



May 1, 2017

Honorable Teresa D. Miller  
Commissioner of Insurance  
Pennsylvania Insurance Department  
1326 Strawberry Square  
Harrisburg, Pennsylvania 17120

RE: Referral to the NAIC Senior Issues (B) Task Force and its Long-Term Care Innovation (B) Subgroup

Dear Commissioner Miller:

The Interstate Insurance Product Regulation Commission (“Commission”) met in Denver on April 7, 2017. The Commission members voted to refer an issue with respect to non-duplication provisions in long-term care insurance policies to the NAIC’s Senior Issues (B) Task Force or its Long-Term Care Innovations Subgroup. The specific issue the Commission is referring is whether the NAIC Long-Term Care Insurance Model Regulation (NAIC Model #641) may need revisions to facilitate a uniform interpretation and/or to clarify the scope and intent of Section 6B(6), a provision for a limitation or exclusion for “expenses for services or items available or paid under another long-term care insurance or health insurance policy.”

The Commission has a five-year review rule where it is required to review its Uniform Standards on a five-year basis to determine the need for continuation, repeal or amendment. During the Commission’s five-year review process for the Core Standards for Individual Long-Term Care Insurance Policies (iLTC Standards) that commenced in April 2016, the Industry Advisory Committee (IAC) requested reconsideration to add a provision based on Section 6B(6) of NAIC Model #641 into the iLTC Standards to address the evolving needs of the marketplace and what they termed a non-duplication of benefits provision.

By way of background, when the iLTC Standards were initially drafted for the Compact, the Limitations and Exclusions section (§3R) included a provision that echoed the language found in Section 6B(6) of NAIC Model #641, allowing for an exclusion or limitation for “expenses for services or items available or paid under another long-term care insurance or health insurance policy.” Upon the request of a Compacting State, the Product Standards Committee (PSC) at that time recommended eliminating that provision before the original 2010 adoption of the iLTC Standards reasoning that coordination of benefits was generally not applicable to individual long-term care benefits and since the application standards contain mandatory questions to elicit information about other insurance in force and replacement, the application and underwriting process would provide an avenue for addressing concerns about over-insurance and fraud.

The IAC noted that some insurers will not issue more than one policy to the same insured without a non-duplication of benefits provision. It should be noted that the proposal by the IAC went beyond the specific language in Section 6B(6) of NAIC Model #641. The IAC stated such a provision would:

- Ensure that the benefits provided under all policies and/or riders covering the insured do not exceed the actual expenses incurred for eligible long-term care services;
- Clarify how multiple policies and/or riders will pay benefits for expenses incurred on a pro-rata basis;
- Maintain tax qualification of the benefits paid because, to be qualified, the benefits paid under any policy or rider must not exceed the actual expenses incurred and in some cases are subject to per diem maximums;
- Maintain Partnership status; since if a policy or rider loses its tax qualification status, it will also lose its Partnership status, if applicable; and
- Enable the companies to price accordingly for such a provision.

The following is the IAC draft language originally submitted in April 2016 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 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. At the option of the company, the policy form may also state that the provision shall apply to policy forms in-force for any one insured and issued by the company.

Since that time, the IAC modified their proposal to limit application to stand-alone long-term care insurance policies issued by the same or affiliated insurance companies. The companies have also stated that the provision would apply only to reimbursement policies, not indemnity plans that pay a set amount regardless of incurred expenses.

Several states were comfortable with permitting a non-duplication provision recognizing that it is generally permitted under state law and NAIC Model #641. However, during the one-year period that this issue has been under discussion both before the PSC and before the Management Committee and Commission, several other states as well as representatives of the Consumer Advisory Committee (CAC) and Legislative Committee raised significant concerns with allowing a company to limit the payment of long-term care benefits under multiple policies even when the total benefits due could exceed the reimbursable, incurred expenses. Some of the concerns included that such a provision could delay claim processing and leave consumers caught between insurers, cause confusion and possibly promote unsuitable sales. Questions were also raised regarding whether there should be a rate reduction when a second or subsequent policy is purchased since two policies

with a lower daily benefit could be individually rated for a higher probability of use than one policy with a higher daily benefit.

The Management Committee requested the PSC develop a draft provision based on the comments and discussion during the public comment period. The final draft language developed by the PSC for the Management Committee's review dated April 7, 2017 contains restrictive language in an attempt to address all of the concerns expressed by regulators, consumer representatives and legislators, specifically:

- The provision only applies to the company or its affiliates when all policies include such a provision and provide reimbursement for incurred expenses, not indemnity.
- The insured must have the option to choose the order of payment of benefits and the company shall provide an explanation of the payment of benefits.
- The policy must state that the insured is not required to use benefits from a life insurance policy or rider or an annuity contract or rider that contains long-term care benefits only in the form of an acceleration of the death benefit or cash value.
- The maximum total amount of benefits payable for the duration of the policy and the maximum total amount of benefits payable under the policy shall not be reduced due to application of the provision.
- Use of the term "coordination of benefits" as a description is prohibited.
- The company must demonstrate that it will charge a reduced premium to an insured that purchases a second or successive policy with the company.

Although the PSC-drafted language would only allow management of benefits when there are two or more stand-alone policies with the same or affiliated insurers, and not have a broader application with unaffiliated insurers or long-term care riders and other hybrid products, the PSC was still unable to reach consensus. At the recent meeting of the Management Committee and Commission, the PSC recommended making no changes to the original iLTC Standards to include a non-duplication of benefits provision. The PSC concluded that Compacting States had different interpretations of Section 6B(6) of the NAIC Model #641 (or the same provision under their respective state law(s)) as to whether a policy provision was permissible limiting long-term care insurance benefits when the benefits payable under more than one long-term care policy exceeded the long-term care expenses. It was unclear whether the intent of Section 6B(6) in the current NAIC Model #641 was to allow for prorating or otherwise for establishing an order of benefit payment for more than one policy. The PSC also questioned whether the provision it drafted would be beneficial as many of the current individual long-term care insurance products in the marketplace are not stand-alone policies and therefore would not be subject to this provision, and that there are still significant policy issues, particularly regarding when to permit such a provision and whether there should be reduced premiums if a policyholder had more than one policy with a company.

After the PSC's feedback, the Commission agreed to refer this remaining issue with respect to the five-year review of the iLTC Standards to the NAIC as it pertained to the interpretation of an NAIC Model and whether revisions were needed to accommodate the specific issues raised with respect to non-duplication of benefits. The Commission is expected to take action on the other five-year review amendments to the iLTC Standards at a conference call in June.

During the course of discussions regarding this issue, the Compact staff has reviewed the meeting minutes for the Senior Issues (B) Task Force as well as the Long-Term Care Working Group for the period when Section 6B(6) of the NAIC Model #641 was added. In June 1998, the Senior Issues (B) Task Force created the Long-Term Care Working Group for the purposes of determining whether the NAIC models should be adjusted to accommodate tax-qualified plans created under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The working group reviewed and discussed draft revisions, including this provision, until December of 1999 when the Task Force adopted the revisions to the Long-Term Care Insurance Model Act and Model Regulation. The provision under Subsection 6B(6) of NAIC Model #641 allowing an exclusion or limitation for “expenses for services or items available or paid under another long-term care or health insurance policy” was added in the February 25, 1999 draft that was discussed when the working group met on March 7, 1999. The minutes state that there was a review of “the draft amendments to the model act and regulation, which were drafted to comport with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).” There was no discussion prior to or following the February 25, 1999 draft regarding any other reason for the addition of this or other proposed revisions and no discussion of this specific provision in any meeting minutes. The amendments to the models, including subsection 6B(6), were adopted by the Working Group on December 5, 1999 and the Senior Issues (B) Task Force adopted the revisions without further discussion on December 6, 1999.

A review of state laws and regulations for the 20 states that are represented on the PSC indicates that 16 of the 20 members, including the states most vocally opposed to the addition of a provision addressing non-duplication of long-term care benefits under multiple long-term care insurance policies, have the specific language in their state statute(s) as Section 6B(6) of NAIC Model #641. The IAC emphasizes the permissibility of Section 6B(6) is not an innovative idea, “but has been allowed in most state regulations for nearly two decades.” Based upon the discussion at the Commission, this issue of the scope of a non-duplication of benefits provision and the extent of its permissibility under Section 6B(6) of NAIC Model #641 is a forward-looking issue as the marketplace for private long-term care insurance evolves and regulators, industry and consumers look for ways to address long-term care needs including purchasing multiple policies over the course of time.

Since 1999, the long term care insurance market has undergone considerable change. Insurers have expressed a desire to offer opportunities for consumers to stage long-term care insurance purchases as they can afford to increase benefits or to combine different kinds of coverage to fit their needs. Regulators and consumer representatives caution that the details of how consumers are protected in situations where policies have different levels of benefits or elimination periods, or when coverage is provided through unaffiliated insurers or hybrid products have not been adequately explored. Questions about whether rate discounts should apply when there is more than one policy also have not been fully vetted by regulator actuaries. Finally, the question of whether there is a documented issue that consumers or providers are attempting to be indemnified beyond incurred expenses remains unanswered.

The Compact Office and the Commission believe that the concept raised during its five-year review process goes beyond the Uniform Standards and includes public policy issues that should be fully vetted and explored through the NAIC committee structure. It is through this discussion that guidance can be provided to regulators regarding the scope and intent of Section 6B(6) of NAIC

Model #641 and whether it allows companies to limit the payment of long-term care benefits under multiple long-term care insurance policies when the benefits exceed the long-term care expenses incurred. If the answer is yes, the NAIC and the appropriate long-term care insurance committee/task force/working groups are better suited to determine if further revisions to NAIC Model #641 are needed to achieve a uniform interpretation and to address the issues raised through the Commission's public consideration process with respect to specific issues involved in how benefits are managed when there is more than one long-term care insurance policy or product that could pay benefits.

On behalf of the members of the Commission, we appreciate the Task Force's consideration of this referral. We have attached the final memo from the PSC to the Management Committee that provides further detail about their recommendations and draft language that was vetted during the Committee's discussions as well as key written comments from the IAC and CAC for your review. Please advise if you have any questions regarding the history of this issue with the Commission or if there is further documentation we can provide to you.

Sincerely,



Karen Z. Schutter  
Executive Director

Cc: Honorable Al Redmer, Jr., Maryland Commissioner of Insurance  
Honorable Eric Cioppa, Maine Superintendent of Insurance  
Honorable Mike Kreidler, Washington Commissioner of Insurance  
Honorable David Altmaier, Florida Commissioner of Insurance  
David Torian, NAIC Health Policy Analyst and Council



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## MEMORANDUM

**TO:** Insurance Compact Management Committee

**FROM:** Product Standards Committee

**DATE:** April 7, 2017

**SUBJECT:** Product Standard Committee Response to Comments Regarding Proposed Amendments to the Individual Long-Term Care Insurance Uniform Standards

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The Product Standards Committee (“PSC”) of the Interstate Insurance Product Regulation Commission (“Commission”) presented the Management Committee (“Committee”) with its recommendations for the Five-Year Review of the Individual Long-Term Care Insurance Uniform Standards on August 25, 2016. The proposed amendments were published on September 1, 2016 for a 60 day comment period. Comments were received on only two areas of the proposed amendments. The Management Committee has asked for the PSC’s feedback on these comments. The first request was for reconsideration of the PSC’s recommendation not to add a Non-duplication of Benefits or Management of Benefits provision to the *Core Standards for Individual Long-term Care Insurance* and the second involved technical changes to proposed revisions to the *Standards for Forms Required to be Used with an Individual Long-Term Care Application*.

The Management Committee held a Public Hearing on November 7th with further discussions at the Joint Meeting of the Management Committee and the Commission on December 9th. During these meetings, the Management Committee heard comments and held discussions specifically regarding the addition of a Non-duplication of Benefits or Management of Benefits provision to the Core Standards. Regulators, consumer advocates and state legislators expressed concerns with consumer confusion, suitability issues, inconsistency in payment of benefits among insurers depending on whether the second policy was issued by the same company or an unrelated company, and questions regarding discounted rates for additional policies due to decreased utilization. Industry representatives commented in support of the provision, noting that it is intended to address expense reimbursement policies and not indemnity coverage so that benefits are not paid over and above the actual expenses incurred and would allow consumers to purchase coverage as they can afford it with multiple policies over the course of time to operate similar in nature as if they purchased all the coverage they needed in one initial policy.

Following receipt of comments and the Public Hearing, the Management Committee asked the PSC to review the written and oral comments and provide final recommendations for their consideration. In the case of the Non-duplication of Benefits/Management of Benefits, the Management Committee asked that in addition to determining if the additional comments changed the PSC recommendation, regardless of that outcome, the PSC provide language for such a provision for the Management Committee to consider.

With respect to the Non-duplication or Management of Benefits issue, the PSC had discussed this subject on two public calls and four member calls of the PSC in 2016 and since the Management Committee's request, the PSC has had an additional three member calls and one public call in 2017. Following exhaustive discussion, the PSC has not reached consensus to add this provision and is not recommending any change to the published recommended amendments to the iLTC Uniform Standards. While the PSC has provided a draft of what a Management of Benefits provision could include, it strongly suggests further vetting and discussion of this provision before it is considered by the Management Committee or Commission for inclusion in the Uniform Standards.

As background, the initial request by the Industry Advisory Committee (IAC) was to add a provision for non-duplication of benefits to the Limitations and Exclusions section of the *Core Standards for Individual Long-Term Care Insurance Policies*. The IAC stated that it is becoming increasingly common for consumers to purchase more than one stand-alone or combination long-term care product, particularly because consumers need to stage their purchases or combine different kinds of coverage to fit within limited budgets. Under the current Uniform Standards, a provision for non-duplication of benefit cannot be included in the policy and they believe this can lead to an insured being reimbursed in excess of expenses incurred, leaving less coverage available for future long-term care services. They stated that there could also be potential tax issues if insureds are receiving tax-free benefits from multiple tax qualified expense long-term care insurance reimbursement policies that exceed actual incurred expenses. Industry stated that multiple policy sales are not prohibited in the *NAIC Long-term Care Insurance Model Regulation #641* and that §6B. Limitations and Exclusions of the Model allows for exclusion or limitation for "expenses for services or items available or paid under another long-term care insurance or health insurance policy."

The PSC notes that the 3<sup>rd</sup> Quarter 1999 NAIC Proceedings indicate that this limitation may have been added to the Model regulation to conform the model to the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPPA). Section 271 of HIPPA, Duplication and Coordination Of Medicare-Related Plans amends Section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A) related to prohibiting duplication of Medicare Supplement plans and states:

- (v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to 'duplicate' health benefits under this title or under another health insurance policy if it
  - (I) provides health care benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof,
  - (II) coordinates against or excludes items and services available or paid for under this title or under another health insurance policy, and
  - (III) for policies sold or issued on or after the end of the 90-day period beginning on the date of enactment of the *Health Insurance Portability and Accountability Act of 1996* discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title or under another health insurance policy.

The PSC believes that the proposal by the IAC exceeds the intent of the addition of this language to Model #641, and therefore further discussion among regulators and interested parties regarding the provision in the Model or extension of its application to the extent requested by the IAC would be necessary before considering such an amendment to the Uniform Standards.

The PSC asked the Insurance Compact Office to draft language for a proposal that tries to address the concerns expressed by some regulators, legislators and consumer representatives, specifically:

- That the provision only applies to the company or its affiliates when all policies include such a provision
- The insured must have the option to choose the order of payment of benefits and the method for calculation of benefit payments must be stated in the policy.
- The insured is not required to use benefits from a life insurance policy or rider or an annuity contract or rider that contain long-term care benefits.
- The maximum total amount of benefits payable for the duration of the policy and the maximum total amount of benefits payable under the policy shall not be reduced because of the provision.
- The maximum daily benefit and the maximum total amount of benefit can't be more than what would be offered under a single policy.
- The term "coordination of benefits" can't be used to describe the provision.
- The rate standards would require a provision that the company must demonstrate that it will charge a reduced premium to an insured that purchases a second or successive policies with the company.

The PSC held a public call on March 14th to hear comments on the draft provision called Other Long-Term Care Insurance With This Company, similar to a provision found in the *Standards for Individual Disability Income Insurance Policies*. In response to questions from the Committee requesting that the IAC quantify the issue, one insurer has indicated that 14% of its policyholders have more than one policy and the IAC has indicated the issue is difficult to quantify because it believes insurers will not sell more than one policy without a non-duplication of benefits provision. Based on the comments and the resulting discussions, the Committee has concluded that the proposal goes beyond the provisions in the current NAIC Long-Term Care Model Regulation, that it is unclear that such a provision would be beneficial since many of the current iLTC products in the marketplace are not stand alone policies and therefore would not be subject to this provision, and that there are still significant policy issues, particularly in regards to when to permit such a provision and whether there should be reduced premiums if a policyholder had more than one policy with a company. As such, the PSC has concluded that it would not be appropriate to include this provision in the current proposed amendments being considered for adoption.

The PSC does not believe it will be able to reach consensus on this issue until there is agreement among regulators for a uniform approach to addressing situations where a policyholder has more than one policy providing benefits for reimbursement of long-term care expenses. Given the increase in alternative product structures being developed, the issue appears to go beyond stand-alone policies. The Committee suggests that it may be beneficial to seek input from the NAIC Senior Issues (B) Task Force or its Long-Term Care Innovation (B) Subgroup on whether amendments to the Long-term Care Model Regulation should be considered to provide clearer guidance on how to address multiple policies. One of the Subgroup's charges is to "Examine whether amendments are needed to current NAIC models or regulations or whether there is a need for new models or regulations to accommodate a changing market." The reason initially noted by the IAC when they

raised this issue – that consumers now sometimes buy the coverage they can afford rather than the coverage needed and make additional purchases as circumstances change – seems to indicate a changing market. If further guidance is provided with respect to this public policy issue or the Model Regulation is ultimately amended, the PSC could then consider proposing further amendments to the Uniform Standards.

The draft language for a potential provision is attached as Appendix A and attempts to address the issues raised during the 12-month discussion of this matter. We have noted the areas where there are still conflicting views among regulators and interested parties. To reiterate, the PSC is not recommending this language be included in the Core Standards at this time, but suggests the draft proposal may provide good background about the nature of the issues that require further discussion.

With respect to the second comment made during the formal rulemaking process, the PSC is not recommending any change with respect to the comments related to the *Standards for Forms Required to be Used with an Individual Long-Term Care Application*. The comments from a company filer requested technical amendments to the Appendix A in the Uniform Standards to add brackets to denote optional information for certain items on the Long-Term Care Insurance Personal Worksheet based on the type of policy offered. Although the PSC understands the rationale for this request, it is noted that Appendix A in the *Standards for Forms Required to be Used with an Individual Long-Term Care Application* is a copy of the most recently adopted version of Appendix B, the Long-Term Care Insurance Personal Worksheet of the NAIC Long-Term Care Model Regulation (Model #641). Under the proposed amendments to the Uniform Standards, section 1A(1)(a) states that the Long-Term Care Insurance Personal Worksheet standards shall be, at a minimum, those prescribed in Appendix A of these standards as subsequently amended in Appendix B of the Model Regulation. The Product Standards Committee does not recommend making changes to Appendix A of its Uniform Standards that are not reflected in adopted amendments to the Appendix B of the NAIC Model Regulation. If the Model Regulation Appendix is amended, the current proposed amendments to the Uniform Standards allow for the Uniform Standards to automatically include any adopted amendments.

*DRAFT LANGUAGE ADDRESSING MANAGEMENT OF LONG-TERM CARE INSURANCE BENEFITS  
WHEN THERE IS MORE THAN ONE POLICY WITH THE COMPANY*

New Provision under § 3 POLICY PROVISIONS of the CORE STANDARDS FOR INDIVIDUAL LONG-TERM CARE INSURANCE POLICIES

**OTHER LONG-TERM CARE INSURANCE WITH THIS COMPANY**

1. The policy may include a provision addressing payment of benefits when the insured has more than one long-term care insurance policy originally issued by a company or its affiliates that provide reimbursement of actual expenses incurred for the covered services or items.

**Drafting Note:** This does not include policies that were assumed by company or its affiliates through merger, sale or other transaction. This provision shall not be permitted if the policy provides indemnity coverage for a daily or monthly amount rather than reimbursement of actual expenses incurred.

**Product Standards Committee (PSC) Comments:** Comments were received from the Consumer Advisory Committee (CAC) suggesting that the insurers must be affiliated at the time of sale and at the time of claim so that the management of benefits provision is not triggered by a new affiliation. A regulator suggested limiting the provision to issuing companies, asking what would happen if a company sells an affiliate prior to claim. The PSC has concluded that the inclusion of affiliated companies is an area where states have not reached consensus and may require further discussion.

2. The provision shall include a statement that the benefits payable for allowable expenses under all long-term care reimbursement insurance policies that include such a provision, cover the same insured and were issued by the same or affiliated company shall not exceed the actual expenses incurred for the covered services or items;

**Product Standards Committee (PSC) Comments:** The Industry Advisory Committee (IAC) suggested deleting the requirement that both policies contain such a provision (by deleting the words “include such a provision”) since it is not clear what public policy concern this addresses. The requirements that both policies contain the provision limits the insurer’s ability to pay benefits that do not exceed the cost of expenses incurred, but may result in unequal claim adjudication if one policy contains a provision and one does not. The PSC notes that requiring the provision in the policy provides the policyholder with the required information on how claims would be handled and without such information, the insured would be uninformed. The PSC does not agree that the limitation on benefits should apply to policies without such a provision.

3. The policy shall specify that at the time of claim, the company shall provide an explanation of the payment of benefits to the insured or claimant who shall have the option to choose the order of payment of benefits under one or more long-term care insurance policy(ies) provided the amount of benefits shall not exceed the actual expenses incurred for the covered services or items. The default method of

calculation of benefit payments shall be stated in the policy in the case where no insured or claimant choice is made.

**Product Standards Committee (PSC) Comments:** As a result of feedback from regulators and interested parties, the PSC revised this provision to clarify that the insured has the choice to determine the order of benefits and that the company specifies a default method of calculation of benefits to be used only if the insured makes no choice. With this clarification, other provisions addressing order of benefits are unnecessary.

4. The provision shall state that the insured is not required to use benefits from a life insurance policy or rider or an annuity contract or rider before or in lieu of using the benefits available under one or more individual long-term care insurance policy(ies) issued by that company or its affiliates..

**Product Standards Committee (PSC) Comments:** The PSC agreed with the CAC suggestion that this provision should be revised to also apply to policies issued by an affiliate of the company. They also revised the language for clarity.

5. The provision shall state that if benefits are paid among more than one policy as permitted herein, the maximum total amount of benefits available for the duration of the policy shall not be reduced.
6. The provision shall state that when the benefits payable have been allocated among more than one policy as permitted herein, the benefit period of the policy shall not limit the company's obligation to provide the maximum total amount of benefits available under the policy.
7. The provision shall state that the company will not limit benefits if maximum daily benefit or the maximum total amount of benefit under more than one policy exceeds the highest maximum daily benefit or maximum total amount of benefit that the company authorizes under a single policy to an insured in the same or similar circumstances on the date the most recent policy subject to management of benefits is issued

***Drafting Note:*** This provision only applies when an insured has more than one long-term care insurance policy issued by the same company or its affiliates and does not apply to the management of benefits under multiple policies issued to the insured by different companies. The provision is intended to be administered in a manner most beneficial to the insured.

**Product Standards Committee (PSC) Comments:** The IAC stated that they understand this paragraph to mean that the last policy sold should not have exceeded a company's issue limits at that time. They note that companies underwrite already for the existence of other LTC coverage and apply internal maximum coverage limits to protect against over-insurance. They state that the same limits are applied regardless of whether one or multiple policies are issued and suggest that this not be a policy provision, but rather a sales practice, unless exceeding the issue limits is in some way going to impact the administration of the provision. The PSC revised the language for clarity and notes that this is an issue requiring further discussion since regulators could not reach consensus on whether this should be a standard or a sales practice.

8. The use of the term "coordination of benefits" shall not be acceptable in describing this provision.

**FOR ADDITIONAL CONSIDERATION:**

Minnesota Department of Commerce is requesting a provision be added to the Rate Filing Standards for Individual Long-Term Care Insurance Policies (both versions) in Section 2, Additional Submission Requirements for Initial Rate Filings as follows:

When a policy includes a provision for payment of benefits in accordance with Core Standards for Individual Long-Term Care Insurance Policies, § 3\_\_\_\_, Other Long-Term Care Insurance With this Company, the company shall demonstrate that it will charge a reduced premium to an insured that purchases a second or successive policies with the company compared to the premium for the same policy when it is the first policy purchased by the insured with the company for purposes of reflecting the fact that the insured already has other coverage with the same company and that second policy includes a management of benefits provision.

**Product Standards Committee (PSC) Comments:** The CAC agreed that there should be a discount rate for additional coverage and suggest this should be referred to the Actuarial Working Group. A state suggested that there not just be a premium reduction at the sale of the new policy, but a return of premium for reduction of benefits from the older policy. The IAC states that they are greatly concerned with including a rate reduction for subsequent policies, which seems to reflect a recurring pricing misunderstanding. They would consider it discriminatory to charge a lower rate for someone buying a second policy relative to someone obtaining the same level of coverage in one policy. They believe there are still some fundamental misconceptions about pricing and would like more discussion. The PSC notes that this as one of the outstanding issues that is the basis for a recommendation of no change at this time, since there is significant disagreement and the issue requires extensive additional research and discussion.

**DATE:** December 1, 2015

**TO:** IIPRC Product Standards Committee (PSC)

**FROM:** Industry Advisory Committee **SUBJECT:** IIPRC Individual LTC Standards 5 Year Review Comments

***Section §3: R. LIMITATIONS AND EXCLUSIONS, Pages 20-21***

The companies are respectfully requesting consideration of adding additional standards as shown below.

In today's marketplace, there are various scenarios where a person may buy more than one LTC benefit:

- A person may buy one LTC policy providing a \$100 daily benefit, and a few years later buy another policy with a \$50 daily benefit.
- A person may buy a life insurance policy or an annuity with an LTC benefit with a \$100 daily benefit, and a few years later buy another LTC benefit for \$50 daily benefit.
- A person may buy an LTC policy and also buy a life insurance policy or an annuity with an LTC benefit; years later, that person may buy another LTC policy and/or another LTC benefit with his life insurance policy or annuity.
- A person's employer may offer worksite LTC coverage to employees, their spouses and family members. Those buying LTC coverage through the worksite may want to buy additional coverage at a later date for various reasons, such as the worksite coverage did not include inflation protection, or included a small daily room and board benefit.

Consumers who can't afford a \$150 daily benefit on the day they apply for LTC benefits are encouraged by the suitability standards to buy what they can afford. As their financial circumstances change where they can afford additional coverage, there are several options available for them to do this. If a person also owns a life insurance policy or an annuity, they may consider adding an LTC benefit to these, or if they already have an LTC benefit with the life policy or annuity, they may buy another LTC policy or another rider to supplement the coverage they already have. If a person does not have a life insurance policy or annuity and wishes to buy one, they may do so and include an LTC benefit or more. Alternatively, the person may just buy another LTC policy to supplement their daily room and board benefit provided under the original LTC policy that was bought.

Some type of a non-duplication of benefits provision is needed in order to:

- ensure that the benefits provided under all policies and/or riders covering the insured so not exceed the actual expenses incurred for eligible long-term care services;
- clarify how multiple policies and/or riders will pay benefits for expenses incurred on a pro-rata basis;
- maintain tax qualification of the benefits paid; to be qualified, the benefits paid under any policy or rider must never exceed the actual expenses incurred and in some cases be subject to per diem maximums;

- maintain Partnership status; if a policy or rider loses its tax qualification status, it will also lose its Partnership status, if applicable; and
- enable the companies to price accordingly for such a provision.

Aside from the tax qualification requirements, if a person who bought multiple policies/riders for the same incurred expenses were able to collect the full benefit amount under each policy/rider, a moral hazard results that cannot be adequately priced for.

We believe that consumers should be encouraged to plan and pre-fund for their future LTC needs and if the sale of multiple policies/riders accomplishes this, then this type of market should be available. The use of multiple policies and/or riders:

- allows consumers to gradually build up their LTC pre-funding;
- provides greater flexibility for designing the type of LTC coverage that a person may need during a specific period of their life;
- enables a person to better manage their premium costs (a person may elect to have inflation protection on some of his coverage but not all);
- reduces the incidence of replacement (a person can add coverage instead of replacing a previous coverage with a new purchase and thereby lose age); and
- provides a combination of benefit pools that may be conserved for use for later claims (not an annual “use it or lose it” risk as may be the case with other lines of coverage, such as health insurance).

The best way to manage multiple policies/riders that are bought by the same person is to include some type of a non-duplication of benefits provision.

We note that in the *NAIC Long-term Care Insurance Model Regulation #641, Section 6.B. Limitations and Exclusions on pages 6-7*, states that “a policy may not be delivered or issued for delivery ...if the policy limits or excludes coverage...., except as follows:

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy”.

We also note that this item was not included in §3.R. LIMITATIONS AND EXCLUSIONS on pages 20-21 of the IIPRC LTC standards.

We believe that the multiple LTC insurance policy/rider market requires including some type of a non-duplication of benefits limitation/exclusion as reflected in subsection (6) of the Model, and we therefore respectfully request consideration of including a new items (1)(f) on page 21, as follows:

“(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 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.

At the option of the company, the policy form may also state that the provision shall apply to policy forms in-force for any one insured and issued by the company.

As used in this item (f), “policy form” means a policy or rider, amendment or endorsement, or any combination of these, which provide long-term care insurance.”

**DATE:** October 30, 2016

**TO:** IIPRC

**FROM:** Sonja Larkin-Thorne, Brendan Bridgeland, Angela Lello, Fred Nepple, IIPRC Consumer Representatives, and Bonnie Burns, California Health Advocates

**SUBJECT: Support for the PSC recommendation to not adopt a “Non-duplication Clause” pursuant to the 5-Year Review process (Phase 6 Long-Term Care Insurance)**

We write to support the IIPRC Product Standards Committee recommendation that the IIPRC not adopt a standard that authorizes a “Non-duplication Clause” for long-term care policies. This Industry Advisory Committee (“IAC”) proposal is, for the reasons stated by the Committee, wrong for long term care policies and unsupported by data and analysis. It will leave consumer claims caught unpaid between insurers and open the door to unsuitable sales. It also lacks any standard for appropriate rating practices. These issues are not mitigated by the expedient of limiting the clause to policies originally issued by affiliated companies.

We applaud the PSC for its thoughtful consideration of this topic. For the reasons stated in the PSC report we urge the IIPRC to reject the IAC proposal.

**DATE:** March 13, 2017

**TO:** IIPRC Product Standards Committee

**FROM:** Sonja Larkin-Thorne, Brendan Bridgeland, Angela Lello, James McSpadden, and Fred Nepple, IIPRC Consumer Representatives, and Bonnie Burns, California Health Advocates

**SUBJECT: Comment on and Opposition to the Draft “Non-duplication Clause” for Long-Term Care Insurance**

We again urge the Committee to recommend against adoption of a “non-duplication” standard. As stated in our February 18<sup>th</sup> memo such a standard opens the door to unsuitable stacking. The IAC has supplied no data to support its adoption. Member states adopted the interstate compact in good faith based on the IIPRC’s explicit rejection of a long-term care insurance “non-duplication” standard. The IIPRC should not engage in “bait and switch.” The difficult “opt-out” process will not mitigate a breach of trust with member states.

We recognize the Compact Office Draft (“Draft”) attempts in good faith to incorporate some level of protection for consumers into the IAC proposal. We remain opposed. Even if every Draft element is adopted the proposal still exposes a vulnerable population to confusing choices, conflicting claim adjudication and unsuitable sales, all to address an issue not supported by any evidence.

In addition we note several specific issues with respect to the details of the Draft. These are described below by Draft paragraph number:

1 & 2: The Draft should state that “non-duplication” may be applied only if the insurers are affiliated both at the time of issue and at time of claim. Otherwise an insurer without an affiliated long-term care insurer may issue a policy with an ineffective non-duplication clause that is subsequently “activated” by a new affiliation.

3: The reference to “method of calculation of benefit payments” and “pro-rata calculation” should be deleted. This paragraph appears to allow the insured to claim all or any portion of expenses against one policy as long as they are not also filed under another policy. The insured, not the insurer, determines the amount claimed under a given policy. The Draft should not imply the insurer might substitute its judgment. Paragraph 2 allows the insurer deny only a duplicate claim.

4: This provision should be revised to also apply to life policies issued by an affiliate of the company.

5 & 6: The references to “prorate” should be deleted for the reasons discussed under paragraph 3.

9: “Non-duplication” should be substituted for “pro-ration.”

Finally we agree with the Minnesota Department of Commerce's recommendation that there should be a discount rate for additional coverage. We suggest this should be referred to the Actuarial Workgroup.

**DATE:** March 17, 2017  
**TO:** IIPRC Product Standards Committee (PSC)  
**FROM:** Industry Advisory Committee  
**SUBJECT:** IIPRC 5 Year Review For Phase 6:

***IIPRC Draft Dated March 2017 For New LTC Provision:  
“Other Insurance With This Company”***

***Product Standards Committee (PSC) Public Call on March 14, 2017***

In response to the various regulator and consumer representatives comments made during the call, we wish to provide the following comments:

As we noted at the outset of the IIPRC 5 Year Review for the Individual LTC Standards, the NAIC Long-term Care Insurance Model Regulation #641 (“the Model”) already has a provision which addresses this issue.

The Model’s Section 6.B. Limitations and Exclusions on pages 6-7, states that “a policy may not be delivered or issued for delivery ...if the policy limits or excludes coverage....., except as follows:

***(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy”.***

The majority of the states on the Product Standards Committee (16 out of 20, including Minnesota) have adopted this Model Limitation/Exclusion.

This provision was the starting point for the IAC’s initial proposal. As we’ve gone through the standards review process, we have revised our proposal in response to comments and concerns expressed by the IIPRC’s PSC and Management Committee, as well as the consumer representatives. The proposed draft most recently prepared by the IIPRC staff is consistent with the Model’s approach, with additional provisions and standards which we believe further appropriately address concerns that have been raised. These include restricting application of the provision to policies sold by the same company and its affiliates, and allowing the insured to select how they would like to have their benefits paid from among their multiple policies. The result is a provision that simply looks at the total coverage of the insured for a company and its affiliates and allows the insured to determine from which policies they would like the expenses reimbursed, while ensuring that the insured is not reimbursed more than the actual expenses incurred. If the insured is unable to, or simply does not, state a preference, the policy provision outlines a process for determining how the expenses will be reimbursed, rather than allowing the company to dictate the process at time of claim.

As stated in our March 10, 2017 comments on the IIPRC staff draft, we support and appreciate that effort, and offer the attached suggested revisions for clarification, and to address the comments on the IIPRC draft from Utah.

We have reviewed Utah's comments and we agree that in the IIPRC staff draft separate provisions were written to address specific concerns, and that some provisions may be redundant in some respects. Item 3 specifically addresses long term care (LTC) insurance policies, which implies that item 5 is redundant. Item 4, however, addresses policies that may not be considered LTC policies, so it should probably be retained.

We believe Utah makes a good point regarding the "pro-rata" language, and we would suggest some generalization in items 6-8 and the final drafting note, as indicated in the attached.

Finally, Utah raises an issue regarding administration of multiple policies with different elimination periods. While this is a valid question, it exists now, and it exists whether or not policies have the provisions in question. Although we agree with Utah that this is how the respective elimination periods would be administered with multiple policies, we don't think this is necessarily an issue that needs to be addressed in the proposed standard.

As most of us are aware, LTC insurance is a challenging business with a broad array of issues. Fortunately, however, very few of those issues pertain to our desire to limit reimbursements from multiple LTC expense reimbursement policies to the full amount of expenses incurred for qualifying long term care services. Comments and concerns continue to be raised by some parties which we believe reflect a misunderstanding of how the product is purchased and priced, and how benefits would be paid under multiple policies. On the issue of whether there would have to be a premium reduction for subsequent policies after an initial policy is purchased, as we have previously demonstrated, the cost of the coverage is the same, regardless of whether someone chooses to buy two \$100 per day policies, or one \$200 per day policy. As long as the appropriate suitability requirements are met for the total amount of coverage that is purchased, the number of policies should not impact the premiums charged for that total coverage.

In addition, as explained in our March 10, 2017 written comments and testimony, under current policy designs offered in the market, the consumer is purchasing coverage that provides a total maximum pool of benefits that may be used for the duration of the policy (or policies). Therefore, to the extent that a portion of a particular policy's maximum daily limit was not used to reimburse a given day's expense, ***that unused portion is not lost; it continues to be available in the benefit pool to reimburse future expenses, effectively extending the period of coverage that benefits could be available.*** Therefore, there is no portion of the premium which is paid for coverage that would not be available for benefits under the policies that were purchased, and no "unused" premium to return.

On the March 14, 2017 public PSC call, Minnesota stated that several of their statutes already require a premium discount for a second policy, but based on our review of the citations provided, ***we respectfully suggest that none of those laws are applicable to the proposed standard.*** The cited statutes either apply to group conversions to individual policies; coverage in

excess of a stated maximum limit determined by the company; altering existing policies; true coordination of benefit provisions (which this proposal expressly is not); or reasonable relationship of benefits to premiums (explained above). ***In fact, we believe many states would find it discriminatory to charge one person a higher premium simply because they bought their total coverage in one policy rather than two.***

With regard to proper disclosure of the proposed provision, as noted in the IAC's original proposal, we believe the current IIPRC standards (IIPRC-LTC-I-3-OC [Outline of Coverage Standards] Section 10. LIMITATIONS AND EXCLUSIONS, Item (e)) already would require this if this provision is included in the LTC standards, but clarification could be added if it is felt necessary.

We respectfully submit that the balance of the significant comments that have been raised in opposition to the proposed standard have been fully addressed in the IAC's previous written and oral comments during the extended review process.

We have never argued that there are too many multiple policies out there today and this is why we need a non-duplication of benefits provision. The repeated request to quantify how many multiple policies have been issued to date is not relevant to the argument that we have been making: over time consumers may want to buy more than one LTC policy to better fund for their future LTC needs, that it is a good public policy to encourage consumers to be more financially responsible for their LTC costs, and that the industry and regulators should support such responsible behavior. In order to increase the sales of multiple policies, the companies need a non-duplication of benefits provision.

In its final decision making consideration for allowing the LTC standards to include the proposed nonduplication of benefits provision, we encourage the PSC to focus on the NAIC Model provision allowing a nonduplication of benefits provision, consumers' ability and desire to purchase incremental policies to fund for their future LTC needs as they can afford to do so, and the companies' need to have a nonduplication provision to be able to sell more multiple policies.

We thank you for the opportunity to submit these comments.

***Submitted by the Industry Advisory Committee:***

Hugh Barrett, Mass Mutual Life  
Jason Berkowitz, IRI  
Brian Deleget, Nationwide  
Michael Hitchcock, Pacific Life  
Angela Schaaf, Northwestern Mutual  
Steve Kline, NAIFA  
Amanda Matthiesen, AHIP  
Rod Perkins, ACLI

**DATE:** April 7, 2016

**TO:** IIPRC Product Standards Committee (PSC)

**FROM:** Sonja Larkin-Thorne, Brendan Bridgeland, Angela Lello, Fred Nepple, IIPRC Consumer Representatives and Bonnie Burns, California Health Advocates

**SUBJECT: “Non-duplication Clause,”** Page 37, IIPRC Office Report and Recommendation to the Product Standards Committee (“PSC”) for the Uniform Standards currently subject to 5-Year Review (Phase 6 Long-Term Care Insurance)

A “Non-duplication Clause,” unless properly constructed, will leave the claims of vulnerable consumer caught between insurers and also subject them to unsuitable sales. We again write to urge the PSC to refer this Industry Advisory Committee (“IAC”) request to the NAIC Senior Issues Task Force so all the issues associated with it may be considered. We also urge you to address and obtain a response to the questions raised in our January 19, 2016 memo (attached).

IIPRC adoption of a Non-duplication Clause will lock it in nationally and foreclose state insurance departments and the NAIC from developing a considered approach to this issue. We also note that the industry sought a “Non-duplication Clause” in 2010 arguing precisely the “assumptions and circumstances” advanced today. The IIPRC rejected those arguments. There is no change in “underlying assumptions and circumstances” that justifies consideration of a Non-duplication Clause, whatever its merits, in the 5-year review process.

If you nevertheless decide to proceed with this poorly considered proposal we ask that you attempt to mitigate some of these issues by asking the Actuarial Workgroup to consider whether there should be separate rate standards for long term care policies sold as additional coverage and by constructing the provision as follows:

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 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.

**DATE:** January 19, 2016

**TO:** IIPRC Product Standards Committee (PSC)

**FROM:** Sonja Larkin-Thorne, T. Ryan Wilson, Brendan Bridgeland, Angela Lello, Fred Nepple, IIPRC Consumer Representatives and Bonnie Burns, California Health Advocates

**SUBJECT:** Industry Advisory Committee (“IAC”) comments relating to the IIPRC Long Term Care Standards 5 Year Review

The IIPRC in 2010 explicitly rejected inclusion of a “non-duplication” clause in the Long Term Care Uniform Standard (“LTC Standard”). We urge the Product Standards Committee to recommend referral of the IAC proposal to resurrect such an exclusion to the National Association of Insurance Commissioners Senior Issues Taskforce. We urge you to take up this proposal only after the NAIC has given it the careful study it deserves.

The need for a thorough examination of this proposal is compelling. The credibility of the IIPRC is at stake. A number of state legislatures enacted the Compact after the IIPRC rejected a “non-duplication” exclusion. Those states made their election under Article VII 4 of the Compact to not prospectively to opt out from participation in the LTC Standard based on that decision.

This history also makes the IAC proposal particularly inappropriate for consideration in a 5 Year Review process. Moreover the IAC does not assert that “circumstances or underlying assumptions have changed since the last time the rule was adopted, amended or reviewed,” the IIPRC scope for a 5 year review amendment.

More important, the IAC proposal does not lend itself to abbreviated consideration. The NAIC Long Term Care Insurance Model Regulation on this topic is vague and does not address the many issues associated with it. It is unknown to what extent state insurance departments approve either inter-company (non-duplication between policies issued by unaffiliated insurers) or intra-company (non-duplication between policies issued by the same insurer) exclusions.

The NAIC has revised the Long Term Care Insurance Model Regulation repeatedly to address issues that have arisen in the marketplace. This IAC proposal invites a thorough inquiry by the NAIC that likely will lead to another revision, including:

- 1) Which state departments disapprove non-duplication exclusions? Why?
- 2) Which states departments approve only intra-company exclusions? Why?
- 3) What forms of non-duplication exclusions are currently in-force?
- 4) Are insurer non-duplication exclusions included in existing in-force policies in reciprocal form and are they all compatible with the proposed exclusion (i.e. are provisions in in-force policies, and the proposed exclusion, reciprocal such that the insured is not left in a claims “gap.”)?
- 5) Have state insurance departments received consumer complaints regarding application of incompatible exclusions or disclosures?
- 6) What compatibility/reciprocal issues have insurer claim departments observed when applying inter-company exclusions?
- 7) How do insurer claims departments apply such an exclusion? How do they determine and react to another insurer’s adjudication of a claim?
- 8) Do insurers apply an exclusion only when both policies permit extending benefits by preserving a “pool” of benefits? To what extent do existing in-force policies lack such a feature for extension of coverage? How are consumers who purchased coverage without such a feature protected from inappropriate loss of benefits?
- 9) What compensation standards do insurers apply to limit incentive for inappropriate sale of unsuitable additional coverage?
- 10) Have state insurance departments observed insurer compensation practices that inappropriately provide incentive for unsuitable sale of additional coverage? Have any departments adopted standards to mitigate such as practice?

- 11) Have state insurance departments observed marketplace practices of sale of additional coverage to circumvent replacement restrictions, including compensation limits?
- 12) Can insurers adopt rating practices for intra-company replacements to enhance coverage that mitigates issue age loss so that replacement coverage, rather than additional coverage, can be appropriately issued?
- 13) What are the rating practices that are applied and that are they appropriate when coverage is offered that provides benefits only on a prorated basis because of application of a non-duplication exclusion.
- 14) Since sale of additional coverage is driven by representations of long term care inflation projections is it appropriate to develop standards for this type of marketing?
- 15) What are the disclosures that are appropriate regarding “non-duplication” exclusions?

These questions need to be asked. The NAIC Senior Issue Taskforce is best positioned to consider these issues and to develop a response that protects consumers and preserves an efficient and uniform long-term care insurance market. We urge you to refer the matter to the NAIC.