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DEPARTMENT OF

**Professional &  
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STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

# **A Report to the Joint Standing Committee on Insurance and Financial Services of the 128<sup>th</sup> Maine Legislature**

## **Regulatory Options for Addressing Issues in Long-term Care Insurance**

**January 2017**

**Maine Bureau of Insurance**

Paul R. LePage  
Governor

Anne L. Head  
Commissioner

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Superintendent

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This Bureau of Insurance (BOI) report is in response to a letter received February 25, 2016 from the Maine Legislative Joint Standing Committee on Insurance and Financial Services (IFS). As outlined in the letter, this report reviews Maine's current laws and regulations pertaining to Long Term Care (LTC) Insurance; analyzes recent National Association of Insurance Commissioners (NAIC) changes to the *Long-term Care Insurance Model Regulation* and the *Model Bulletin on Alternative Filing Requirements for Long-term Care Premium Rate Increases*; and provides recommendations for statutory or regulatory action.

## **I. MAINE’S LONG-TERM CARE INSURANCE MARKET**

The long-term care insurance market presents many challenges for policyholders, insurance carriers, public policy makers, and regulators alike in Maine and throughout the United States.

Companies that began selling policies in the early 1980s in Maine, and nationally, did not accurately anticipate future increases in health care costs or sustained low interest rates, or the low lapse rates and longevity of policyholders. These factors became clear, when companies eventually began paying benefits, that policies had been underpriced for the rich benefits they provided<sup>1</sup>. As a result, after years of stable premiums, consumers began to see significant rate increases. These increases have burdened consumers who have worked hard and planned ahead, especially retirees on fixed incomes.

Given the factors noted above, the market for long term care insurance dwindled rapidly once companies began to pay benefits and accumulate claims experience. A survey by America’s Health Insurance Plans in the year 2000 reported that 125 insurers were selling long-term care insurance in the United States. By 2014 only 15 insurers sold more than 2,500 individual long term care insurance policies in the United States.<sup>2</sup> Today, there are only ten companies writing individual policies in this market in Maine.

The failure of companies to accurately project costs and consumer behavior has resulted in insolvency for a number of companies. Prime examples of that are Penn Treaty Network America Insurance Company (PTNA) and its subsidiary, American Network Insurance Company. On July 27, 2016 the Pennsylvania Insurance Commissioner

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<sup>1</sup> Long term care insurance is what is known as a “long tail” line of insurance, that is, reserves are established and held for the payment of claims many years in the future. Interest earned on reserves is accordingly another important pricing factor for insurers.

<sup>2</sup> “The State of Long-Term Care Insurance, The Market, Challenges and Future Innovations”, National Association of Insurance Commissioners and the Center for Insurance Policy and Research, May 2016, p. 12.

petitioned a Pennsylvania court to place PTNA and American Network Insurance Company into liquidation. According to the Petition, it is undisputed that these companies are insolvent. “As of May 2016, PTNA has admitted assets of less than \$454 million, liabilities exceeding \$4.28 billion, and a resulting surplus deficit of more than \$3.82 billion. The Company is insolvent by more than \$3.82 billion and that insolvency will deepen over time.”<sup>3</sup>

### **Maine Long-Term Care Insurance Rate Review**

Maine Rule 420 applies to long-term care insurance policies issued prior to October 1, 2004. These products were priced with a minimum loss ratio of 60% (the amount that must be spent directly on benefits).

During the mid-2000s, the NAIC adopted new rating standards designed to encourage insurers to set better initial rates, by increasing the standards for insurers to obtain subsequent rate relief. These standards apply to Maine policies issued on or after October 1, 2004, as outlined in Maine Rule 425. These “post rate-stabilization” policies are required to have a minimum loss ratio of 85% for future premiums after a rate increase.

Maine has not adopted the most recent model revisions or bulletin, adopted by the NAIC on June 10, 2014, however, the Bureau already administratively applies many of the concepts embodied in these revisions and carriers voluntarily make filings in accord with other NAIC provisions. Nevertheless, to the extent these revisions are at least as stringent as current Maine requirements the Bureau will be proposing amendment to existing Rule Chapters 420 and 425 to incorporate them.

Currently, companies must receive approval prior to increasing rates on long-term care insurance policies issued in Maine. Form and rate filings may be made, at the insurer’s

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<sup>3</sup> Only American Network Insurance Company was licensed and did business in Maine. Preliminary information suggests that American Network has approximately 50 Maine policies in effect.

option, with either the BOI or the Interstate Insurance Product Regulation Commission (IIPRC), which has adopted the 2014 revisions to the NAIC model into its review guidelines. Long-term care policies approved by the IIPRC for proposed rate increases of 15% or more must be reviewed and approved by each compacting state.<sup>4</sup>

Those policies that are not under Maine Bureau of Insurance jurisdiction are individual policies sold or issued in other states (even when the policyholder later moves to Maine), employer group policies issued in other states, and policies approved by the IIPRC for proposed rate increases less than 15%.

For rate filings under Maine's jurisdiction, Bureau staff carefully review the requested increase and then send it to an actuarial consulting firm for independent review. The carrier must provide specific information supporting its rate request. Companies are not permitted to recoup past losses through premium increases.

The type of review conducted by the Bureau will depend upon whether the filing applies to pre or post rate-stabilization policies. After careful review of a proposed rate increase, the Bureau may disapprove a proposed rate increase, approve a lower increase, or approve the filing as submitted if actuarially justified. Carriers are encouraged to spread larger increases (greater than 15%) over several years – with full disclosure to policyholders – in an effort to reduce the impact of a rate increase.

Most long-term care insurers offer consumers reduced benefits as an alternative to rate increases, for both the older legacy policies and the post-stabilization policies. By reducing benefits, such as inflation protection (from 5% to 3%, for example) or lifetime payments (to a fixed number of years), a policyholder can often avoid or lessen a

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<sup>4</sup> On September 1, 2016, the IIPRC published proposed amendments to nine uniform standards relating to long term care insurance. These proposed amendments may be found at [http://www.insurancecompact.org/compact\\_rlmkng\\_docket.htm](http://www.insurancecompact.org/compact_rlmkng_docket.htm).

premium increase. A *contingent non-forfeiture benefit*<sup>5</sup>, available in some instances for larger increases meeting a prescribed threshold, allows a policyholder to stop paying premiums while retaining benefits – up to the total premium paid-in under the policy.

## **STAKEHOLDER INPUT**

The Maine Bureau of Insurance is supportive of creative initiatives that present constructive fixes for the long-term care insurance market, such as innovative benefit designs and pricing structure, and is continuing to actively explore these ideas with stakeholders on both a state and national level.

The Bureau held a public forum on long-term care insurance May 9, 2016 at the Augusta Civic Center, which was available via live-stream over the internet. Written presentations and statements as well as the webcast recording are posted to the Bureau's website.<sup>6</sup> The forum featured Bureau presentations about the rate review process, Maine's Long-Term Care Insurance Partnership Program<sup>7</sup> and new claims processing requirements. Consumers submitted written and in-person comments about their experiences as policyholders. Individuals representing the insurance industry, MaineCare, and consumer advocate organizations presented their views on the challenges presented by the long-term care situation in Maine.

On a national level, Maine is a member of the NAIC's Senior Issues Task Force and its Long Term Care Innovation Subgroup. The goal of the Subgroup is to develop actionable, realistic policy options that will increase the popularity of private insurance

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<sup>5</sup> A *nonforfeiture* clause is a clause in an insurance policy that allows for the insured to receive all or a portion of the benefits or a partial refund on the premiums paid if the insured misses premium payments, causing the policy to lapse.

<sup>6</sup> [http://www.maine.gov/pfr/insurance/LTC/Long\\_Term\\_Care\\_Webcast.html](http://www.maine.gov/pfr/insurance/LTC/Long_Term_Care_Webcast.html)

<sup>7</sup> Maine's Long Term Care Partnership program is intended to reduce reliance on MaineCare as a funding vehicle for long-term care costs. It allows purchasers of qualifying partnership program policies to retain assets in the amount of paid out policy benefits, thereby increasing MaineCare eligibility spend-down thresholds.



and provide additional asset protection options for more middle-income Americans, using potential product modifications and appropriate incentives.<sup>8</sup>

Below, in brief, are some of the ideas presented to the Subgroup that will be considered moving forward.

## **Innovation**

- Policies that have simpler benefit choices, standardized benefit packages, standardized definitions and exclusions, and more affordable options.
- “Retirement LTC insurance” – a product lower in cost, designed to cover 2-4 years of benefits after a deductible or exclusion period is met, and includes coinsurance. Funds may be used from retirement accounts to pay premiums and early withdrawals would be penalty free. Standard inflation protection would be updated annually, non-level premiums would be updated for growth in the Consumer Price Index, and carriers would be required to revise premiums up or down every three years, based on actuarial assumptions.

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<sup>8</sup> More specifically, the Innovation Subgroup has the following 2016 Charges:

- Examine the future of financing long term care given the significant impact of long term care costs on state budgets through state Medicaid programs, including an assessment of the role the private market should play.
- Review the number of alternative products structures being developed and, in some cases, sold by companies (i.e., LTC/life combination products, term products, and universal LTC policies). Consider whether these are viable alternative products and what other types of products may assist in financing long term care costs. This does not include examination of rating issues facing the legacy long-term-care insurance products.
- Examine whether amendments are needed to current NAIC models or regulations, whether there is a need for new models or regulations to accommodate a changing market, or whether federal action may be necessary and should be encouraged.
- Discuss the legal and regulatory barriers that may need to be overcome to improve the functioning of the private long-term care insurance market to assist in financing long term care needs.
- Consider the pricing issues with any potential new long term care financing products and whether the pricing of these products creates a stable market.
- Work with private insurance companies, consumers, and consumer advocates about the future role of insurance in financing long term care given the history of long term care insurance over the last few decades, including the role they see for the private market and the types of products that are most appealing to them.

- “Term funded product” - premiums would gradually rise until a set age and then level off.
- Develop a high deductible LTC insurance product (with a longer-than-typical waiting period).
- Index LTC insurance premiums and benefits, reducing inflation risk and the initial reserves necessary for companies to start offering LTC insurance.
- Allow Medicare Supplement Insurance carriers to include long-term care coverage, as an option for consumers.
- “Family Long-Term Care Account” – an individual or family savings product designed with a long-term care insurance element added.
- Design a LTC insurance policy that “looks like” a health insurance policy (high deductible, coinsurance, tax-advantaged savings fund that accumulates over time, out-of-pocket maximum, provider networks, integration/coordination with all providers).

### **Affordability and Availability**

- Provide incentives to employers who sponsor retirement plans to also offer LTC insurance on an opt-out basis. For example, employers who offer LTC insurance might be offered a safe harbor (to limit fiduciary liability) and expanded “catch-up” contributions if the employer automatically enrolls employees (who would have the ability to opt-out).
- Permit retirement plan participants (ages 45 and older) to make a distribution from a 401(k), 403(b) or IRA to purchase LTC insurance with no early withdrawal penalty.
- States could offer LTC insurance to public employees.
- Allow LTC insurance to be sold through state and federally operated online health insurance marketplaces similar to those operated for medical insurance under the Affordable Care Act.

- Allow federal tax deduction up front (rather than for expenses over 7.5% of AGI) each year a LTC insurance policy is in force.
- Allow more flexibility in plan design regarding inflation protection, including an option of no inflation protection for partnership qualified plans.
- Permit LTC insurance to be available for purchase through cafeteria plans.
- Consider elimination of the requirement to offer a 5% compound benefit increase option.
- Consider making shorter-term maximum benefit plans (<1 year) tax qualified, to allow market expansion through lower-priced, shorter duration products that may fill a gap for consumers.

## **Other**

- Clearer regulatory guidelines regarding rate increases might attract companies back into the private LTC insurance market.
- Consider developing a multi-state reinsurance pool as a backstop. Fund the pool through a small assessment on each insurer to offer protection to the industry, while potentially lowering premiums.
- Promote consumer education regarding the importance of planning for LTC needs, and options for financing LTC. NAIC should create and make available to all public and private outlets one or a series of standardized and generic educational presentations that could be used by states, employers, agents and others.
- Make LTC insurance training part of a producer's general life and health insurance training.
- Consider retooling and rebranding private LTC insurance; it's not nursing home insurance any more but maybe it shouldn't be LTC insurance either.
- Reexamine the amount of disclosure a consumer receives at the time of sale to ensure that key messages are not lost in the extensive required disclosures.

### **III. ANALYSIS**

#### **Analysis of Current Maine Statute and Regulations Compared to the NAIC Model 641 Revisions**

Revisions to NAIC Model 641 (Appendix B) were adopted by the Health Insurance and Managed Care Committee of the NAIC on June 10, 2014. The changes to the model regulation include:

1. For initial rate filings, Section 10 of the revised model requires a 10% minimum composite moderately adverse experience (MAE) margin. The model previously did not stipulate a minimum. The new 10% minimum margin encourages more conservative pricing to reduce the need for future rate increases. While the minimum is not explicitly required by Maine's regulations, many carriers are including it in their initial rate filings. However, the Bureau does not allow it to be as justification for subsequent rate increases.
2. Section 15 modifies reporting requirements to require the insurer to submit an annual actuarial certification to the Bureau attesting to the sufficiency of the current premium rate structure. This requirement applies to newly issued policies and annually, thereafter. This annual review of claims experience by an independent actuary is intended to encourage an insurer to file a rate increase when needed, rather than delay the request, which could result in a larger rate increase later. The effect of delaying a justified increase for several years raises the amount that can be justified, so it is in the best interest of both carriers and consumers to implement them as they are needed. Maine currently requires carriers to annually certify premium sufficiency after a rate increase for post-rate stabilization policies but only for three years. The Bureau will be proposing to adopt this change.

3. Section 20 loosens certifications requirements to permit the regulator to consider and approve a rate increase that is lower than required under the rate-stabilization requirements. The drafting note in this section also indicates that, in lieu of a large increase, a series of smaller increases implemented over time are permitted. In general, consumers who have filed long-term care increase complaints have stated that they prefer several smaller rate increases over time rather than one large rate increase. A revision was made to the premium rate schedule increase section to allow an insurer to request a lower rate increase than otherwise required by their premium sufficiency certification to accommodate multiple smaller increases. The Bureau has been accepting lower rate increases under the Superintendent's discretion, with disclosure to the policyholder that future rate increases could be needed. The Bureau also already encourages phased-in increases for large rate approvals, but will be proposing to adopt the change to codify the practice.
4. Section 20.1 increases the minimum loss ratio requirement for post-rate stabilization blocks of business. The previous model had a 58% minimum required loss ratio for past premium and claims when an increase is proposed. The revision increases the minimum past claim to premium loss ratio for post-stabilization policies to the greater of (1.) the original 58% or (2.) the target loss ratio established by the insurer in their initial rate filing for the block of business.<sup>9</sup> Maine currently holds carriers to this standard as part of the rate review process; however the Bureau will be pursuing its formal adoption by regulation.
5. Section 27 strengthens consumer disclosure requirements at the time of a rate increase by requiring that the policyholder notice include an offer to

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<sup>9</sup> An 85% lifetime loss ratio requirement also applies prospectively to the blocks of business with rate increases. Thus, post rate-stabilization blocks of business, which have been affected by rate increases, are subject to a higher dual loss ratio requirement.

reduce benefits and the effect of reducing benefits for partnership policies. The Bureau already requires this as part of the rate review process.<sup>10</sup>

6. Section 28 reduces contingent nonforfeiture benefit triggers for older pre-stability policies; and for policyholders with issue ages of 54 and younger. It lowers the rate increase trigger of cumulative rate increases from the current 110 - 200 percent to 100 percent. Maine already requires a contingent nonforfeiture benefit for pre-stability policies similar to the NAIC's provision for post-stability policies, and many carriers voluntarily offer the limited contingent nonforfeiture for large rate increase requests. The model changes could aid more consumers who decide to let their policies lapse following a rate increase, by providing an opportunity to receive a paid up coverage benefit. The Bureau will be proposing this change.

### **Analysis of Current Statute and Regulations Compared to NAIC Bulletin**

Model Bulletin: Announcement of Alternative Filing Requirements for Long-Term Care Premium Rate Increases was adopted by the NAIC on June 10, 2014 (Appendix B). The provisions suggested in the bulletin include:

Approval of Rate Increases: The first section of the bulletin that addresses rate increases discusses a review of actuarial assumptions to determine if rate increases are necessary. This section allows the state to charge the insurer if the state uses an independent actuary to review the assumptions. The Bureau currently contracts with an independent actuarial firm to review actuarial assumptions but does not pass the cost on to the insurer.

The following portion of the rate section provides that either: (1.) the entire requested increase be approved with no further increases for three years, or (2.) there be a series

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<sup>10</sup> Model consumer disclosure requirements associated with long-term care insurance rate increases are currently under review by the NAIC's Long-Term Care Consumer Disclosure Subgroup of the Senior Issues Task Force.

of scheduled rate increases that are actuarially equivalent to the single amount requested. The Bureau currently encourages phased-in increases when the request is greater than 15%.

Requirement to Administer Contingent Benefit Upon Lapse: This requirement applies the contingent benefit upon lapse to pre-stability policies. It also requires that increases meeting the minimum contingent benefit upon lapse threshold be treated as triggers whether the rate is implemented all at once or whether phased-in over time. Maine's Rule 425 already requires these provisions.

For policies that have been in force for twenty years or more, consistent with the Bulletin, the Bureau will propose to require the insurer to provide the contingent benefit upon lapse benefit. For any policies not in place for twenty years any percentage value in excess of 100% would be reduced to 100%. These changes could provide more consumers who decide to let their policies lapse following a rate increase with an opportunity to receive a paid up coverage benefit.

Policyholder Notification of Premium Increase: This section requires the insurer to file the premium increase notification letter with the Bureau with the premium increase filing request and stipulates what should be stated in the letter. Maine already requires the policyholder notification letters to be submitted prior to approving a rate increase, and staff review the letters for compliance with the model law. (The Bureau is a member of the NAIC subgroup reviewing suggested disclosures for policyholder notices.)

Application of New Loss Ratio Standards: This section requires the use of the 60%/80% dual loss ratio for pre-stabilized rate policies, with the 60% requirement applied to the initial filing and the 80% applied to subsequent increases. Maine already has more stringent dual loss ratio requirements for pre-stability policies requiring 60%/85% loss ratios and adjustment of past premium increases back to the initial basis to prevent insurers from recouping past losses.

Consideration of New Approaches: This section encourages consideration of other options that may be available to policyholders to mitigate the impact of rate increases. The Bureau continues to seek stakeholder input to long-term care insurance problems.



## CONCLUSION

Many challenges confront the ongoing viability of long-term care insurance as a meaningful component of financing long term care. The Bureau of Insurance is actively engaged on a state and national level in the effort to seek solutions to these challenges.

There are some provisions in the 2014 revisions to the NAIC *Long-term Care Insurance Model Regulation* and the *Model Bulletin on Alternative Filing Requirements for Long-term Care Premium Rate Increases* that could be beneficial to consumers and enhance state uniformity for rate review. Although Maine has administratively incorporated many of these provisions into the current rate review process and carriers are voluntarily abiding by others, the Bureau will be proposing amendments to existing Rule Chapters 420 and 425 to incorporate the 2014 model and bulletin provisions – except in instances when the current Maine rules are more stringent than the Model.

Some further reading on challenges and possible solutions for the market include:

- The NAIC’s Center for Insurance Policy and Research May 2016 publication: “The State of Long Term Care Insurance, The Market, Challenges and Future Innovations”.<sup>11</sup> This study of the national market has twenty-one authors representing industry, consumer advocate, academic and regulatory interests. .
- The NAIC’s Long-Term Care Actuarial Working Group Pricing Subgroup’s September 2016 survey of state long term care rating regulations and practices. Forty-nine states, the District of Columbia and the IIPRC responded. The survey results are contained in the Appendix to this Report.

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<sup>11</sup> As October 2016 this study may be found online at [http://www.naic.org/documents/cipr\\_current\\_study\\_160519\\_ltc\\_insurance.pdf](http://www.naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf). A disclaimer notes that this study represents the opinions of the author(s) and is the product of professional research. It is not intended to represent the position or opinions of the NAIC or its members, nor is it the official position of any staff members. Any errors are the responsibility of the author(s).

## APPENDICES

## **Appendix A**

February 25, 2016 letter from Insurance and Financial Services Committee to  
Superintendent of Insurance



## **Appendix B**

2014 NAIC Long Term Care Insurance Model Regulation Revisions and Model  
Bulletin

Draft: 7/24/14

Revisions to Model 641

Adopted by the Health Insurance and Managed Care (B) Committee, 6/10/14

Adopted by the Senior Issues (B) Task Force, 3/29/14

Underlining and overstrikes show the changes from the existing model.

**LONG-TERM CARE INSURANCE MODEL REGULATION****Table of Contents**

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**Section 4. Definitions**

For the purpose of this regulation, the terms “long-term care insurance,” “qualified long-term care insurance,” “group long-term care insurance,” “commissioner,” “applicant,” “policy” and “certificate” shall have the meanings set forth in section 4 of the NAIC Long-Term Care Insurance Model Act. In addition, the following definitions apply.

**Drafting Note:** Where the word “commissioner” appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

- A. “Benefit trigger”, for the purposes of independent review, means a contractual provision in the insured’s policy of long-term care insurance conditioning the payment of benefits on a determination of the insured’s ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in §7702B of the Internal Revenue Code of 1986, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

**Drafting Note:** This definition is not intended to be a required definitional element of a long-term care insurance policy, but rather intended to clarify the scope and intent of §31. The requirement for a description of the benefit trigger in the policy or certificate is currently found in §8.

- B. (1) “Exceptional increase” means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:
- (a) Due to changes in laws or regulations applicable to long-term care coverage in this state;  
or

- (b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.
- (2) Except as provided in Sections 20 and 20.1, exceptional increases are subject to the same requirements as other premium rate schedule increases.
- (3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.
- (4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

- C. “Incidental,” as used in Sections 20J and 20.1J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Drafting Note: The phrase “value of the benefits” is used in defining “incidental” to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

- D. “Independent review organization” means an organization that conducts independent reviews of long-term care benefit trigger decisions.
- E. “Licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment.

Drafting Note: For purposes of Section 31, it may be appropriate for certain licensed health care professionals, such as physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists, to review a benefit trigger determination. However, some of these health care professionals may not meet the definition of a licensed health care practitioner under Section 7702B(c)(4) of the Internal Revenue Code. For tax-qualified long-term care insurance contracts, only a licensed health care professional who meets the definition of a licensed health care practitioner may certify that an individual is a chronically ill individual.

- F. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.
- G. “Similar policy forms” means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

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#### Section 10. Initial Filing Requirements

- A. This section applies to any long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation], except that Subsection B(2)(d) and Subsection B(3) apply to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

- B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

**Drafting Note:** States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

- (1) A copy of the disclosure documents required in Section 9; and
- (2) An actuarial certification consisting of at least the following:
  - (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
  - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
  - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
  - (d) ~~A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:~~  
A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in (i) or the specification of and justification for a lower margin as required by (ii).
    - (i) ~~Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;~~  
A composite margin shall not be less than 10% of lifetime claims.
    - (ii) ~~A statement that the assumptions used for reserves contain reasonable margins for adverse experience;~~  
A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.
    - (iii) ~~A statement that the net valuation premium for renewal years does not increase (except for attained age rating where permitted); and~~  
A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

**Drafting Note:** For the justification required in (iii) above, examples of such considerations, if applicable to the product and company, might be found in Society of Actuaries research studies entitled “Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance” (2012) and “Understanding the Volatility of Experience and Pricing Assumptions in Long-Term Care Insurance Programs” (2014).

- (iv) ~~A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;~~



A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

Drafting Note: Actual margins may be included in several actuarial assumptions (e.g. mortality, lapse, underwriting selection wear-off, etc.) in addition to some of the margin in the morbidity assumption. The composite margin is the total of such margins over best-estimate assumptions.

Drafting Note: When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

- (I) ~~An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;~~
- (II) ~~If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection C based on a standard age distribution; and~~
- (c) (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
- (ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Drafting Note: In the event a series of increases is being applied to another policy form, intermediate premium levels are not to be used in this comparison.

Drafting Note: It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

- (f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
  - (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
  - (ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
- (3) An actuarial memorandum prepared, dated and signed by the member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:
  - (a) An explanation of the review performed by the actuary prior to making the statements in Paragraph (2)(b) and (c).
  - (b) A complete description of pricing assumptions; and

(c) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in Paragraph (2)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

(d) A demonstration that the gross premiums include the minimum composite margin specified in Paragraph (2)(d).

- C. ~~(1) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.~~

In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

Drafting Note: The commissioner may accept a review done for another state or states if such review is for the same policy form or where any differences in benefits and premiums are not material and such review was completed within eighteen months of the date of the actuarial certification in Subsection B(2) above.

- ~~(2) In the event the commissioner asks for additional information under this provision, the period in Subsection B does not include the period during which the insurer is preparing the requested information.~~

~~Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not address fully the questions that triggered the request for the actuarial demonstration.~~

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## Section 15. Reporting Requirements

- A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
- B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)
- C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.
- D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)
- E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)
- F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix B)

G. For purposes of this section:

- (1) "Policy" means only long-term care insurance;
- (2) Subject to Paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
- (3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
- (4) "Report" means on a statewide basis.

H. Reports required under this section shall be filed with the commissioner.

I. Annual rate certification requirements.

- (1) This Subsection applies to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].
- (2) The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this section.

(a) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

(i) A statement of the sufficiency of the current premium rate schedule including:

(1) For the rate schedules currently marketed,

a. The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

b. If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within sixty (60) days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify its approval of the form for future sales pursuant to [Reference State form approval authority and administrative procedures rules].

Drafting Note: In accordance with the anticipated changes to Section 10, in situations where the premium rates have been approved with less than the normal minimum margin for moderately adverse experience, any adverse experience should be reviewed to determine if the lower margins can be continued for new business.

- (II) For the rate schedules that are no longer marketed,
  - a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or
  - b. That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.
- (i) A description of the review performed that led to the statement.
- (b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:
  - (i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (1)(a).
  - (ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

Drafting Note: ASOP No. 18, the NAIC *Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation* and the Academy of Actuaries Practice Note "Long-Term Care Insurance, Compliance with the NAIC Long-Term Care Insurance Model Regulation Relating to Rate Stability" all provide details concerning the key pricing assumptions, underlying actuarial judgments and the manner in which experience should be monitored.

- (iii) A description of the credibility of the experience data.
- (iv) An explanation of the analysis and testing performed in determining the current presence of margins.
- (c) The actuarial certification required pursuant to Paragraph (2)(a) must be based on calendar year data and submitted annually no later than May 1st of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to Paragraph (2)(b) must be submitted at least once every three (3) years with the certification.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not certify to the maintenance of margins.

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#### Section 19. Loss Ratio

- A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10, ~~and 20~~ and 20.1.
- B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a

manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- (1) Statistical credibility of incurred claims experience and earned premiums;
- (2) The period for which rates are computed to provide coverage;
- (3) Experienced and projected trends;
- (4) Concentration of experience within early policy duration;
- (5) Expected claim fluctuation;
- (6) Experience refunds, adjustments or dividends;
- (7) Renewability features;
- (8) All appropriate expense factors;
- (9) Interest;
- (10) Experimental nature of the coverage;
- (11) Policy reserves;
- (12) Mix of business by risk classification; and
- (13) Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
- (3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;
- (4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and
- (5) An actuarial memorandum is filed with the insurance department that includes:
  - (a) A description of the basis on which the long-term care rates were determined;

- (b) A description of the basis for the reserves;
- (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
- (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
- (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- (f) The estimated average annual premium per policy and the average issue age;
- (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

**Drafting Note:** The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 19 above which removes the word "individual": (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

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#### Section 20. Premium Rate Schedule Increases

**Drafting Note:** Section 20 applies to policies issued for effective dates prior to the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC on [insert NAIC adoption date]). Policies issued on or after that date should adhere to the requirements of Section 20.1 instead of Section 20. Section 20 and Section 20.1 are identical with the exceptions of Subsections A, C and G.

- A. This section shall apply as follows:
  - (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] and prior to [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].
  - (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

- B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval." States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

- (1) Information required by Section 9:
- (2) Certification by a qualified actuary that:
  - (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
  - (b) The premium rate filing is in compliance with the provisions of this section;
  - (c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10.B(2)(e) or Section 20.B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

- (3) An actuarial memorandum justifying the rate schedule change request that includes:
  - (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
    - (i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
    - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
    - (iii) The projections shall demonstrate compliance with Subsection C; and
    - (iv) For exceptional increases,
      - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
      - (II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;
  - (b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

- (c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
  - (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; ~~and~~
  - (e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and
  - ~~(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.~~
  - (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
  - (5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
  - (2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
    - (a) The accumulated value of the initial earned premium times fifty-eight percent (58%);
    - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
    - (c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
    - (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;
  - (3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and
  - (4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group



insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

- E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:
- (a) Premium rate schedule adjustments; or
  - (b) Other measures to reduce the difference between the projected and actual experience.

*Drafting Note:* The terms “adequately match the projected experience” include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer’s projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

- (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.
- G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:
- (1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and
  - (2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).
- H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
- (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
  - (b) The rate increase is not an exceptional increase; and
  - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

- (2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
- (a) The offer shall:
- (i) Be subject to the approval of the commissioner;
  - (ii) Be based on actuarially sound principles, but not be based on attained age; and
  - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
- (i) The maximum rate increase determined based on the combined experience; and
  - (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).
- I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

**Drafting Note:** States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

- (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
  - (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4BC, if the policy complies with all of the following provisions:
- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  - (2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
    - (a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
    - (b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and

- (c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];
- (3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];
- (4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
  - (a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];
  - (b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and
  - (c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].
- (5) An actuarial memorandum is filed with the insurance department that includes:
  - (a) A description of the basis on which the long-term care rates were determined;
  - (b) A description of the basis for the reserves;
  - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
  - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
  - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
  - (f) The estimated average annual premium per policy and the average issue age;
  - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
  - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:
  - (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

- (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 20.1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

Drafting Note: Section 20.1 applies to policies issued for effective dates on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC on [insert NAIC adoption date]). Policies issued prior to the date that is six (6) months after adoption of the amended regulation should adhere to the requirements of Section 20 instead of Section 20.1. Section 20 and Section 20.1 are identical with the exception of Subsections A, C and G.

A. This section shall apply as follows:

- (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].
- (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval." States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

- (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
- (b) The premium rate filing is in compliance with the provisions of this section;
- (c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10.B(2)(e) or Section 20.B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

- (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
- (i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
- (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
- (iii) The projections shall demonstrate compliance with Subsection C; and
- (iv) For exceptional increases,
- (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
- (II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;
- (b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
- (c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
- (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
- (e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and
- (f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.
- (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
- (5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
- (2) Premium rate schedule increases shall be calculated such that the sum of the lesser of (i) the accumulated value of actual incurred claims, without the inclusion of active life reserves, or (ii) the accumulated value of historic expected claims, without the inclusion of active life reserves,

plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

- (a) The accumulated value of the initial earned premium times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;
  - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
  - (c) The present value of future projected initial earned premiums times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
  - (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;
- (3) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;
- (4) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and
- (5) All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section 11A]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

- (a) Premium rate schedule adjustments; or
- (b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms “adequately match the projected experience” include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer’s projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

- (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.
- G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section.
- H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
- (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
  - (b) The rate increase is not an exceptional increase; and
  - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
- (2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
- (a) The offer shall:
    - (i) Be subject to the approval of the commissioner;
    - (ii) Be based on actuarially sound principles, but not be based on attained age; and
    - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
  - (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
    - (i) The maximum rate increase determined based on the combined experience; and
    - (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

- I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

- (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
- (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

- J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
  - (a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
  - (b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and
  - (c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];
- (3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];
- (4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
  - (a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];
  - (b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and
  - (c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].
- (5) An actuarial memorandum is filed with the insurance department that includes:
  - (a) A description of the basis on which the long-term care rates were determined;
  - (b) A description of the basis for the reserves;



- (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
  - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
  - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
  - (f) The estimated average annual premium per policy and the average issue age;
  - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
  - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:
- (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
  - (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

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## Section 27. Right to Reduce Coverage and Lower Premiums

- A. (1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
    - (a) Reducing the maximum benefit; or
    - (b) Reducing the daily, weekly or monthly benefit amount.
  - (2) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.
  - (3) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.
- B. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

- C. ~~The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.~~  
The premium for the reduced coverage shall:
- (1) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
  - (2) Be consistent with the approved rate table.
- D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
- E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7A(3) of this regulation.
- F. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- G. The requirements of ~~Subsections A through F~~ this Section shall apply to any long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].
- H. A premium increase notice required by Section 9E of this regulation shall include:
- (1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;
  - (2) A disclosure stating that all options available to the policyholder may not be of equal value; and
  - (3) In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.
- I. The requirements of Subsection H shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].

Drafting Note: Compliance with this Section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

#### Section 28. Nonforfeiture Benefit Requirement

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:
- (1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and
  - (2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.
- C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in

this Section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection D(4) shall still apply.

- D. (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.
- (2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
- (3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%

84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

- (4) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (5) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:
- (a) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting consistent with the requirements of Section 27~~ so that required premium payments are not increased;

**Drafting Note:** The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

- (b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and
- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above unless the automatic option in Paragraph (6)(c) applies.
- (6) On or before the effective date of a substantial premium increase as defined in Paragraph (4) above, the insurer shall:
- (a) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting consistent with the requirements of Section 27~~ so that required premium payments are not increased;

**Drafting Note:** The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

- (b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse

times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and

- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forth percent (40%) or more.

(7) For any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

(a) In the event the policy or certificate was issued at least twenty (20) years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the above table; and

(b) Values above 100% in the table in Paragraph (3) above shall be reduced to 100%.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection D(3) but not Subsection D(4), are described in this subsection:

- (1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).
- (2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).
- (3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection F.
- (4)
  - (a) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.
  - (b) Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
    - (i) The end of the tenth year following the policy or certificate issue date; or
    - (ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
- (5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

- G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.
- H. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:
- (1) Except as provided in Paragraph (2) and (3) below, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.
  - (2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.
  - (3) The last sentence in Subsection C and Subsections D(4) and D(6) shall apply to any long-term care insurance policy or certificate issued in this state after six (6) months after their adoption, except new certificates on a group policy as defined in Subsection 4E(1) one year after adoption.
- I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 19, ~~or Section 20~~ or Section 20.1, whichever is applicable, treating the policy as a whole.
- J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection D(3) or D(4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.
- K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
- (1) The nonforfeiture provision shall be appropriately captioned;
  - (2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and
  - (3) The nonforfeiture provision shall provide at least one of the following:
    - (a) Reduced paid-up insurance;
    - (b) Extended term insurance;
    - (c) Shortened benefit period; or
    - (d) Other similar offerings approved by the commissioner.

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## **Appendix C**

Comparison of Maine Insurance Rules Chapter 420 and 425 to 2014 NAIC Model  
Regulation Revisions and Model Bulletin

## Appendix C

<u>Topic</u>	<u>Maine's Rule 425/420</u>	<u>NAIC Revised Model Regulation 641/Model Bulletin</u>	<u>Comments</u>
Moderately Adverse Experience Margin in Initial Filing	No minimum.	Model – section 10 requires a minimum margin for moderately adverse experience of 10%	Encourages more conservative pricing
Annual Actuarial Certification	Only after an rate increase and only for 3 years – Rule 425	Yes, both - Section 15 in Model requires the insurer to submit an annual actuarial certification regarding the sufficiency of the current premium rate structure.	Annual review of experience encourages insurer to file for a rate increase when needed rather than delay, which could produce bigger increases later.
3 year rate guarantee after rate increase	No.	Bulletin – Yes  Model -no	Delay could lead to bigger increases later.
Approve series of Smaller increases	No.	Yes, both -section 20 in Model allows regulator to consider a rate increase that is lower than required under rate stabilization certification.	We do this in practice even though our regulation doesn't require us to.  Smaller increases are generally more manageable for consumers than large ones.
Contingent Nonforfeiture Benefit Upon Lapse	Yes. Statutory requirement for mandatory offers of nonforfeiture benefits and, in the case of policyholders declining the offer, contingent nonforfeiture benefits upon lapse that must be made following a substantial increase in premium rates was enacted in 1999. 24-A M.R.S.A. section 5077. Implementing rules were adopted in 2004. Slightly different provisions apply to	Yes, both-section 28 in Model reduces contingent nonforfeiture benefit triggers for older policies and lowers the rate increase trigger to 100% for policyholders with issue ages 54 and younger.	Changes may provide greater value to consumers who decide to lapse their policies following a rate increase.



## Appendix C

<u>Topic</u>	<u>Maine's Rule 425/420</u>	<u>NAIC Revised Model Regulation 641/Model Bulletin</u>	<u>Comments</u>
	policies issued prior to Oct. 1, 2004 and those issued thereafter.		
Special Contingent Benefit Upon Lapse for 20 year old policies	No.	Yes, both – Section 28(D) (7) in Model	
Application of Loss Ratio Standards	<p>Rule 420 - 60% based on propose increase from inception/85%</p> <p>Rule 425 – None for initial rates, 58%/85% for rate increases. Interstate Insurance Product Regulation Commission approves new products and rate increases not exceeding 15%.</p>	<p>Bulletin - greater of 60% or the lifetime loss ratio used in the original pricing, applied to the current rate schedule/80% individual applied to any premium increase filed after that date/75% group.</p> <p>Model – section 20.1 requires insurer to replace the “58” in the current 58/85 test with the greater than 58% and the original lifetime loss ratio with the moderately adverse margin specified in the initial filing.</p>	
Consumer Disclosures	<p>Yes. Rule 425, but not as detailed.</p> <p>Rule 420 – we review notices and approve language.</p>	Model Section 27 – specific disclosures about effects of reducing benefits on partnership policies, reducing inflation protection, etc.	NAIC LTC Disclosure group continuing to work on recommendations.
Charging Insurer for Services of Independent Actuary	No.	Bulletin - Department may charge insurer for cost of independent actuary.	

## **Appendix D**

Survey of State Long Term Care Insurance Rating Regulations and Practices

# Survey of State Long-Term Care Rating Regulations & Practices

## Survey Questions:

1. Do you have rate approval authority in the individual and/or group long-term care (LTC) markets?
2. a. Have you adopted the 2000 rate stabilization amendments to the NAIC *Long-Term Care Insurance Model Regulation* (#641)?
2. b. Have you adopted the 2014 rate stabilization amendments to Model # 641?
2. c. If neither, do you have minimum statutory loss ratio requirements, and if so, what are they?
2. d. Did your state utilize the model bulletin regarding alternative filing requirements for long-term care insurance premium rate increases, and if yes, did your state issue the model out as a bulletin or did some or all of the model provisions require regulatory and/or procedural adoption?
3. Do you have LTC rate increase caps? if so what are they, and are they statutory in nature or only internal guidelines?
4. Provide a brief description of the major factors considered during review and analysis of LTC rate increases.

State	1	2a	2b	2c	2d	3	4
AK	Yes, we have Long Term Care premium rate filing authority; however, we have not developed any regulations yet to implement that process.	No	No	No	No	NA	NA
AL	No	Yes	No	NA	No	No	Loss ratio. If assumptions are appropriate. Impact on consumer.
AR	Yes, both.	No	No	60%	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	Our Commissioner looks at all increases above 10% and generally does not grant more than 25%.	Loss ratios, state and national data, credibility of data, past rate change history
AZ	Individual, yes, group, no.	Yes	No, but will soon.	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	No	Actuarial justification, certification that no further rate increases are anticipated, state v. national experience, # of AZ policyholders, historical aggregate rate increase % in AZ and other states.
CA	Yes, both.	Yes	No	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	No	Actual-to-expected ratios, portion of increase request attributed to lapse-mortality-morbidity, appropriateness of the initial pricing assumptions when made, justification of any pricing assumption changes.

CO	Yes, both.	Yes	No	NA	No	.No explicit rate caps, but internal guidelines are that rate increases for a single year are not allowed > 25%. So a 70% rate increase allowed would need to be spread over multiple years.	Lifetime Loss Ratio (LT LR) projection is evaluated at multiple interest rate scenarios, not just the current low valuation rate, account for higher historic investment rates from inception. Limit an issuer from coming back after allowing a rate increase, require experience to deteriorate another 15% before coming back, cannot recoup prior losses. Review impact of rate changes due to changes in actuarial assumptions: Mortality, Morbidity, Voluntary Lapses, etc... Review LT LR projections by benefit levels (5% compounded, no-inflation,Lifetime, 5-year,...) Review LT LR projections at On-Rate Level premium (past rate increases applied back to year 1), LT LR at original assumptions versus current assumptions,... Ask for % of members on paid-up status, how are they handled in calculations. Old closed plans with members at high average attained ages (near 80) - we are more likely to disapprove rate increases, can't make up premium late in policy life, review demographics. Limit ability of issuers to make up for past losses, spread losses between company & policyholders (review Kansas DOI type spreadsheet) Ask for list of what other states the company requested the increase, what other states have approved/disapproved the proposed rate increases. We will on occasion discuss the rate filings directly with another state insurance department that we know is reviewing the same proposed increases and data from a company. Review IBNR loads in most recent two years of actual historical claims to see how much those are loaded up, margins put in those reserves in rating. High level financial review to see company's financial condition: RBC, Surplus, Net Income and UW gain, Capital and Reserve levels and recent year's reserving actions.
CT	Yes, both.	No	No	60% individual, 65% group	No	No, but increases approved over 20% have to be phased in over 3 years.	Historical CT & nationwide experience, an actual-to-expected analysis from inception-to-date, etc.
DC	Yes, both.	No	No	60%	No	10% per year cap; Statutory in nature	We first inquire why carriers need rate increases. If they (carriers) cite one of the prohibited reasons from DOI's Reg. Bulletin , then they get no relief for that part of their request. Then they (carriers) get to have no more than 10% increase at a time ( annual cap) --- (and also we may carve out of the 10% the disallowed portion if they cite a forbidden reason).Then they put together figures showing that they will still be providing at least the Min Loss Ratios (60%) after the rate increase.Also, the carrier justifies the " adverse" lapse assumption, with maximum values allowed.

DE	Yes, both.	No	No	65% Group, 60% Individual	No	The Commissioner generally tries to cap rate increase to no more than 15%	The major factors considered are the loss ratio results which are developed by the Company projections and also by independent projection and inequality test.
FL	Yes, both.	Yes	No, but will within 12 months.	NA	No	No	We review differences between actual experience and pricing assumptions including but not limited to lapse, mortality, incidence, claim termination.
GA	Yes, both.	Yes	No	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	No	Most LTC rate increase proposals come from older blocks of business, priced and sold many years before modern Rate Stabilization, etc. As such, we consider everything submitted as supporting documentation, but we generally concentrate on emerging cumulative loss ratio, actual to expected loss ratio, statistical significance and credibility of Georgia block in relation to national claims experience, discussion of a company's particular performance characteristics in how their actual lapses, earnings on reserves, claims, degree of average length of benefit period of coverage, inflation protection trends and original LTC structural model and pricing design flaws are affecting the Georgia LTC block as actuaries present their lifetime loss ratio projections.
HI	Yes, both.	Yes	No	NA	No reply	No	LTC rate increase filings for policies sold after January 1, 2008, the date our LTC rate stabilization statutes became effective, are reviewed as prescribed in statute. See HRS §431:10H-207.5. LTC rate increase filings for policies sold prior to January 1, 2008 are also reviewed as prescribed in statute. See HRS §431:10H-226. As the statute is less clear, Commissioner discretion is applied where we believe the statute allows for interpretation. Carriers must achieve a 60% loss ratio minimum when premiums are restated back to inception and adjusted for past rate increases and using original pricing interest rate in order for a rate increase to be considered. The amount of the rate increase allowed is directly related to the amount by which the minimum loss ratio is exceeded. If the carrier is not able to allow for plan benefit options to mitigate a justified large increase, we may further ask the carrier to collect the increase over multiple years.

IA	Yes, both.	Yes	No	NA	No	There are no official caps, however, Iowa is very aggressive with the rate review process and over the last few years, we've negotiated virtually 100% of all large LTC increases to a significantly lower level, i.e., 15 to 18 percent is the rough average.	The rate review process for long term care insurance is similar to other lines of business, however, the long-tail projections involved in such a product complicate the process. Given such projection lengths, the projection models can be sensitive to several inputs. Some of the factors and issues we consider include, but are not limited to the following: past experience and resulting loss ratios, projection of future anticipate experience (must be greater than the minimum so that past losses cannot be recouped), interest rates, morbidity, mortality, and lapse rates. The lapse rate factor is a particularly sensitive input, and as you know – has been a significant factor in rate increase proposals over the last 20-years. Other non-actuarial factors include the impact to the consumer, which is the main reason Iowa has an aggressive review process. Our view is that many of these current policyholders wouldn't have signed up for such coverage if a 200% rate increase was a possibility down the road. Consequently, we have told the carriers that re-rates will be accomplished over a long period of time in phases.
ID	* IDAPA 18.01.06.025.01 requires insurer to notify director 30 days before rate increase, and there are qualifications the filing must meet. There is no prior approval authority.	Yes	No	NA	?	No	Projected lifetime loss ratio (including 58/85 test), original loss ratio target at discount rate, justification for assumption changes, ratio of future premium to past premium, projected lifetime LR if proposed rates were from issue date, cumulative rate increases to date, cumulative rate actions of other states, PAD/margin, comparison to actively marketed products, number of remaining lives.
IIPRC	Yes, both.	Yes	No	NA		No	The IIPRC has not yet received any rate increase requests for LTC policy forms approved by the IIPRC. Should a rate increase be filed, requirements in Section 4 of the Rate Filing Standards apply. The major factors specified are changes in experience in comparison to assumptions and margins in the initial rate filing.
IL	No, but the LTC statute says that the Director may adopt rules and regulations establishing loss ratio standards for LTC insurance policies.	Yes	No, but will.	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	No	Mainly limited by the contents of the LTC regulation (50 IAC 2012). We also request compliance with the SITF Model Bulletin. If prior rate increases have been generally higher than in other states, we request experience which has been adjusted to the Illinois rate basis.

IN	Yes, both.	No	No	60%	No	No, but we haven't allowed any increase over 20% over the past few years.	The major factors we use are comparison of A/E morbidity, persistency and interest. We also look back at historical experience and look at the loss ratio had the proposed increase been effective from inception. We do not allow for a carrier to recoup past losses. There are a number of other factors, but these are they major ones.
KS	Yes, both.	Yes	No	NA	No	No	KID takes in account many different factors when reviewing LTC rate filings including, but not limited to, best estimate assumptions future assumptions, assumptions used during initial rate development, size of remaining block, rate history, and reserves.
KY	Yes, both.	Yes	No	NA	No	No	a) does a reasonable relationship exist between benefits and premiums (this encompasses the review of past experience, all projection assumptions, review of transition between past experience and future experience for reasonableness), b) previous rate level, proposed rate level and current market rate level and c) impact of the increase on policyholders (equity by class, increase history in other states, benefit reduction options, benefit and premium impact of termination of inflation riders with review of contractual language).
LA	Yes, both.	Yes	No, but will.	NA	No	No	The major factors that the actuarial department considers when reviewing a requested LTC rate increase includes: the incurred to date loss ratio, the experience development since the last requested rate increase, the accumulated history of rate increases and other aspects of actuarial judgment. The actuarial department places more emphasis on the incurred to date experience, believing that variance of future experience expands with duration (the expanding funnel of doubt).
MA	Although we do have authority to review LTCI products, we in Massachusetts are in the process of updating our LTCI regulations to incorporate many of the 2000 rate stabilization amendments and do not have clear answers to the noted questions				No reply		

MD	Yes, both.	Yes	Working on adopting.	NA	No	15%, statutory.	Quantitative support for assumption changes, and new assumptions. Their impact to the life time loss ratio. Past experience and future projection by calendar year exhibit for the whole block. Discuss how the overall rate increase was determined.
ME	Yes, both.	Yes	No, but review already includes some RS 2014 provisions.	NA	No	No, but we suggest multi-year phase-in for large increases.	Reasonableness of projection assumptions – voluntary lapse, mortality, morbidity, and interest. Experience exhibits including historical, projected, lifetime and actual to expected loss ratios. Distribution – breakdown by gender, inflation option, & benefit period
MI	Yes, both.	Yes	No	NA	No	No	We primarily review for compliance with statutory lifetime loss ratios. Outside actuaries perform an independent calculation of lifetime loss ratio with consideration for credibility of Michigan vs. national experience. MCL 500.3927 requires a minimum loss ratio of 60% and MCL 500.3926a has a 58/85 inequality requirement for rate increases for policies effective after 6/1/2007.
MN	Yes, both.	Yes	No	NA	No	No	Minnesota Statutes section 62A.02, subd. 3 provides that benefits must be reasonable in relation to the premiums charged, rates must be adequate and not excessive, and the data provided must justify the rate. Minnesota requests extensive supporting information in the form of an objection letter in response to a rate increase request.
MO	Not approval authority, but can review to ensure actuarially justified and not excessive.	Yes	No	NA	No	Internal guidelines: Any rate increase under 25% that is actuarially justified is approved. Any rates over 25% we ask the company to split the increase over a couple years. We ask companies with large rate increases to demonstrate their hurt in the increase.	We request Missouri specific data. If MO specific data is not actuarially sound, we allow the companies to provide contiguous state data to justify rate increases; companies cannot submit rates based on national data only. Actuarially justified? Last time since rate increase and whether actual performance reflected anticipated assumptions in the previous rate filing. The impact of large rate increases on shock lapse for closed blocks: will closed block remain viable after implementation of large rate increase? Do not allow the combination of pre and post rate stabilization plan rates.
MS	Yes, both.	No	No	60%	No reply	Mississippi Bulletin 94-1 applies to LTC which limits rate increases to 25% annually.	Restatement of nationwide earned premiums to Mississippi basis, credibility of experience, actual-to-expected results for each assumption, comparison to original loss ratio expectations with the actual mix of business sold, comparison of rates in Mississippi versus the rates average rates approved nationwide, and a detailed review of assumptions and projections.



MT	Yes, both.	Yes	No	NA	No	No	<p>Our analysis includes variations of lifetime loss ratio calculations and future loss ratios. The final method to minimize the recouping of past losses is based on the lifetime loss ratio with the assumption that all premium increases were assumed to occur since inception. Although no method is perfect, we believe this approach fairly takes into account what is most appropriate for the current policyholders and the company's need to manage these blocks of business.</p>
NC	Yes, both.	Yes	No	NA	<p>Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.</p>	<p>Currently, we do not have LTC rate increase caps. However, legislation just passed places a 25% per year cap on implementation of a LTCi rate change, regardless of the rate filing being approved that may justify a larger % increase. The legislation is effective October 1, 2017 and does not change the filing requirements; it simply places a limit on the % increase that an insured may see in a given year.</p>	<p>Does the revised rate scale meet the statutory requirements (not excessive, not inadequate, not unfairly discriminatory; exhibit a reasonable relationship to the benefits provided)? Are the applicable minimum lifetime loss ratio standards reasonably anticipated to be met? How and to what extent has the past experience deviated from the originally anticipated experience? Is there enough credible past experience on the subject form to justify a rate increase? What percentage of the originally issued business for the subject policy form remains in force? Does the requested rate increase transfer an excessive amount of the cost of revised assumptions and/or past adverse experience to the remaining policyholders? How does the requested rate scale compare to the rate scale that would have produced the originally anticipated lifetime loss ratio if that rate scale had been in place from inception? How does the requested rate scale compare to the rates of similar products currently available from the company or any affiliate of the company? How does the history of past rate increase approvals in our state compare to the approved rate increases nationwide? (The experience in our state alone is not credible in most cases, so we rely on nationwide experience data. For rate stabilization business, what would the originally anticipated lifetime loss ratio have been, based on the original pricing assumptions applied to the business actually issued, if the earned premiums and incurred claims are discounted at the average maximum valuation rate of interest for the policies subject to the rate increase request? For rate stabilization business what is the level of rate increase that would be required in order for the actuary to certify that no future rate increases are anticipated? What is the financial condition of the company?</p>

ND	Yes, both.	Yes	No	NA	No	No	We examine experience history, projections, past increases, and various assumptions used in the projections.
NE	Yes, both.	No	No	60%	Yes - Issued the model out as a bulletin	No	1) We lean our review heavily on the list of considerations in our statute in the Loss Ratio section because we have a "deemed reasonable" standard for premiums associated with a 60% Loss Ratio. 2) Mix of business. 3) Maturity of the block. 4) Policyholder communication and company intentions. 5) Impacts of past shock lapses and whether the company adjusts for these impacts.
NH	Yes, both.	Yes	No	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	Rates are capped based on age under rule INS 360o, Table 3601.1 <a href="http://www.gencourt.state.nh.us/rules/state_agencies/ins3600.html">http://www.gencourt.state.nh.us/rules/state_agencies/ins3600.html</a> ,	Age, length of contract, renewability, benefit level, lapse rates, projected new business, history, interest rates on cash valuation and reserve levels.
NJ	Individual, yes, group, no.	Yes	No	NA	No	We now limit LTC rate increases to 10% per year for up to 3 years. These limits are based on internal guidelines adopted in May 2016. Additional increases can be requested every three years.	Pre-rate stabilization LTC increases are based on lifetime loss ratios developed using an interest rate that is a meaningful measure of the insurer's earnings on this block of business – not the average portfolio rate, statutory reserve rate, or bulletin rate. In addition, all other loss ratio assumptions (e.g., lapse, morbidity, expenses) must be realistic and justified, based on credible experience.
NM	Yes, both.	Yes	No	NA	No	Subject to a maximum of 15%, we are generally granting the increases we project (usually using the filer's projection assumptions, but not always) will be necessary, if repeated annually (though only approved for one year at a time), to achieve the minimum permissible loss ratio (65% or 58%/85%). These are internal guidelines.	It would not be possible to be brief; we are pretty thorough. However, as advice: always check the company's projections against those of previous filings.
NV	Yes, both.	Yes	No	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	No	Incidence rates, lapse rates, utilization rates, etc. Essentially, all their assumptions. Additionally, we review cash flow projections and how current assumptions differ from original assumptions.

NY	Yes, both.	No	No	70% for group LTC, 65% for individual LTC ages 65 & over, and 60% for individual LTC ages 64 & under. If a premium rate increase is granted, the loss ratio on the increased portion of the premiums is 75%.	No	No	Projected future claims, accumulated loss ratios, projected loss ratios, lapse rates, morbidity, mortality and the interest rate environment. The Department restricts the assumptions used in the projected loss ratios and the projections are examined by age as well as in total.
OH	Yes, both.	Yes	No	NA	No	Internal, 15%.	Actuarial justification of any rate increase, what increases have been approved in the past compared to other states, impact to the consumer.
OK	Yes, both.	Yes	No	NA	No reply	Internal, 10% cap.	Magnitude and history of prior rate increases.
OR	Yes, both.	Yes	Yes	NA	Yes - Issued the model out as a bulletin	No	Lifetime loss ratio. How many people are likely to drop (lapse) their policies before they make significant claims? Will a plan have enough Oregon policyholders to accurately set premiums based on Oregonians' claims or will Oregon members be part of a national pool? How will an "average" rate increase affect different policyholders since not everyone sees the same increase? In other words, how much of the increase will be shouldered by an 85-year-old compared to a 58-year-old? Are insurers including a margin of error in their rate setting so that policyholders are less likely to get an unexpected premium increase that forces them to drop coverage after years of paying premiums? Since March 1, 2006, insurers have had to certify that the premiums they charge will cover anticipated costs over the life of a policy. For policies issued before March 1, 2006, have companies complied with a requirement to offer consumers options if they seek a rate increase greater than 40 percent during any three-year period? Options include the right to trade reduced benefits for lower premiums. If a company seeks a rate increase, is at least 85 percent of the additional premium going to pay benefits versus administration and profit?

PA	Yes, both.	Yes	No	NA	No	We do not have statutory caps but we do generally prefer to try to limit increases to about 20% in any single year.	We consider the projected lifetime loss ratio, past increases on the product, the company's explanation of the need for the increase, the company's solvency, and the mitigations options available to policyholders.
RI	Yes, both.	Yes	In process of adopting	NA	No	No	Actuarial justification. If the rates are actuarially justified we look at the rate shock implications for consumers and attempt to minimize the rate shock with phased in rate increases and offers of benefit reduction in exchange for rate reduction.
SC	Yes, both.	Yes	No	NA	No	South Carolina, with few exceptions, limits rate increases to a maximum of 20%. Internal guideline.	A majority of the rate increase filings we receive are on old blocks of policies subject to the 60% minimum loss ratio standard. In reviewing these filings, we review for compliance with the 60% loss ratio standard, as well as review actual to expected loss ratios. We also review revised assumptions for reasonableness.
SD	Yes, both.	Yes	No	NA	No	No	The major factors reviewed are the original pricing assumptions (lapse, morbidity, mortality, interest rate), current projection assumptions (lapse, morbidity, mortality, interest rate), historical rate increases, proposed rate increase, historical experience, actual to expected historical loss ratios, the actual projection of future experience and whether or not it is reasonable, the pertinent loss ratio tests (either lifetime loss ratio or 58/85 test), credibility of state experience, credibility of nationwide experience, comparison of distribution of business between state vs nationwide in force, impact of both inflation option and lifetime period experience, margin for adverse deviation and how it is quantified by the Company, block of business (open or closed) and policy benefit descriptions.
TN	Yes, both.	Yes	No	NA	No	An internal guideline of 100% cap, between 40% and 80% we require the increase be split over 2 years and over 80% must be split over 3 years.	The expected loss ratio evaluating claims credibility, trends, claims fluctuation, expense factors, etc., inequality testing on the proposed rates, past rate increase history, and comparison of Tennessee rates to the nationwide rates.

TX	Yes, both.	Yes	No, but will in 2017	NA	No	No	Since most LTC rate increases are driven by changes to key assumptions such as lapse, morbidity, and interest rate, the focus of our review is primarily on the adequacy of the supporting documentation for the changes to the assumptions.
UT	Yes, both.	Yes	No	NA	No	No	Technical aspects of the filing: Support for current assumptions; Demonstration that the experience diverges from the original assumptions; Loss ratio compliance using current best estimate assumptions; Drivers of the adverse experience; Consistency of the information with that in the prior filings.
VA	Yes, both.	Yes	Yes	NA	Yes - Did not issue the model out as a bulletin. Required some or all of the model provisions to be adopted through regulatory and/or procedural mechanisms.	No	Restatement of nationwide earned premiums to Virginia basis, credibility of experience, actual-to-expected results for each assumption, comparison to original loss ratio expectations with the actual mix of business sold, comparison of rates in Virginia versus the rates average rates approved nationwide, and a detailed review of assumptions and projections.
VT	Yes, both.	Yes	No	NA	No reply	No	The Vermont Department of Financial Regulation performs actuarial review of rate filings and lifetime loss ratio exhibits as set forth in H-2009-01. We do not allow companies to make up for past losses. We require that cash flows and accumulations be discounted at the pricing interest rate. We consider the consumer-facing criterion of affordability, and the criteria that the rate increase filing is not unjust, unfair, inequitable, misleading, or contrary to the laws of Vermont.
WA	Yes, both.	Yes	No	NA	No	No	We approve LTC rate increases if they are actuarially justified. We consider the impact to consumers and may require the increase to be phased in over a few years.

WI	No, Wisconsin statutes provide that rates are filed. We do have a consulting actuary that reviews LTC rate filings to verify that rate increases are actuarially justified.	Yes	No	NA	No	No	If the proposed rate increase appears to be based upon nationwide experience because the Wisconsin experience is not creditable, we ask the company to explain the fact that this ignores the possibility that overall Wisconsin morbidity could be lower than the national averages. We ask the company to explain loss ratios that make a rate increase look like Wisconsin is subsidizing insureds in other states where similar rate increases have not been implemented. We ask the company to demonstrate actuarial equivalence of the various options that have been proposed to make the proposed rate increase smaller. We ask the company to describe the source of the assumptions being used in detail, especially to what extent the assumptions are based upon company experience and to what extent the experience is based upon Wisconsin data and justify any use of non-Company non Wisconsin experience. Comments for a filing are based on each company and our consulting actuary's questions.
WV	Yes, both.	Yes	No	NA	No	Internal - attempt to stay under 20% in any year.	Overall losses and if the company is trying to recoup past losses.
WY	Notwithstanding a minimum loss ratio standard as established by state rules (60%), Wyoming does not have rate authority for LTC policies.	No	No	60%	No	No	. In addition to the minimum loss ratio standard, Wyoming will request carriers to offer a reduction in benefits or a nonforfeiture option with substantial rate increases.