

DATE: October 26, 2016
TO: IIPRC Management Committee
FROM: Industry Advisory Committee
SUBJECT: IIPRC 5 Year Review For Phase 6:

Summary of the 5 Year Review Comments and PSC Recommendations for Phase 6: Individual Long-Term Care Insurance Uniform Standards, Dated August 25, 2016

Re: Rate Requirements For Long-Term Care Benefits, Issue Age and Modified Phased- In of Rate Increases Not Actuarially Justified Pages 9-10, Items Raised But Not Recommended, Item 1

The Item concerns the filing of LTC rate schedule increases that are less than actuarially justified and that may be on a phased-in basis over a specified period of time. The industry had requested that the uniform standards be updated to reflect the new §20B.(2) (c) of the NAIC Long-Term Care Insurance Model Regulation #641 and the NAIC Long-Term Care Rate Increase Model Bulletin.

On Page 10, the PSC’s summary states the following:

“The PSC concluded that no change should be recommended to the current provisions and that requests for premium rate schedule increases less than actuarially justified or for phased in rates should be filed directly with the states.”

In response to this, we wish to draw the Management Committee’s attention to the following current IIPRC LTC uniform standards:

- Rate Filing Standards for Individual Long-Term Care Insurance, Issue Age Rate Schedules Only, page 9, §4 A. (2), (4), (5) and (6).
- Rate Filing Standards for Individual Long-Term Care Insurance, Modified Rate Schedules, pages 12-13, §4 A. (2), (4), (5) and (6).

These standards allow the IIPRC to accept rate schedule increase filings that exceeds a rate increase of 15%, and outlines a process for review and development of an advisory opinion, with an eventual transmittal of the filing and advisory opinion to the respective Compacting States for which the rate increase filings were intended to apply.

With regard to these current standards, we seek a confirmation of the following:

If a company files a rate schedule increase on a phased-in basis over a specified period of time, such as 3 years, and such increase in total exceeds a rate increase of 15%, will the IIPRC accept such a filing under the current standards and review, develop an advisory opinion and transmit the filing with the advisory opinion to the respective Compacting States for which the rate increase filing was intended?

If the answer is “yes”, then we will withdraw the comments that we submitted for the LTC 5 Year Review requesting an update to the current rate filing standards to reflect the new §20B.(2) (c) of the NAIC Long-Term Care Insurance Model Regulation #641 and the NAIC Long-Term Care Rate Increase Model Bulletin.

If the answer is “no”, then we will continue to argue that the rate filing standards need to be updated to reflect the new §20B.(2) (c) of the NAIC Long-Term Care Insurance Model Regulation #641 and the NAIC Long-Term Care Rate Increase Model Bulletin.

We strongly disagree with the PSC’s argument in the Summary on page 9 stating that the Model Regulation and Bulletin changes were only intended to allow Commissioners the ability to approve less than an actuarially justified rate increase and to phase in a rate increase, and not the IIPRC. The PSC and the Management Committee should be reminded that if an NAIC Model or Bulletin existed for an individual or group life, annuity, disability income or long term care insurance product, that the IIPRC standards development process for such product was based on such available Model/Bulletin. If an NAIC Model/Bulletin was amended subsequent to the adoption by the IIPRC of certain standards, then the IIPRC would update the impacted standards accordingly as soon as reasonably possible. As an example of this intent, the PSC and the Management Committee should note the definitions of “Model Act” and “Model Regulation” on page 3 of the Core Standards for Individual Long-Term Care Insurance Policies”, which state “as adopted by the NAIC on _____, ***and as subsequently amended.***”

Additionally, why is it appropriate to make all the other rate increase changes reflected in the new Model/Bulletin amendments to the IIPRC LTC uniform standards, but not this particular one?

***Re: Industry Proposal To Allow A Nonduplication of Benefits Provision
Page 11-12, Items Raised But Not Recommended, Item 3***

On pages 11-12, the PSC’s summary states the following:

“The PSC concluded that there was insufficient documentation of the need for such provision; the purpose of the nonduplication provision in the NAIC [Long-term Care] Model [Regulation] did not appear to coordinate benefits, rather to address HIPAA requirements related to Medicare Supplements; the [IAC] request was more of a coordination of benefits than a limitation or exclusion for duplicative benefits; the recommended language did not detail how benefits would be coordinated, and the issue

of coordination of benefits for long-term care benefits has not been fully vetted through regulators and the NAIC Long-term Care Models at this point. For these reason[s], the PSC is not recommending the requested revision.”

As we had advised in our August 8, 2016 comments, due to the significance of this issue for both companies and our customers, we request reconsideration of the above non-recommendation of the IAC requested change to add a nonduplication of benefits provision.

Based on some of the comments quoted above, there appear to be some fundamental misunderstandings about the proposed standard and how it would operate for the long-term care insurance policies in the market.

The proposed nonduplication of benefits standard is based on the existing NAIC Long-term Care Model Regulation #641 that provides that companies may limit benefits for “expenses for services or items available or paid under another long-term care or health insurance policy.” ***The standard is not intended to be a coordination of benefits provision as applied in the medical insurance context***, with an ordering of payment and primary and secondary payers. The standard is intended to ensure that expenses that are reimbursed under a long-term care insurance policy do not exceed the actual expenses that have been incurred by the insured, and that insureds are not reimbursed more than once for those actual expenses.

As explained in our previous comments, there are many reasons why consumers may want to have the opportunity to purchase more than one long-term care insurance policy in order to more fully plan in stages for their future long-term care needs. We’ve explained why the ability to issue more than one policy is important for LTC planning purposes as consumers’ needs and finances change over time. It is important to understand that under current policy designs, ***insureds are buying a pool of money for benefits – policy benefit periods don’t set a maximum time limit on benefits, but a minimum.*** To the extent an entire daily or monthly benefit limit is not used for a given day or month of expenses, then the coverage remains in the insured’s benefit pool for later use and extends the insured’s period of coverage. ***As such, this is quite a different from a typical coordination of benefits provision as used in medical insurance.***

Example 1: A policyowner with more than one policy that each include a nonduplication of benefits provision:

A policyowner has two policies with Company A, each with a \$100 daily benefit and 3-year benefit period. The total pool of money available to the policyowner under each policy (assuming no inflation protection) is \$109,500 (\$100 a day times 365 days times 3 years equals \$109,500), or a total of \$219,000 for the two policies.

Now let's assume that the policyowner has a long term care event. On day one, they incur \$100 of eligible expenses. They would receive \$100 of reimbursement. On day two, the policyowner incurs \$200 of eligible expenses. They would receive \$200 of reimbursement. As a result, the policyowner has the flexibility to receive reimbursement up to the combined benefit of the two policies owned. In this example, the policy benefits could last 4.5 years (assuming that eligible expenses are incurred in alternating \$100 and \$200 increments). ***The benefit period does not***

limit the years that benefits can be received. Rather it is simply used to determine the overall pool of benefits by acting as a multiplier (\$100 a day times 365 days times 3 years equals \$109,500).

When considering the policies in aggregate, the policyowner can receive up to \$200 a day reimburse for 3 years or \$100 a day for 6 years. Moreover, if the policyowner uses \$150 a day, their benefits will last 4.5 years and if they use \$50 a day, their benefits will last 12 years.

Example 2: A policyowner with two policies with Company A as described above, however, there is NO nonduplication provision:

On day one, the policyowner incurs \$100 of eligible expenses. They would receive \$200 of reimbursement even though they only incurred \$100 of expenses. In essence, they are profiting from having two policies. On day two, the policyowner incurs \$200 of eligible expenses. They would receive \$200 of reimbursement. Under this scenario, benefits would be paid in excess of expense and the policyowner would exhaust their benefits in 3 years (vs. 4.5 years in the hypothetical above).

“Premium Adjustment” Issues

The August report/recommendation also reflected a misconception about a “premium adjustment” when a nonduplication provision is included. There is no reason to refund or reduce a portion of the premium, because the balance of the coverage purchased under each policy remains in place (as part of their respective “pools of money”) for later use to reimburse subsequent expenses. Policies are priced to only reimburse once for a given expense charge, and already include assumptions based on patterns of benefit utilization that result in some level of savings to insureds. ***If policies are subject to duplicate payments for the same expense, this pricing is not viable or sustainable.***

It is difficult for us to conceive of any public policy benefit to facilitating an insured’s ability to be reimbursed multiple times for the same incurred expense. We believe that it is for this reason that regulators included in the NAIC Long-term Care Model Regulation #641 the option for companies to limit benefits for “expenses for services or items available or paid under another long-term care or health insurance policy.” Throughout the IIPRC product standards development process for life, annuity, disability income and LTC products, ***the intent has always been to reflect existing Models, if any.*** In contrast to the other products, we have a Model Act and Model Regulation for LTC that provide extensive product specifications and regulatory intent. We believe that our request for a nonduplication of benefits provision is consistent with the regulatory intent of the Model Long-term Care Regulation and therefore should not be dismissed.

If the companies would not have the option to include a nonduplication of benefits provision in IIPRC LTC filings, some companies may likely and others will limit the ability to purchase a second policy. At a time when most of the population is not properly funding for their LTC needs in the future, we believe that this unintended consequence is not in the best interest of consumers.

Companies are not be able to issue more than one policy without it.

We strongly urge the Management Committee to reconsider the PSC's previous decision and allow the inclusion of a nonduplication of benefits provision. If the language we have suggested needs further editing to include more information, we would be more than willing to work with the PSC and/or the Management Committee to develop such language.

Submitted by the Industry Advisory Committee:

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