Draft date: 8/7/23

2023 Summer National Meeting
Seattle, Washington

LONG-TERM CARE ACTUARIAL (B) WORKING GROUP
Saturday, August 12, 2023
12:30 – 2:00 p.m.
Columbia Ballroom CD - Level 3 - Hyatt Regency Seattle

ROLL CALL

Paul Lombardo, Co-Chair	Connecticut	Michael Muldoon	Nebraska
Fred Andersen, Co-Chair	Minnesota	Anna Krylova	New Mexico
Charles Hale	Alabama	Jennifer Li	New Hampshire
Ahmad Kamil	California	Bill Carmello	New York
Benjamin Ben	Florida	Laura Miller	Ohio
Weston Trexler	Idaho	Andrew Schallhorn	Oklahoma
Nicole Boyd	Kansas	Jim Laverty	Pennsylvania
Marti Hooper	Maine	Andrew Dvorine	South Carolina
Kevin Dyke	Michigan	Aaron Hodges	Texas
William Leung	Missouri	Tomasz Serbinowski	Utah

NAIC Support Staff: Eric King

AGENDA

1. Consider Adoption of its July 19, June 7, and May 1 Minutes — Attachment A
   —Fred Andersen (MN) and Paul Lombardo (CT)

2. Discuss Drafting Changes to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual* to add Tables from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute's Final LTCI Mortality and Lapse Study
   —Fred Andersen (MN) and Paul Lombardo (CT)

3. Discuss a Referral from the Health Risk-Based Capital (E) Working Group Regarding *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) — Attachment B
   —Fred Andersen (MN) and Paul Lombardo (CT)

4. Hear a Presentation on Public/Private Long-Term Care (LTC) Funding Solutions —*Steve Schoonveld (FTI Consulting)* — Attachment C

5. Hear an Update on a Single Long-Term Care Insurance (LTCI) Multistate Rate Review Approach—*Fred Andersen (MN) and Paul Lombardo (CT)*

6. Discuss Any Other Matters Brought Before the Working Group — *Fred Andersen (MN) and Paul Lombardo (CT)*

7. Adjournment

Draft: 8/2/23

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
July 19, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met July 19, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Ahmad Kamil (CA); Lilyan Zhang (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); Michael Muldoon (NE); Jennifer Li (NH); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman (OH); Jim Laverty (PA); Andrew Dvorine (SC); Aaron Hodges and R. Michael Markham (TX); and Tomasz Serbinowski (UT).

1. Discussed Comments Received on a Request for Comments on Various LTCI Rate Increase Review Methodologies

Andersen said the Working Group exposed a request for comments on the Minnesota and Texas approaches, as described in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) and the Utah proposal (Attachment) for an alternative approach to LTCI rate increase reviews. He said the comments received will be discussed in the context of developing a single actuarial approach to multistate long-term care insurance (LTCI) rate increase reviews and that the Working Group will continue this discussion during its Aug. 12 meeting. He said the Utah proposal reflects adjustments to the Minnesota approach, with the primary adjustments being the absence of an explicit cost-sharing provision and a faster grading by duration of the lower if-knew premium from the higher make-up premium during the blending process. He said initial informal testing of the Utah proposal indicates higher rate increases early in a product's life and lower increases later when compared to the Minnesota and Texas approaches.

Andersen said comments were received from the Colorado Division of Insurance (Attachment), the Texas Department of Insurance (DOI) (Attachment), and the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment). Markham gave an overview of the Texas DOI comments.

Jan Graeber (ACLI) gave an overview of the ACLI/AHIP comments. Lombardo said that if a single actuarial approach is ultimately adopted, there will still be flexibility to modify it in the future if state insurance regulators and interested parties determine it needs to be. Andersen said any proposed single approach will need to be adopted by the Working Group and the Long-Term Care Insurance (EX) Task Force before it will be implemented as part of the LTCI MSA Framework. Serbinowski said he is concerned that adequacy of premiums may be given too much weight in assessing an actuarial approach and that by using this as a criterion, rate increases may be denied due to the inadequacy of resulting premiums. He said that rate adequacy can be achieved by increasing active life reserves for the block of policies. Leung said that if what is considered an excessive premium cannot be objectively defined, applying whether a premium is excessive as an evaluation criterion will be difficult. Andersen said the Minnesota approach, and he assumes the Texas approach, verifies that the total of premiums paid over time do not exceed the expected benefits and expenses to be paid over time. Lombardo said there should never be a situation where potential benefits paid are less than potential premiums. He said there needs to be a mechanism in any approach used that lessens the increase for policyholders at later policy durations, as they have likely paid more in cumulative rate increases than policyholders at earlier durations. Andersen said it is possible to modify the Minnesota approach to account for this by increasing the cost sharing for insurers for policies at later durations and decreasing insurer cost sharing at earlier durations. He said the Working Group will discuss this further during its Aug. 12 meeting. Serbinowski said the Working Group should also discuss the impact of waiver of premium and the interest rate to be used in the approach.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023_Summer/07-19-23 LTCAWG/Minutes_LTCAWG_07-19-23.docx

Draft: 7/3/23

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
June 7, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met June 7, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Ahmad Kamil (CA); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); William Leung (MO); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman and Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Aaron Hodges (TX); and Tomasz Serbinowski (UT).

1. Discussed Comments Received on Exposures of Ideas for a Single LTCI Rate Increase Review Methodology

Andersen said the Working Group exposed a request for comments on ideas (Attachment) for a single, improved long-term care insurance (LTCI) rate review methodology approach for use in multistate actuarial (MSA) filing reviews. He said a methodology that the Utah Insurance Department (Attachment) proposed was also exposed for comment. He said comments were received from the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment), as well as from the Virginia Bureau of Insurance (Attachment).

Serbinowski gave an overview of the Utah proposal. Andersen said the Utah proposal will need to be tested to compare its results to the currently used Minnesota and Texas approaches.

Jan Graeber (ACLI) gave an overview of the ACLI/AHIP comments. Serbinowski said that a metric will need to be established to evaluate whether an approach satisfies ACLI/AHIP's proposed guiding principle 1 and that it is difficult to say what is intended. Graeber said the intent is not to have specific criteria for evaluating this, but rather to determine what a given approach uses to judge the reasonableness of premiums in relation to benefits and use this as the evaluation standard. Miller said that if these principles are to be used to evaluate an approach, the criteria for principle 2 will need to be elaborated upon.

Miller said that there will need to be more detail as to what is considered an appropriate balance for principle 3. Andersen said that any difference between the makeup premium and the approved increased premium is a cost-sharing element in the Minnesota approach.

Andersen said the ACLI/AHIP guiding principles will not be exposed for comment, but may be used by the Working Group in developing a set of principles if it is decided it is needed.

Serbinowski said defining "classes of insured" as used in principle 9 could be difficult.

Referring to principle 10, Trexler and Boyd said it needs to be determined if rate increases should continue to be allowed to include a margin for moderately adverse experience.

Andersen said comments from the Virginia Bureau of Insurance will be addressed at the Working Group's next meeting. Serbinowski said he can address in writing questions asked about the Utah approach in the comments.

Andersen said he is hesitant for the Working Group to adopt a set of principles for evaluating LTCI rate review methodology approaches. He asked if the Working Group should further examine the proposed Utah approach, including comparing its results to the Minnesota and Texas approaches, and if it is helpful and necessary to produce a set of principles before it produces a single approach. Lombardo said the Working Group should focus

on evaluating whether the Utah approach is one that could be adopted for use in MSA reviews. He said he does not think the Working Group necessarily needs to adopt a set of principles, but that it should ask questions similar to those that the ACLI/AHIP proposed when an approach is evaluated.

2. Exposed Three MSA Actuarial Approaches

Andersen said the Working Group will expose the Minnesota, Texas, and Utah approaches for a 30-day public comment period ending July 10. He said one option for the form of comments being sought is a scorecard assessing the approaches' success in meeting key principles. He said these principles can be from the list provided in the ACLI/AHIP comment letter or as developed or thought of by the commenter. He said the other option is assessment of the rate increase amounts resulting from the three approaches, including for various types of situations, such as older and newer business, or blocks with short or lengthy rate increase histories.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023_Summer/06-07-23 LTCAWG/Minutes_LTCAWG_06-07-23.docx

Draft: 5/12/23

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
May 1, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met May 1, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Charles Hale (AL); Ahmad Kamil (CA); Lilyan Zhang (FL); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman and Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Aaron Hodges (TX); and Tomasz Serbinowski (UT). Also participating was: Eric Unger (CO).

1. Discussed Comments Received on Proposals to Revise the Nationally Coordinated LTCI Rate Increase Review Checklist and Comments Received on an Exposure of the Minnesota and Texas LTCI Rate Increase Review Methodologies

Andersen said the Working Group exposed a request for comments on the Nationally Coordinated Long-Term Care Insurance (LTCI) Rate Increase Review Checklist and the Minnesota and Texas approaches as used in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). He said comments were received from the Colorado Division of Insurance (Attachment XX), the American Academy of Actuaries (Academy) (Attachment XX), and the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment XX).

Unger gave an overview of Colorado's comments on the Checklist and the Minnesota and Texas approaches. He said a large discrepancy between the results of the Minnesota and Texas approaches has been observed in some multistate actuarial (MSA) filings, and he suggested considering using a single approach in the LTCI MSA Framework reviews. Lombardo asked Unger to elaborate on the suggestion for producing a less technical version or an additional section of the MSA Advisory Report. Unger said non-actuarial audiences within an insurance department may find it difficult to understand the MSA Advisory Report as it is currently structured. Andersen said the use of a single approach for LTCI MSA Framework reviews will be discussed later in the meeting.

Jamala Arland (Academy) gave an overview of the Academy's comments. Andersen said the Academy issue brief, *Long-Term Care Insurance: Considerations for Treatment of Past Losses in Rate Increase Requests*, mentions past persistency in excess of what was expected and past claims in excess of what was expected as potential sources of past losses. He said the Minnesota and Texas approaches treat past losses associated with excess persistency in significantly different ways. He said the Minnesota and Texas methods treat past losses associated with excess claims in a similar manner. He asked if past persistency in excess of what was expected should be considered to be a past loss for the purpose of LTCI MSA Framework reviews. Serbinowski said part of the problem with addressing past losses comes from framing them in terms of loss ratios. He said excess claims contribute to loss ratio calculations, but the calculation does not accurately reflect variances in persistency. He said the Texas approach provides no relief for higher-than-expected persistency. He said if variances from expected investment returns are to be included, the loss ratio formula needs to be adjusted to account for this. Lombardo said he believes it is very difficult to define past losses in a way that all actuaries will agree on.

Jan Graeber (ACLI) and Ray Nelson (AHIP) gave an overview of their organizations' comments. Miller referenced the ACLI/AHIP's comment on the Checklist, "… we recognize that an individual state might be interested in information specific to their state, we suggest that the checklist clarify that state-specific information is not needed or used for purposes of an MSA review," and she said Ohio has an interest in seeing its state-specific

cumulative increase and would also want to be able to compare it with that of other states. She said she agrees with that, and she would like to see a deeper analysis of the Minnesota and Texas approaches. Lombardo said Connecticut has seen insurers report implemented cumulative rate increases that are less than the rate increases approved in Connecticut. He said the MSA Advisory Reports attempt to identify such situations for each state, and he believes improvements in how the MSA Advisory Reports show and detail cumulative rate increases should be considered.

2. Exposed Ideas for a Single Improved MSA Actuarial Approach

Andersen said given the comments received on the Minnesota and Texas approaches, combining features of both to develop a single rate increase review approach for use in the LTCI MSA Framework may be warranted. He gave an overview of a draft principles document (Attachment XX) that outlines potential considerations and principles for evaluating proposals for a single approach. He said the prior evaluation performed on the Minnesota and Texas approaches can also be used in the consideration of a single approach.

Andersen said the Working Group will expose the draft principles document for a public comment period ending June 2.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023_Summer/05-01-23 LTCAWG/Minutes_LTCAWG_05-01-23.docx

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Commissioner Andrew N. Mais (CT), Chair of the Health Actuarial (B) Task Force and Fred Andersen (MN), Chair of the Long-Term Care Valuation (B) Subgroup

FROM: Steve Drutz (WA), Chair of the Health Risk-Based Capital (E) Working Group

DATE: Feb. 25, 2022

RE: AG 51 – Asset Adequacy Testing

The Health Risk-Based Capital (E) Working Group established the Health Test Ad Hoc Group in 2018 to review the health test language within the *Annual Statement Instructions* due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Currently, a company passes the health test if the following requirements are met:

- The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

  AND

- The entity passing the Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

  AND

- At least 75% of the entity's current year premiums are written in its domiciliary state.

  OR

- The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

The intent of the Ad Hoc Group was to evaluate if changes were warranted to the health test because of industry changes since its original development. The Ad Hoc Group has drafted a phase 1 proposal that will delete the requirements for an entity being licensed and actively issuing and/or renewing business in five states or less and at least 75% of the entity's current year premiums being written in their domicile state. The Ad Hoc Group is continuing to evaluate the current 95% premium and reserve ratios.

Through the evaluation and discussion of the 95% reserve ratio, there was a question brought up as to whether an entity would still be required to perform asset adequacy testing of long-term care (LTC)

business if the entity moved from the life blank to the health blank. It is the Ad Hoc Group's understanding that asset adequacy testing is required, regardless of the blank if the criteria for asset adequacy testing are met. The Working Group is asking the Health Actuarial (B) Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that would indicate that regardless of the blank the entity files, asset adequacy testing is required by the entity if the criteria are met.

This clarification would help to make it abundantly clear that all companies with LTC exposure that are subject to asset adequacy testing would still be required to meet these requirements, regardless of the blank they are filing on.

If you have any questions regarding the suggested clarification, please contact Crystal Brown (cbrown@naic.org).

cc: Eric King, Crystal Brown

Attachment C

2023 National Association of Insurance Commissioners Summer Meeting
LTC Actuarial Work Group

An LTC Industry Update: Public/Private Collaborations

Steve Schoonveld, FSA, MAAA; Managing Director

FTI CONSULTING

August 12, 2023

Long-Term Care Insurance Products

Note, the WA state effect in 2021 increased sales by **37%** for Hybrid products and standalone LTC by **118%.**

	Type	2021 Policies	2022 Policies	% increase	2022 Annualized Premium
New Business	Standalone LTC	90,752	36,872	-59.4%	137,799,414
	Hybrid Life w/Extension	40,411	25,940	-35.9%	270,571,855
	Hybrid LTC Acceleration	158,859	98,075	-38.3%	500,270,703
	CI Acceleration	291,681	290,590	-0.4%	2,164,297,602
	Total	**581,733**	**451,477**	**-22.4%**	

In Force	Standalone LTC	**~ 6 million***
	Hybrid	1,720,727

Source: LIMRA 2022 US Individual Life Combination Product and Long-Term Care Insurance Product Sales and In Force Surveys. *NAIC Form 1

Long-Term Care Insurance Products

Observations from NAIC form 1:

- Were 120+ carriers "truly" writing LTC?

  - 5,981,777 total policies in force over 114 holding companies,
  - 35 have More than 10,000 policies with an average inforce of 167,380, and
  - 79 have Less than 10,000 policies with an average inforce of 1,563

  - Of the top 20 carriers:
    - Average inforce is 277,237 policies,
    - **14/20** continue selling long-term care solutions (Standalone LTC/Riders/etc.)

In addition, there are dozens more carriers placing worksite, Life/LTC riders, Life/Annuity riders, Chronic Illness riders, Short-Term Care, and supplemental health policies covering LTSS needs.

About 600 Medicare Advantage plans cover LTSS benefits including Adult Day Care, Transportation and Meals
(source: Forbes Feb 28, 2023 quote of ATI Advisory analysis of CMS PBP files, excludes EGHPs, PDPs, MMPs, Part B-only plans, and PACE)

Reaching the Middle-Income Market – "the Red Box"

			General Idea of where "clients" are served for HCBS			
Family Income	**MN Population**	**Medicaid Programs**	**OAA Programs**	**EW Programs**	**Personal pay**	**Private pay**
<$10,000	44,763	X		X		
$10,000-24,999	186,569	X	X	X		
$25,000-49,999	233,175	X	X	X		
$50,000-74,999	177,876		X		X	
$75,000-99,999	102,906				X	
$100,000-$124,999	67,775				X	X
$125,000-$149,999	30,726				X	X
>=$150,000	76,885					X
Total	**920,675**					

Minnesota DHS: Options to Increase Access to Long Term Care Financing, Services and Supports in Minnesota

Primary Objective and Goals of the Study :

- Improving access to LTSS for Minnesotans that typically do not qualify for Medicaid,
- Examining and evaluating integrated LTSS funding options, and
- Transforming the LTC funding system.

Provide **Stakeholder-led** comprehensive recommendations addressing the needs of individuals, families, caregivers, government programs, insurance programs, and many others.

An emphasis on options that; enable older adults to receive care in their homes, improve the caregiver supply, and develop a broad base of support for positive recommendations.

Encourage **simplicity**, system **integration**, **equity**, and **accessibility** of LTSS services.

Considers **revised roles** for private LTC insurance, for Minnesota's Medicaid program and for other funding sources including Medicare LTSS and Older Americans Act programs.

Explores new and innovative models of LTC financing and service delivery.

Building Upon What Works in MN: It's All About the Supports!

Minnesota's existing LTSS approaches:

Partners including the Area Agencies on Aging, Counties, Tribal Nations, and Managed Care Organizations

A "no wrong door" approach: Senior LinkAge Line, Office of Ombudsman for Long-Term Care, MN Adult Abuse Reporting Center, etc.

A provider capacity that taps all revenue streams, including private pay.

Reaching older adults and family caregivers further upstream from Medical Assistance (Medicaid).

Minnesota Medicaid - Managed Care for Seniors:

- PMAP: Over 35 years experience with managed care for Medicaid seniors.
- 65,000+ Medicaid seniors currently required to enroll statewide.
- PMAP for seniors changed to Minnesota Senior Care (MSC) and MSC+ statewide during 2005.
- Minnesota Senior Care Plus (MSC+): Adding Elderly Waiver and 180 days of nursing home services to managed care. Statewide phase in completed in 2009
- MSHO: 25+ years experience with integration of Medicare/ Medicaid and primary/acute/LTC service delivery

Public/Private Coordinated Plan Designs from the MN RFP

Range of Policy Options:

"Back End Catastrophic" Public Program Option

- Financial support for longer duration care situations (i.e. 3 or more years). It would require a waiting period (or deductible dollar amount) be met before people could begin accessing benefits. Enables integration with other potential funding sources to fill the initial waiting period gap.

Home and Community-Based Services

- A public program providing funding for care and services for middle income older Minnesotans similar with more modest benefit levels and caps on the benefit duration to keep the program costs down. Like Option 1, this program will have a waiting period or dollar deductible.

Early Intervention Benefit for Medicare Recipients Option.

– A public program providing modest, capped dollar, at-home benefits to Medicare recipients to delay or mitigate their need to spend out of pocket funds for paid care or spend down to be eligible for Medicaid. Provides care coordination and preventative support services before they first begin to evidence the need for LTSS.

Private Long-term Care Insurance Incentives Option

- Strengthen the appeal and encourage innovation within private long term care insurance to help address gaps in funding. Includes regulatory or legislative modifications that can make private long term care insurance more affordable and more accessible to middle income adults.

A Sampling of Potential Designs Under Consideration based on Minnesota Stakeholders:

Option 1: Early Intervention and Support

A state developed program to provide a care support structure that leverages existing services, provides strong awareness and education, and supports informal caregivers. This option would also provide modest, capped, at-home benefits with the goals of delaying or mitigating their need to spend down to be eligible for Medicaid. A Care Navigation service will also focus on obtaining access to community services offered by waiver and alternative care programs and be the platform to support residents and their caregivers. The aim is to maintain a safe home environment and preserve the safety net.

Option 2: Medicare MLTSS

A mandatory state sponsored LTSS program of 1 year of coverage, purchased by non-Medicaid eligible residents during Medicare enrollment or earlier. Participants receive care support and preventive services coordinated with their Medicare plans. The program will also offer additional options to buy-up for more than a year of coverage. Purchase/funding options prior to age 65 and with employer support may be offered. The approach is modelled after the comprehensive care coordination approaches of MLTSS plans.

Option 3: Catastrophic Coverage

A mandatory state insurance program to help pay for long-lasting, long-term care expenses that exceed 2 years, without Medicaid's income and asset restrictions. The program will be self-funded by a state specific payroll deduction for all workers 21 years of age and over. The deductions will go into a restricted fund for this program's use only.

THE Essential Criteria 2.0 – A MN Version

Quantitative:	
Access	Improves access to and usage of LTSS by Minnesota's older adult population.
Costs and Efficiency	The system improves efficiency and generates savings for public programs, consumers and their families/caregivers.
Benefits	Total benefits are reasonable in relation to the total costs borne by the consumers across the system of public/private/ personal approaches.
Sustainable	The funding mechanism is sustainable and adjusts to changing economics, demographic eras, changes in family composition, and care support conditions. Sustainability applies across all stakeholder groups including consumers (out of pocket costs), public and private programs (solvency), and care providers (reasonable reimbursement).
Qualitative:	
Systemic Change	Provides fundamental positive changes to the way LTSS funding and service delivery is coordinated in Minnesota.
Feasibility	Implementation of the financing program is feasible and with limited obstacles and limited administrative costs to implement.
Integration	The care and supports, financing, and care coordination/management between private, public and other sources should be part of an integrated system.
Incentivization	The financing approach encourages support for care, prevention, and wellness initiatives. The approach aligns stakeholder needs. The system promotes consumer responsibility.
Supportive:	
Adaptable and Supportive	The system is flexible and adaptable related to market conditions, demographic shifts, and availability of care providers and resources. The system is responsive to cultural needs and embraces caregiving approaches of different cultures and family composition.
Understandable and Marketable	Eligibility for LTSS benefits, the financing approach, and the processes are simpler, clearer, and more understandable to consumers and their families/caregivers, providers, employers, and other stakeholders.
Equity of Access	Equity of access applies across urban and rural areas and across demographic and ethnic groups.

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