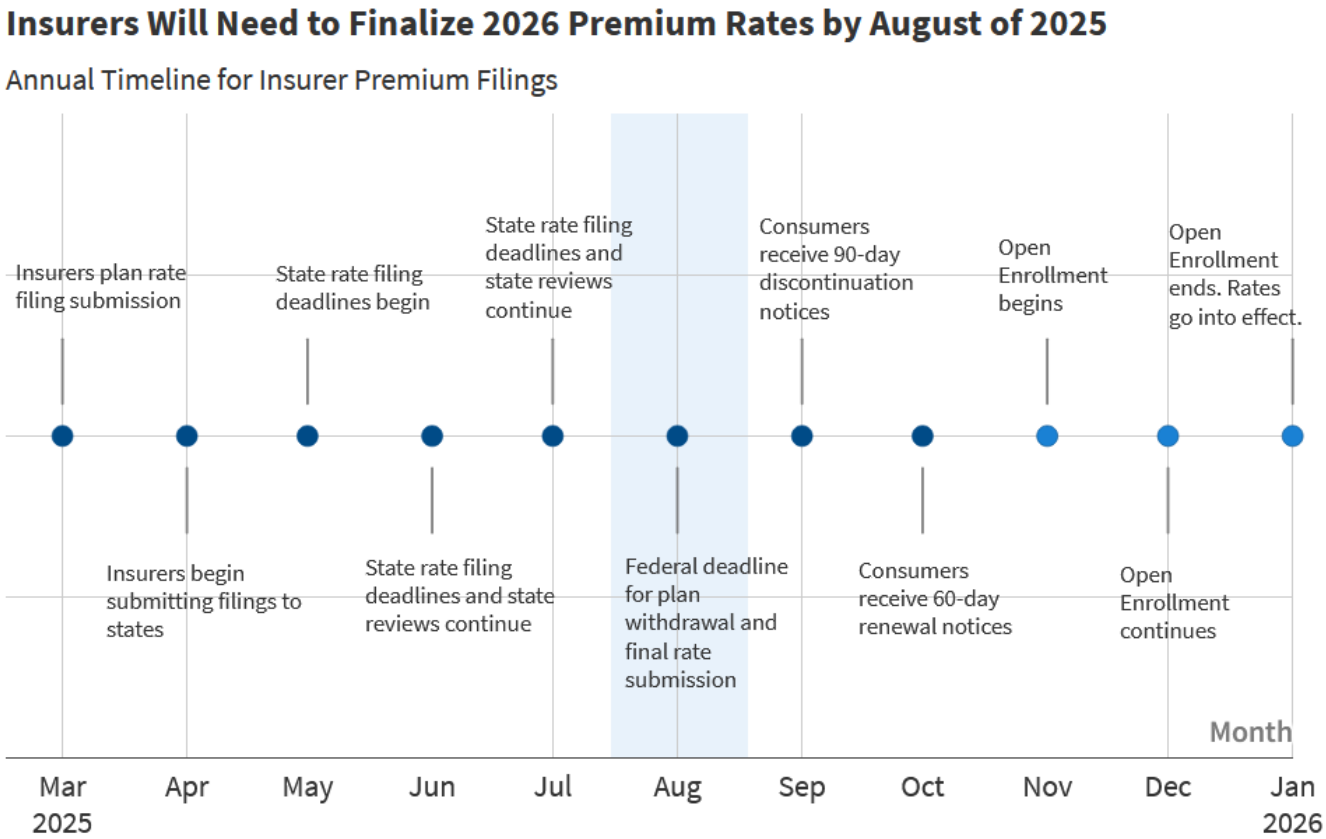
- **Significant Economic Impact by 2026**: The analysis anticipates a substantial downturn, with a $26.1 billion decrease in federal tax credits. Predictions include a $34.1 billion drop in state GDPs, a $57.0 billion decline in economic output, and a nationwide loss of 286,000 jobs[1].

- These estimates do not consider the significant broad impacts that would result from changes or federal funding reductions to Medicaid.

COVERED CALIFORNIA

Citation: 1. Leighton Ku et al., (2025) *The Cost of Eliminating the Enhanced Premium Tax Credits: Economic, Employment, and Tax Consequences* (Commonwealth Fund, Mar. 2025). https://doi.org/10.26099/1arx-7a88

TIMING CONSIDERATIONS FOR OPEN ENROLLMENT 2026



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Source: KFF https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/

STATE REGULATOR CONSIDERATIONS

- **Market Instability** – Enrollment losses resulting from the end of these enhanced tax credits will have a destabilizing impact on individual markets. Risk pool degradation due to healthier consumers disenrolling and associated premium growth are anticipated, and states should be aware of any potential changes to insurer participation as a result.

- **Plan and Rate Filing Approaches Given Uncertainty** – It is unlikely there will be certainty on the extension of the enhanced subsidies by the time plans and rates are filed for 2025. State regulators will need to work with plans and consider strategies that account for all contingencies (two sets of rates, etc.).

- **Interplay with Other State Initiatives (1332s, state affordability programs, BHPs)** – Loss of the enhanced tax credits may impact funding for other existing state initiatives such as 1332 waivers and BHPs. Some states may also consider new or alter existing state affordability programs.

- **Coordination with State-Based Marketplaces** – State-based marketplaces will be navigating significant operational challenges, including system changes, consumer notification and support, and potentially significant revenue reductions as most are funded through PMPM user fees.

CONCLUSION AND TAKEAWAYS

- ❑ If the enhanced tax credits expire at the end of 2025, health care premiums will rise, on average, by 93% for marketplace enrollees, while middle-income enrollees (making more than $60,240 annually) will lose eligibility for tax credits entirely.
- ❑ As estimated 4 million Americans will lose health insurance entirely.
- ❑ Timely action to extend the enhanced tax credits would prevent premium spikes and guard against market instability.

Sources: https://www.urban.org/data-tools/health-insurance-premium-tax-credit
https://americanscovered.org/about/about-the-issue/

FOR QUESTIONS OR TO REQUEST MORE INFORMATION, PLEASE CONTACT:

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Agenda Item #6

Hear a Status Update on the Braidwood Management Inc. v. Becerra Case—*Sabrina Corlette (Georgetown University Center on Health Insurance Reforms [CHIR])*

National Association of Insurance Commissioners

2025 Spring National Meeting
March 26, 2025

Uncertainty for the Affordable Care Act's Preventive Services Benefit: A Roadmap for States to Protect Consumers

Georgetown University
Center on Health Insurance Reforms (CHIR)
Sabrina Corlette, J.D.

GEORGETOWN UNIVERSITY
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CENTER ON HEALTH INSURANCE REFORMS

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Georgetown University Center on Health Insurance Reforms

Nationally recognized health insurance experts

- Part of McCourt School of Public Policy
- Legal & policy analysis
  - Laws and regulations
  - Market trends
- Published reports, studies, blog posts, white papers
- Technical assistance

Support for this presentation was provided by the Robert Wood Johnson Foundation's State Health & Value Strategies project. The views expressed here do not necessarily reflect the views of the Foundation.

ACA Preventive Services Benefit: Level Set

- Group health plans and issuers must cover, without cost-sharing:
  - Preventive services recommended with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF);
  - Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP); and
  - Women's and children's preventive services recommended by the Health Resource and Services Administration (HRSA)
- ~151M Americans have access to free preventive care
- Covered services include screenings for cancer, hypertension, diabetes, substance use and depression; pre-natal services, well-woman and child visits, and contraception

Legal and Administrative Risks to Preventive Services Access

- *Braidwood Management, Inc. v. Kennedy*
  - SCOTUS decision expected June or July 2025
  - Oral arguments April 21
  - At issue: do members of USPSTF need to be nominated by the President and approved by the Senate?
  - Trump administration continues to defend law
  - Amici include provider organizations, patient groups, state AGs, public health officials, and more
- Administrative risks
  - Secretary can remove, appoint new members at will
  - Secretary is responsible for final decisions on recommended items and services

Preserving Preventive Services Access: Legislative Options

States enforce, oversee protections for state-regulated plans

- Codify Sec. 2713 into state law
  - At least 15 states have already done so
- Review state statutes in light of current risks
- Consider state fallback if federal recommendation process is halted or weakened

Preserving Preventive Services Access: Administrative Options

- Review EHB
  - Ensure inclusion of recommended items and services
  - Require issuers to adhere to recommendations regarding service frequency, target populations, target age ranges
- Leveraging standardized plans
  - 13 SBMs require standardized health plans
  - Ensure plans include $0 cost-sharing for high-value preventive benefits
- Market Oversight and Communications
  - Enforce existing law
  - Monitor changes in benefit design
  - Require advance notice for consumers and policyholders of benefit design changes
  - Inform lawmakers and the public about changes in benefit design that reduce access

Questions?

State Health & Value Strategies Roadmap

By Sabrina Corlette and Tara Straw

https://www.shvs.org/protecting-access-to-preventive-services-a-state-roadmap/

State Health & Value Strategies

https://www.shvs.org/

Georgetown University Center on Health Insurance Reforms

https://chir.georgetown.edu/

Manatt Health

https://www.manatt.com/health

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PREVENTIVE SERVICES MANDATE LITIGATION
STATUS UPDATE FOR
KENNEDY v. BRAIDWOOD MANAGEMENT, INC.

U.S. Supreme Court Status. Petition for Writ of Certiorari was filed on September 19, 2024, by the Secretary of Health and Human Services, Xavier Becerra (Petitioner). The Petitioner is now captioned as Robert F. Kennedy, Jr. U.S. Supreme Court granted certiorari on January 10, 2025. Oral argument is scheduled for April 21, 2025.

Respondents. Six individuals and two businesses that want the option to purchase health insurance that excludes or limits coverage of currently required preventive care that they consider to be not wanted or needed (in particular contraceptives, PrEP, and mandated no cost-sharing). Braidwood Management is a self-insured for-profit Christian company providing health coverage for 70 employees.

Question Presented. Whether the Fifth Circuit Court of Appeals erred in holding that the structure of the ACA's U.S. Preventive Services Task Force (USPSTF) violates the Appointments Clause of the U.S. Constitution, Article II, Section 2, and Clause 2 (relating to "Officers" of the United States).

Federal District Court, ND Texas. September 7, 2022, the court ruled that the members of the USFSTF are "Officers" of the United States due to their independence and significant unreviewable authority to issue directives having the force and effect of law. Their selection must undergo presidential appointment and Senate confirmation but did not as is required by the Appointments Clause. The district court vacated the preventive services recommendations and enjoined the enforcement nationwide.

Fifth Circuit Court of Appeals. June 21, 2024, the court affirmed the district court's ruling with respect to the Appointments Clause violation. However, the court ruled that the district court erred with respect to broadly vacating all agency enforcement and erred in issuing a nationwide injunction. The court of appeals enjoined government from enforcing the requirements only against the specific plaintiffs who are challenging the USPSTF recommendations. This is because Braidwood did not make a claim under the APA that would have allowed "vacatur".

Trump Administration Arguments. On February 18, 2025, the Trump Administration filed its brief at the Supreme Court. Like the Biden Administration, the brief argues that the USPSTF members are not Principal Officers but are Inferior Officers because: (1) they can be removed at-will by the Secretary of HHS (a Principal Officer); and (2) the Secretary is responsible for and can delay the legally binding nature of the task force's recommendations. The brief also argues that the statutory "non-reviewability" of the task force recommendations was "severable."

Agenda Item #7

Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities
—Peter Nelson (CCIIO)

Agenda Item #8

Hear a Discussion on Next Steps for Transitioning the Special (EX) Committee on Race and Insurance's Health Workstream's Work to the Committee—*Commissioner Grace Arnold (MN)*

Agenda Item #9

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