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, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Product Identifier

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

	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	

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Long-Term Care Stand-Alone and Hybri7 Ƭd.ÐTc Ƭw Alone and

Schedule 5––Claimant Request Determinations Timeliness

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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.

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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.

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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 becaus caund(r)-1.7 (r)-1.7 (005 T2.6(t)-8 (r)-3. (e)1.2 ( )] 0 Tw 12.761 0 .4[(A)0.9 .003

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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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