Market Conduct Annual Statement
Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Line of Business: Individual Stand-Alone Long-Term Care
Individual Long-Term Care Hybrid Products:
Life-LTC Hybrid Products
Annuity-LTC Hybrid Products

Reporting Period: January 1, 2023 through December 31, 2023

Filing Deadline: April 30, 2024

Product Identifier

1. **SALTC** **Stand-Alone – Long-Term Care Products**
2. **LifeLTC** **Life – Long-Term Care Hybrid Products**
3. **AnnLTC** **Annuity – Long-Term Care Hybrid Products**

Schedule 1—Interrogatories

ID	Description	Comment
1-01	Does the company have data to report for Stand-Alone Long-Term Care?	Yes/No
1-02	Does the company have data to report for Life Long-Term Care Hybrid?	Yes/No
1-03	Does the company have data to report for Annuity Long-Term Care Hybrid?	Yes/No
1-04	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-05	If Yes above, explain:	Comment
1-06	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-07	If Yes above, explain:	Comment
1-08	Annuity LTC Hybrid – Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-09	If Yes above, explain:	Comment
1-10	Stand-Alone LTC - Has all or part of this block of business been sold, closed, or moved to another company during the reporting period?	Yes/No
1-11	If Yes above, explain:	Comment
1-12	Life LTC Hybrid - Has all or part of this block of business been sold, closed, or moved to another company during the reporting period?	Yes/No
1-13	If Yes above, explain:	Comment
1-14	Annuity LTC Hybrid - Has all or part of this block of business been sold, closed, or moved to another company during the reporting period? Yes/No	Yes/No
1-15	If Yes above, explain:	Comment
1-16	Additional state specific Stand-Alone Long-Term Care comments (optional):	Comment
1-17	Additional state specific Life Long-Term Care Hybrid comments (optional):	Comment
1-18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):	Comment

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Schedule 2—General Information

ID	Description
2-19	Number of policies/contracts in-force as of the beginning of the reporting period.
2-20	Number of new business policies/contracts issued during the period.
2-21	Number of free look cancellations during the period.
2-22	Number of lapses during the period.
2-23	Number of rescissions during the period.
2-24	Number of policies/contracts in-force as of the end of the reporting period.
2-25	Number of internal replacements during the period.
2-26	Number of external replacements during the period.
2-27	Number of policies/contracts replaced where age of insured at replacement was <65.
2-28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.
2-29	Number of policies/contracts replaced where age of insured at replacement was >80.
2-30	Number of complaints received directly from consumers.

Schedule 3—Claimants

ID	Description
3-31	Number of claimants approved for benefits as of the beginning of the period.
3-32	Number of claimants with pending claimant request determinations as of the beginning of the period.
3-33	Number of new claimants during the period.
3-34	Number of claimants with pending claimant request determinations as of the end of the period.
3-35	Number of claimants approved for benefits as of the end of the period.

Schedule 4—Claimant Requests Denied/Not Paid

ID	Description
4-36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity/death).
4-37	Number of claimant requests denied or not paid because of preexisting condition exclusion.
4-38	Number of claimant requests denied or not paid because elimination or waiting period not met.
4-39	Number of claimant requests denied or not paid because services provided not covered under the policy.
4-40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.
4-41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.
4-42	All other claimant requests denied or closed without payment.

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Schedule 5—Claimant Request Determinations Timeliness

ID	Description
5-43	Number of claim request determinations made within 0 - 30 days.
5-44	Number of claim request determinations made within 31 – 60 days.
5-45	Number of claim request determinations made within 61 – 90 days.
5-46	Number of claim request determinations made beyond 90 days.

Schedule 6—Benefit Payment Requests

ID	Description
6-47	Number of benefit payment requests pending as of the beginning of the period.
6-48	Number of benefit payment requests received during the period.
6-49	Number of benefit payment requests denied or not paid during the period.
6-50	Number of benefit payment requests pending as of the end of the period.

Schedule 7—Benefit Payment Request Timeliness

ID	Description
7-51	Number of benefit payment requests paid within 0 – 30 days.
7-52	Number of benefit payment requests paid within 31 – 60 days.
7-53	Number of benefit payment requests paid within 61 – 90 days.
7-54	Number of benefit payment requests paid beyond 90 days.
7-55	Number of benefit payment requests denied or not paid within 0 – 30 days..
7-56	Number of benefit payment requests denied or not paid within 31 – 60 days
7-57	Number of benefit payment requests denied or not paid within 61 – 90 days.
7-58	Number of benefit payment requests denied or not paid beyond 90 days.

Schedule 8—Lawsuit Activity

ID	Description
8-59	Number of lawsuits open as of the beginning of the period.
8-60	Number of lawsuits opened during the period.
8-61	Number of lawsuits closed during the period—total.
8-62	Number of lawsuits closed during the period with consideration for the consumer.
8-63	Number of lawsuits open as of the end of the period.

In determining what business to report for a particular state, all reporting companies should follow the same methodology/definitions used to file the Financial Annual statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

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Schedule 9– Long-Term Care Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
9-64	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
9-65	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
9-66	Overall Comments for the Period

General Instructions – All LTC Products:

For the purpose of the MCAS Long-term care insurance reporting blank:

1. "Long-term care insurance" means that as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), with the exception that long-term care insurance riders attached to a life insurance policy or an annuity contract, and group insurance plans are not included.

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2. Schedules 3, 4 and 5 refer to claimants and claimant requests. A claimant request is the initial request for LTC benefits under the policy or contract. It is the determination by the insurer that the claimant is entitled to benefits under the policy or contract.

3. Reporting for schedules 3 through 5 is to be done on a "per claimant" basis (counts each individual who makes one or a series of requests or demands for payment of benefits under a policy) [Model #641, Appendix E]

4. Schedules 6 and 7 refer to individual benefit payment requests following the initial determination by the insurer that the claimant is entitled to benefits under the policy or contract. The purpose of the schedules is to differentiate between initial coverage request activities (Schedules 3, 4 and 5) and benefit payment request activities (Schedules 6 and 7) once the insurer has affirmed the initial coverage requests.

5. Reporting for schedules 6 and 7 is to be done on a "per transaction" basis (counts each benefit payment request pending and benefit payment made). [Model #641, Appendix E]

General Instructions –Life and Annuity Hybrid LTC

1. For purposes of the LTC Hybrid Product MCAS, "LTC Hybrid Product" means those products providing Long-Term Care insurance as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), as part of a Life-LTC hybrid insurance policy or Annuity-LTC hybrid contract. Such LTC hybrid benefits may be built into the life policy or annuity contract, or may be attached to such policy or contract by a rider. Report experience for Life-LTC hybrid products separately from Annuity-LTC hybrid products in the schedules provided. Report experience on individual LTC hybrid policies and contracts only. Do not report experience on group policies and contracts.

2. For Schedule 2, report experience for all policies or contracts with LTC hybrid benefits. For all data elements in Schedule 2, report the number of policies or contracts with Life-LTC hybrid or Annuity-LTC hybrid benefits and which meet the definition of the specific data element. For example, for data element 2-19 in the Life-LTC hybrid schedules, report the number of life insurance policies with LTC benefits in force at the beginning of the reporting period. For data element 2-19 in the Annuity-LTC hybrid schedules, report the number of annuity contracts with LTC benefits in force at the beginning of the reporting period. For data element 2-20, report the number of new business policies or contracts with LTC hybrid benefits.

3. For Schedules 3 through 7, report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, report experience for claimants, claimant requests denied/not paid,

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claimant request determination timeliness, benefit payment requests, and benefit payment request timeliness only for the LTC benefit portion of the LTC hybrid product.

4. For Schedule 8, report experience for those policies or contracts with some form of LTC benefit. Report lawsuit experience for all lawsuits related to the LTC product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.

Definitions:

Benefit Payment Request—A request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. (See Claimant Request and Claimant Request Determination, below.) Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment request. The data elements in Schedule 4 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

Claimant—An insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.

Claimant Request—A request or demand for payment made by an insured, or a representative of the insured, for a loss that may be included within the terms of coverage of the LTC stand-alone or LTC hybrid policy or contract. It does not include events that were reported by the insured for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment.

If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

Claimant Request Determination—A determination as to whether an insured has met a contractual provision of an LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of this blank, the term applies to the initial claimant request, and captures the period of time from notice of claim to the benefit trigger/claimant request determination date. For claimant requests that are denied/not paid, report the period of time from the date of notice of claim to the date the claimant was notified of the determination to deny or not pay the claim.

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Claimant Request Denied or Not Paid because Benefit Eligibility Criteria Not Met—A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

Claimant Request Denied or Not Paid Because Claimant Did Not Pursue—A claimant or policyholder made a request or demand for payment for the purpose of receiving a benefit trigger/claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again (inactivity could be the result of death.)

Claimant Request Denied or Not Paid Because Elimination or Waiting Period Not Met—A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed.

Claimant Request Denied or Not Paid Because Services Provided Not Covered—Expenses incurred for services and support which are not eligible for reimbursement under the LTC benefit of a policy or contract, such as an expense incurred for home health care when the policy or contract only provides benefits for nursing home confinements.

Claimant Request Denied or Not Paid Because of Preexisting Condition Exclusion—A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services are subject to a restriction as a pre-existing condition for a period of time following the effective date of coverage of an insured person.

Claimant Request Denied or Not Paid Because Provider or Facility Not Qualified—A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.

Complaint—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

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Denied or Not Paid—A request or demand for payment that is not paid for any reason.

Under Schedule 4, if a denial could be reported under more than one of the categories, report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant's request was denied, the denial should not be counted more than once.

Under Schedule 5, exclude denials for failure to meet the waiting or elimination period or because of an applicable preexisting condition.

The term does not include a request or demand for payment that is in excess of the applicable contractual limits.

Elimination Period—A period of time, as specified in the policy or contract, during which the insured incurs qualified long-term care services and support for which benefits are not payable until the end of such period.

Free Look—A set number of days provided in an insurance policy or contract that allows time for the owner/purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

Lapse—The termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for LTC hybrid products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;

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- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

New Business Policy or Contract—A newly written agreement that puts insurance coverage into effect under a policy or contract during the reporting period

Pending Claim–A claim that has not yet been paid or denied.

Replacement—Replacement of any life policy, annuity contract or LTC policy already in force with a new policy or contract with LTC insurance coverage.

- External Replacement—If the policy or contract to be replaced was issued by another insurer.
- Internal Replacement—If the policy or contract to be replaced was issued by your company.

For Data Elements 2-25 (Number of Internal Replacements) and 2-26 (Number of External Replacements), report the number of policies included in data element 2-20 (Number of new business policies) which are replacements of any type of life, annuity or long-term care policies.

Rescission—Invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).

Waiting Period—See definition of Elimination Period.

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