DATE: December 28, 2016

TO: IIPRC Product Standards Committee (PSC)

FROM: Industry Advisory Committee

SUBJECT: IIPRC 5 Year Review For Phase 6:

Discussion of Comments Regarding Product Standards Committee Recommendation of Phase 6 Five-Year Review Amendments to Individual Long-Term Care Insurance Uniform Standards

Potential Questions for Discussions
Prepared by IIPRC Office

- Provide clarification of the current request from the Industry Advisory Committee for the parameters of this provision?

The goal of the IIPRC standards development process has been and is to establish national standards based on the majority regulatory view and existing NAIC to the degree practical and possible. The 2010 decision made by the IIPRC to exclude the option for a nonduplication of benefits provision violated both of these goals. Insurers have received approvals for a nonduplication of benefits provision in many states, and the NAIC Long-Term Care Insurance Model Regulation #641 Section 6.B.(6) states that a policy may exclude or limit coverage for "expenses for services or items available or paid under another long-term care insurance or health insurance policy."

It is becoming increasingly common for consumers to own or purchase more than one standalone or combination LTC products. This is often because consumers want to cover LTC risks but need to stage their purchases or combine different kinds of coverage to fit within limited budgets. This may be more common for clients of companies with career agents, since those agents tend to develop lifetime relationships with clients for LTC insurance and other financial services needs. When consumers purchase multiple policies, they are doing so to plan for a possible LTC need. They are not buying multiple policies to generate or replace income, therefore, the purchase of multiple LTC policies is part of their plan to pay for the possibility of an LTC need. However, it is problematic for insurers to issue multiple policies to a consumer without addressing the issue of "betterment" as a result from duplication of benefits.

While the industry supports opportunities for consumers to adequately fund for their future LTC needs and allow the purchase of multiple LTC plans, it needs the nonduplication of benefits

provision to be able to allow multiple purchases but at the same time not allow consumers to receive benefits over and above the actual expenses incurred.

There are several reasons why owning multiple policies can be beneficial to consumers in their LTC planning:

- **Part of a planning process.** The sale of LTC insurance has become more a part of a financial planning process to protect retirement assets than a pure product sale. LTC insurance may be purchased in phases over a client's lifetime, not just once as part of the consumer's financial planning process. For example, a policyowner may purchase LTC at age 40 to meet *some* of the need for LTC coverage (there might be personal budget constraints that comes into play), but as part of the policyowner's financial security plan, this policyowner may wish to purchase a second LTC policy at age 50 to more fully meet the need, at a time when they might have to the financial wherewithal to afford this additional coverage.

- **Provides flexibility.** By purchasing multiple policies over time and as the consumers' financial situation changes, consumers may benefit from increased flexibility in designing coverage that meets their specific ever-changing needs. Depending on which options and features are most important to the client, there are numerous alternative coverage configurations that could be considered. By purchasing multiple policies with various benefits, consumers can manage their premium costs while meeting their specific needs for mitigating their long-term care risks through insurance. For example, consumers may choose to index only a portion of their coverage for inflation protection. Rather than an all or nothing approach, multiple policies can be used to provide complimentary pieces of coverage, if so desired.

- **Supplements employer sponsored coverage.** Another important scenario is where employers are providing individual policies which qualify for a multi-life discount. An employer plan typically provides for a base level of coverage; however, often the employee wishes to buy additional coverage either at the same time or in the future in the form of other individual policies that supplement the employer-sponsored coverage and may have different benefit configurations or optional benefits. In order for these employees to fully meet their desired level of protection for LTC risk mitigation, it is important to accommodate such multiple policies.

We propose the following provision for consideration:

"Expenses for services or items available or paid under another long-term care or health insurance policy. A policy form may include a non-duplication of benefits provision that states that the benefits provided for allowable expenses under all long-term care insurance policy forms covering the insured issued by the company or its affiliates do not exceed the actual expenses incurred for the covered services or items. If included, the provision shall describe how the ratio will be calculated to determine the proportional benefits that would be paid on a pro-rata basis under the policy form. Application of a non-duplication of benefits provision shall not reduce the maximum total amount of benefits payable for the duration of the policy."

- If the purpose of the provision is to make sure the payment of benefits are limited to the expenses incurred, what if it were a provision within the Payment of Claims section with respect to payment of claims under multiple insurance policies for long-term care benefits rather than phrased as a limitation on the benefit?

We would be fine with this approach as long as it provides the protective language we need and addresses the concern of duplicating benefits paid. However, we based our proposal on the NAIC model, which provides for non-duplication as a limitation and it seems desirable to stay with the model framework where possible for IIPRC standards. At a minimum, we need language to address the situation where claims for reimbursements from a company exceed the actual expenses incurred.

- Some of the industry comments have indicated a provision allowing management of benefits under multiple insurance policies is a better alternative to replacement in order to get more coverage – can you explain the importance of preserving the coverage under previous policies including reference to not losing "age"?

If the previously purchased policy form is still being marketed by the company, some companies may be able to add additional benefits at attained age rates, e.g. the original $3,000 of monthly benefits might be at issue age 60, and the additional $3,000 of benefits might be at attained age 63. However, if the policy form is no longer being marketed, a replacement sale would have all $6,000 of benefits at issue age 63. Even if the policy form is still being marketed, some companies' administrative systems may not be able to have coverage units at two different issue ages. In either case, the coverage in total becomes more expensive for the consumer, because the original benefits are effectively re-issued at the higher age.

- Some of the industry comments have indicated a provision allowing management of benefits under multiple insurance policies is beneficial to consumers of a Partnership policy or receiving or need to apply for Medicaid – can you explain what the consequences are when this provision is not allowed and full benefits have to be paid even when excess of reimbursable expenses?

The benefits payable under an LTC plan (standalone policy or combination product where an LTC rider is attached to a life insurance policy or an annuity contract) are tax-qualified if the benefits reimburse tax qualified services and supplies. If the benefits paid exceed the actual expenses incurred, then the excess amounts may not be considered tax qualified and the insured may incur a tax liability for such excess amounts. Since the actual tax-qualification status will be determined by the appropriate authority at tax payment times during the term of the LTC policy/rider, insurance companies include a disclosure on the front page of the LTC form stating that the benefits of the LTC policy/rider are "intended" to be tax-qualified. While the insurance company and the insured may intend for the LTC plan to be tax-qualified, this will only be the case if the LTC policy/rider is determined to comply with all the tax-qualification requirements.

If an LTC policy/rider is determined to have violated the tax-qualified requirements, the tax qualification status may be voided, appropriate tax would be due, and if the policy/rider had also been issued as intended to be qualified for Partnership status (meeting the Deficit Reduction Act requirements for partnerships which include a tax-qualified status), the Partnership status may also be voided. If this occurs, when the insured applies for Medicaid benefits, the asset disregard (an amount equal to all the tax qualified benefits paid under the tax-qualified LTC policy/rider) may either be reduced or eliminated entirely by the benefits paid that exceeded actual expenses incurred.

While such consequences are in the control of the respective proper authorities, we believe that a nonduplication of benefits provision is a useful tool in avoiding such consequences and is therefore in the best interest of consumers seeking to purchase tax qualified LTC products.

- Do legislators or consumer representatives have concerns that an overpaid insured could jeopardize or adversely affect their partnership status or Medicaid eligibility?

We are not responding to this question since it is addressed to legislators or consumer representatives.

- What if there are better benefits under one policy – say one has an inflation rider and the other does not? Should there be a priority in terms of which coverage to pay on first?

Different companies may have varying levels of flexibility in administering benefits, but the consensus among the companies is that they would offer flexibility to the insured during claim time and provide them with guidance on what would be most beneficial to them long-term, but ultimately, this would be up to the insured as to how they would like their benefits paid. For

example, if an insured owns a standalone LTC policy and a life insurance policy with an LTC rider (combination LTC plan), a company would advise that it is more advantageous to the insured to have benefits paid first from the standalone policy until such benefits are exhausted – this would preserve the life insurance death benefit.

- It sounds like the current proposal is to allow companies and their affiliates (intra-company) to manage or pro-rate the payment under their policies when the benefit exceeds the total reimbursable expenses. If so,

    - Please confirm the proposal does not including forcing an insured to include an accelerated life or annuity benefit rider to be part of the proration?

Companies who currently have non-duplication of benefits provisions in their LTC policies/riders advise that they do not force insureds to decrease their death benefits. Most companies do not include a non-duplication of benefits provision in their accelerated death benefits.

    - Please explain what is meant by affiliates – is it affiliates at time of claim or time of issue?

Affiliates are defined in law, but generally, we'd suggest we are considering a parent and subsidiaries here. If it would help to clarify this meaning, the sentence in the proposed standard could be revised to state:

"A policy form may include a non-duplication of benefits provision that states that the benefits provided for allowable expenses under all long-term care insurance policy forms covering the insured issued by the company or its parent company or subsidiaries ~~affiliates~~ do not exceed the actual expenses incurred for the covered services or items."

From a practical perspective, we suggest that this be affiliates/subsidiaries at time of claim. With claims occurring decades after issue, the original affiliate relationships may be unknown. In any case, both policies would have to have a non-duplication provision for benefits to reimburse no more than expenses incurred. We feel this is consistent with the expectations of consumers buying expense reimbursement policies. The Industry Advisory Committee modified its original proposed nonduplication provision to limit its application to "policies issued by the company or its affiliates" in order to address concerns expressed by the PSC about how unrelated companies might apply their respective provisions differently at the time of claim. That concern should not be an issue for a company and its parent/subsidiaries, since they will be in a position to administer their own internal provisions consistently at the time of claim.

- What about companies that buy another company's block of closed business – want the ability to pro-rate with business originally issued by the company?

If a block of business is purchased by a company, there is no affiliate relationship; all of the business is in the same legal entity. Again, both policies would have to have a non-duplication provision, and the expenses incurred would be fully reimbursed.

- The industry indicates "policies are priced to ...include assumptions based on patterns of benefit utilization that results in some level of savings to insureds."

Yes. On average, customers purchase a higher level of coverage than is used if the customer goes on claim in the early durations of the policy. The proportion of maximum daily or monthly benefits paid is referred to as the utilization rate. In pricing, a company might assume that, say, 70% of maximum benefits will be paid for claims occurring in the first policy year. Generally, this percentage increases over time at a rate that depends on the inflation protection included on the policy. Actual expenses are reimbursed, and any monthly benefits that are not used in a month remain in the benefit pool and extend the period over which benefits will be paid. The benefit period is not a maximum; it is used to determine the initial benefit pool, and represents the minimum period that benefits will be paid.

  - If only one policy was purchased, that policy would have higher utilization than where multiple policies were purchased and prorated, correct?

Generally, we would say that is not true. Utilization would be a function of the total coverage available. If someone has one policy with $6,000 of monthly benefits, or two policies with $3,000 of monthly benefits each, utilization will be the same if $5,000 of expenses are incurred. The single policy would pay the full $5,000, while the prorated policies would pay $2,500 each.

  - If benefit utilization is likely lower when have multiple policies, do companies treat a second policy issued to an insured with a previous policy issued by the company or its affiliates as a new issue? If so, why?

Maybe an example would help to explain. If one insured has a single policy with $6,000 of monthly benefits, they would pay the same premium as another insured who has two policies with $3,000 of monthly benefits each, if issued at the same age. Under this scenario, we would have no reason to expect the benefits to be any different for the two insureds.

- How is the rate determined for subsequent policies after the insured has one policy and buys multiple policies for additional coverage? Would these insureds receive a discount due to lower issue expenses and lower expected utilization of the additional benefits?

Again, the utilization is the same for the additional coverage whether purchased with the original policy or with a subsequent policy. The issue expenses are actually higher for multiple policies, since the insured has to be underwritten again to add benefits, and more administrative costs will be incurred to issue the additional coverage.

- If the provision would only apply to policies purchased from the same insurer, please explain why the additional benefit purchase cannot be provided using an endorsement to the original policy instead of issuing a second policy. Are there any reasons this approach would not be desirable for the insured?

For adding benefit dollars, the insured should be indifferent as to whether the coverage is provided in one policy or two. Any additional coverage would be provided at attained age rates regardless, and benefits should be the same. However, this is not just a matter of adding benefit dollars. Consumers who plan for their future LTC needs may want to stage purchases of multiple LTC policies/riders over time, or combine policies with different features to best fit their budget. Consumers' circumstances and needs often change after the first LTC policy/rider is purchased, and having multiple policies may provide additional flexibility in tailoring their coverage.

- If the rates are not affected when an insured purchases additional coverage in a subsequent policy rather than under the original policy, would there be concern if this requested provision, provided the right for the claimant / insured to request or choose the entire purchased benefit even though it may exceed the reimbursable expenses provided the insured understands the risks?

Yes. Again, the policy is priced anticipating that benefits are fully reimbursed, and any unused benefit in a month is used to extend the period that benefits will be paid. Providing an option to receive the full monthly benefit regardless would make the policy an indemnity policy, and could provide an opportunity for an insured to use the policy as a source of income in addition to reimbursement.

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