DATE: June 16, 2016

TO: IIPRC Product Standards Committee (PSC)

FROM: Industry Advisory Committee

SUBJECT: IIPRC 5 Year Review For Phase 6: 

*IIPRC 5 Year Review Report Distributed June 8, 2016*

**Consistency Issues With References to “Policyholder”, “Insured” and “Owner”**

On page 3, note item (2) where it says “insured (owner if there is one designated under the policy)”. When there is an option or right reserved under the policy, we stated this.

However, in the last sentences on page 5 Item (1)(a), page 6 Item (1)(b), page 8 item (4)(a), and page 10 Item (4)(b), the term “owner” is used.

For the sake of consistency, the PSC should decide which is the better approach: saying “insured (owner if there is one designated under the policy)” or saying “owner”. We believe the best approach is to stick with “insured (owner if there is one designated under the policy)”.

The following are related comments:

**Page 3, Item (4)**

The use of “policyholder” is an error that we did not catch – this language came from the Model which flip flops between “insured”, “policyholder” and “owner”. In the IIPRC standards we stuck with “insured” and if there is a right or option reserved, we used the language as shown in item (2).

This item should say “allow the insured (owner if there is one designated under the policy)…”.

**Page 4, Item 5(d)**

Same change for “policyholder” as in Item (4) above.

**Page 5, Item (1)(a)**

The last sentence should say “the insured (owner if there is one designated under the policy)…”.

**Pages 6, Item (1)(b)**

The last sentence above the table should say “the insured (owner if there is one designated under the policy)…”.
In the last sentence on the page, it should say “the insured (owner if there is one designated under the policy)…”.

**Page 7, Items (c)(iii) and (d)(iii)**

The references to “policyholder” should be changed to “the insured (owner if there is one designated under the policy)…”.

**Page 7, Drafting Note**

It should say “the insured’s right (owner’s right if there is one designated under the policy)…”.

**Page 10, Item (1)(b)**

At the end of the item below the table, it should say “at the option of the insured (owner if there is one designated under the policy)...”.

**Page 11, Items (c)(iii), Drafting Note and Item (d)(iii)**

Same comments as for Page 7 above.

**Pages 21-22, Item (4)(b)**

We believe that the item is not consistent with the NAIC Model Regulation #643 as adopted by the NAIC on August 19, 2014.

On page 21, there are two sub-items (i) and (ii) in (4)(b). Our comments are in regard to the (i) and (ii) imbedded in (4)(b).

In (4)(b)(ii), it should say “the accumulated value of historic expected claims”. Unless this change is made, the item (b) is saying that a company takes the lesser of actual claims and historic claims, and both of these are the same.

At the end of item (4)(b), it states “plus the present value of future projected incurred claims”. Model #643 says “plus the present value of future expected incurred claims”. This is important because in item (4)(b)(v) on page 22, the last sentence, it says “Expected claims shall include margins for moderately adverse experience…”’. This language was added to clarify that margins are included in the projections of future claims, so it is important to use the term “expected” consistently.
Page 39, Revision of Misstatement of Age Provision

We are providing the requested responses, as follows:

1. What is generally the maximum issue age for Long-term Care products?

   **Response:** The companies have advised that the maximum issue age varies from age 75-79. The companies wish to note that each company’s maximum issue age is a public record in each state as well as in IIPRC filings, reflecting the company’s intent not be in the market for ages beyond the maximum ages. Applicants whose ages exceed the maximum issue age are denied coverage. It would be unfair and discriminatory to other consumers to allow a consumer with a misstated age (where the true age of a consumer is beyond the maximum issue age) to have coverage for which the company never intended to be on the risk. Companies should have the right to decide what risks they want to assume, and regardless of how, why or when the correct age is established, companies should not be forced to assume a risk for a consumer beyond the maximum issue age.

2. How often do companies encounter circumstances where issue age is misstated and the correct age was beyond the maximum issue age? (we added bold text to clarify what we believe was intended by the PSC).

   **Response:** The companies have advised that this is a rare occurrence, but if and when this does occur they would want to reserve the right to return the premiums paid and rescind the policy. A few companies have had this language approved for several years in the states for filings that they have filed directly with the states, and accordingly they believe that it is appropriate to also allow this language for IIPRC filings. While rare, it is appropriate for the standard to discourage someone from applying for coverage they are not eligible to purchase, out of fairness and equity to all our other applicants who disclose their correct age.

3. What are usually the circumstances surrounding such misstatements (typographical error, agent error, knowing misrepresentation, etc.)

   **Response:** in short, all of the above. Additionally, the company may have made the error when entering the data into its systems. There may also be intentional misstatement of age by the family of the applicant when the family wants coverage issued. Once such error is found, intent is usually hard to prove, and regardless of the intent, the fact remains that someone who is now insured was never eligible for insurance based on the company’s maximum issue age rules.

4. What underwriting practices are used to verify age? Is MIB used to verify age? What other processes are used?

   **Response:** The companies rely in good faith on the age shown in an application. The typical underwriting process includes various cross-checks for the date of birth, such as with medical records if these are requested, when a telephone history interview is conducted, during a face to face assessment, in an MIB report, etc. It is rare that an age error is not caught during the underwriting process, and the errors can be corrected by adjusting the premium or benefits
accordingly if the correct ages are below the maximum issue age. If the correct age is beyond the maximum issue age, the application is rejected. Although the companies do a reasonably thorough job in their underwriting process, they may not always catch a misstated age that is beyond the maximum issue age.

The PSC is also requesting comment on the following proposed revision to the IAC suggestion:

For a policy that has been in force for less than two years, and prior to receiving notice of a claim, the company may terminate coverage and refund premiums if the correct age, at the time of policy issue, is outside the issue age ranges of the policy.

**Response:** Since a misstated age in an application that was missed during the underwriting process will likely be found at the time of claim, the above proposed language would be of little help to deal with intentional misstatement for the purpose of getting coverage issued when an applicant would otherwise be deemed not eligible for coverage. If such a misstatement is found in a claim submitted during the first 2 years of a policy, why shouldn’t a company have the right to defend its maximum issue age rules at this time?

It is important to note that on page 19 of the IIPRC standards, P. INCONTESTABILITY, item (2) (a) would already permit rescission during the first 6 months of policy for a misstated age, regardless of whether or not a claim has been submitted. Item (2)(b) would likely not be useful since it is only applicable to a “condition”. Item (2)(c) is likely not useful since it is only applicable to “health”. The language proposed above may contradict these standards.

**Pages 43-44, Allowance for Non-Duplication of Benefits Provision**

We are providing the requested responses, as follows:

- How will non-duplication provisions be coordinated, given the broad proposed language for the standard stating that “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.”

**Response:** The companies that have filed and secured approval for the non-duplication of benefits provisions filed directly with the states advise that an adjustment to the benefits otherwise payable under the policy is made on a pro-rata basis with other existing LTC coverage. To administer this provision, the companies ask about other existing LTC coverage both in the initial application and on the claim form submitted at the time of claim. If the application shows that other existing LTC coverage is not being replaced, the companies take this into account in applying internal LTC coverage limits to protect against over-insurance. The companies would treat a non-disclosure of other LTC coverage in the application as a material misrepresentation. At the time of claim, failure to disclose other existing LTC coverage in the claim form would be considered potential claim fraud. While the companies recognize that they may not get full disclosure of other existing LTC coverage, they do have a policy provision and a process to obtain and apply that information in administering their non-duplication of benefits provision.
• What would happen if two companies had very different methods of determining the pro-rata benefit or if one company had a provision and the other company did not.

Response: As noted in our separate response to the comments submitted by consumer representatives on April 7th, also submitted with these comments, if a company elects not to include an LTC non-duplication of benefits provision in its LTC policy/rider to allow them to adjust benefits to account for the existence other LTC coverage, then such company’s policy/riders would be required to pay their benefits in full, regardless of other existing LTC coverage. As long as each company that has a non-duplication of benefits provision defines its proportionate ratio, each such company would be bound to apply its provision to the claim submitted to it by the insured.

• Does the proposed language allow the company to require the consumer to submit a claim for benefits under other policies or riders?

Response: The companies advise that the answer is “No”. The non-duplication of benefits provision is designed to protect against paying for the same expenses twice and ensure that the total amount of expenses being reimbursed will not exceed the actual expenses incurred. While the insured is not required to submit a claim under all other LTC policy/riders owned, a company with a non-duplication of benefits provision will use the total available coverage to determine what its policy/rider pro-rata amount will be. Companies using the pro-rata approach have advised that they are willing to work with insured at the time of claim to apportion the expenses reimbursements differently, if so desired by the insured, as long as the companies are not reimbursing for more than the actual expenses incurred and the payment of benefits is within the coverage limits for the LTC policy/rider.

• Some members expressed the view that proper underwriting at the point of sale and suitability would be the preferred way to address instances where more than one policy is in effect

Response: While the companies do underwrite for the existence of other LTC coverage and apply internal maximum coverage limits to protect against over-insurance, the members’ view fails to take into account our previous comments to the effect that 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.

• Other members stated that they understood the concern expressed by Industry; however as written, the consumer is caught in the middle.

Response: The companies believe that as long as consumers are able to be reimbursed for the actual expenses they incurred, they are not caught in the middle.
• If the provision applied to long-term care riders as well as policies, the consumer might be forced to utilize rider provisions that decrease the death benefits on a life policy because another company had a provision allowing for only a pro-rata portion of a long-term care expense.

Response: Companies who currently issue 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.

• Some members commented that they would consider a provision that established more specific parameters, allow the consumer the option of submitting a claim to more than one insurer so the consumer could control when benefits are exhausted and planning for future long-term care needs, and was limited to the same or affiliated insurers so the provisions in the policy would be more likely to coordinate.

Response: The companies advise that they are not opposed to this approach conceptually, depending on the language of the standard. While we have proposed a standard based on the NAIC model which does not restrict non-duplication to a company’s own policies, and such restriction does not fully address the “betterment” issue (or the tax qualification or partnership issues that were raised in our initial comments) it would at least accommodate a planning approach by consumers that would allow for a company to issue additional coverage over time that supplements or compliments existing coverage that was already issued. See suggested wording in response to question 5 below.

• The PSC seeks more specific detail about how benefits are coordinated.

Response: The companies have provided the following examples of how LTC benefits are calculated when there is other LTC coverage using the pro-rata approach:

**Example 1**

Insured has a Company A policy and a second policy with another carrier (OC). The two policies are the same. Both have a maximum daily limit of $100.00. The daily cover charge is $160. To calculate the daily benefits with other coverage, use the following method:

\[
\text{Benefit Paid} = \frac{\text{Daily Covered Charge} \times \text{Maximum Daily Limit}}{(\text{Maximum Daily Limit} + \text{OC Maximum Daily Limit})}
\]

\[
\$160.00 \times \$100.00 \div (\$100.00 + \$100.00) = \$80.00
\]

**Company A Daily Benefit is $80.00.**
**Example 2**
Insured has a Company A policy and another carrier (OC). The polices are the same with the exception that the Company A policy has a maximum daily limit of $100.00 and the OC has a maximum daily limit of $300. The daily cover charge is $160. To calculate the daily benefits with other coverage, use the following method:

\[
\text{Daily Covered Charge} \times \frac{\text{Maximum Daily Limit}}{\text{Maximum Daily Limit} + \text{OC Maximum Daily Limit}} = \text{Benefit Paid}
\]

\[
$160.00 \times \frac{$100.00}{($100.00 + $300.00)} = $40.00
\]

*Company A Daily Benefit is $40.00*

**Example 3**
Insured has a Company A policy and a second policy with another carrier (OC). The two policies are the same. Both have a maximum daily limit of $100.00. The daily coverage charge is $250.00. Because the total of the maximum daily limits ($100 + $100 = $200) is less than the daily coverage charge ($250), the daily benefit is not adjusted.

*Company A Daily Benefit is $100.00*

**Example 4**
Insured has a Company A policy and a second policy with another carrier (OC). Both have a maximum daily limit of $100. However, the Company A policy has a 91 Beginning Date and the OC policy has a 121 Beginning Date. The daily coverage charge is $160.

For the first 91st through the 120th day of qualifying expenses, there is no adjustment of benefits (OC policy does not begin paying benefits until the 120th day).

*Company A Daily Benefit from 91 to 121 days of qualifying expenses is $100.00.*

After the 120th day, daily benefits with other coverage is:

\[
\text{Daily Covered Charge} \times \frac{\text{Maximum Daily Limit}}{\text{Maximum Daily Limit} + \text{OC Maximum Daily Limit}} = \text{Benefit Paid}
\]

\[
$160.00 \times \frac{$100.00}{($100.00 + $100.00)} = $80.00
\]

*Company A Daily Benefit beginning on the 121st day of qualifying expenses is $80.00.*

Note: If the other policy has a shorter benefit period than the Company A policy, calculated daily benefits with other coverage ends once the other policy's benefit period expires. Then 100% of Company A benefit would be paid up to the maximum daily limit.
In addition to the concerns noted above, the PSC seeks input on the following:

1. It appears from what has been proposed by the IAC, that the non-duplication provision would apply to both indemnity and reimbursement policies. The PSC has concerns with non-duplication provisions applying to a policy that pays a set amount regardless of expenses. Why would this be appropriate?

   **Response:** The companies advise that it is not their intent to apply the non-duplication of benefits provision to indemnity plans. The intent is to apply the provision to reimbursement plans that reimburse for actual expenses incurred. Since the standard we proposed was framed in terms of “expenses for services or items available or paid under another long-term care or health insurance policy,” we do not believe this would sweep in indemnity plans.

2. Can you provide more specific, non-anecdotal data/information on the frequency of policyholders having more than one LTC policy? How often are there two or more reimbursement policies?

   **Response:** One company advises that in the states that permit the use of a non-duplication of benefits provision, 94% of their policyholders own only one policy, and 6% own more than one. The company does not have compiled data on how many of their policyholders own LTC coverage with other companies.

3. Do companies require the insured to submit the claim to all insurers or does the insured have a choice? (for example if the second policy is a life rider, can the insured choose not to present a claim to the second insurer so the death benefit is not lowered)

   **Response:** Please note the response given to the 3rd bullet question above.

4. Why can’t the concern with excessive coverage be addressed via application questions, suitability requirements and underwriting review?

   **Response:** The companies advise the proposed language for the non-duplication of benefits provision was not intended to address “excessive” coverage. It was intended to address the concept of betterment by insureds getting reimbursement more than once for the same expense incurred. See our response above for 4th bullet question.

5. What feedback does the IAC have regarding the suggested language from the Consumer Advisory Committee dated April 7, 2016? (Listed below)

   **Section 3. R. Limitations and Exclusions**

   “(f) Expenses for services available or paid for under a similar policy form issued by this company but only if:
1. This policy permits accumulation of benefits deferred due to this exclusion;

2. The application of non-duplication of benefit provisions does not reduce benefits provided under this policy and the similar policy form to less than the total amount of expenses for services or items for which benefits are otherwise available or payable for under both policies; and

3. The similar policy form complies with the following:

   a. It has no non-duplication of benefits provision or has a non-duplication provision that reciprocates with this policy provision on a prorate basis.

   b. It permits accumulation of benefits deferred due to application of a non-duplication of benefits provision, if any.”

**Response:** The companies do not believe that it is appropriate to develop an IIPRC standard for a policy form that would specify requirements for a “similar policy form” that is not the form submitted for review. It should be sufficient to state the standard for an acceptable non-duplication provision for the policy form that is submitted; the submitted form should stand on its own. Therefore, we would not support (f)(3).

The companies advise that while they have been advocating for a non-duplication model that would not be restricted to their own LTC issued plans, the companies are willing to consider a provision limited to “all long-term care insurance policy forms covering the insured and issued by the company or its affiliates do not exceed …”.

The companies are not opposed to including language to address the concept in (f)(2). Doing so would eliminate the concerns raised in (f)(1).

In lieu of the consumer representatives’ suggested language, we propose the following.

f) 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 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.

**Rate Requirements For Dollar For Dollar Long-Term Care Benefits, Pages 45-47**

We support the Kentucky DOI’s advocacy for a separate set of IIPRC standards for the dollar for dollar LTC benefits and are in agreement with their proposed standards.
Submitted by the Industry Advisory Committee:

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