Regulator Use Only
NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation

March 11, 2005
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Section I. INTRODUCTION

A. PURPOSE OF THE MANUAL

This manual is intended to be used to evaluate compliance with the revised rating requirements contained in the Long-Term Care Insurance (LTCI) Model Regulation (Model Regulation) that was adopted by the NAIC in August 2000, and amended in August 2014 and for the contingent benefit upon lapse provision adopted in 2005, and amended in August 2014.

The direct application of this guidance manual is limited to those states that have passed the revised NAIC LTCI Model Regulation without modification. However, many aspects of the manual may apply to states that have modified the Model Regulation, and other portions may be readily adaptable to fit such modifications. No attempt will be made in this manual to describe such modifications, however. Of course, in cases where any portion of this manual is inconsistent with an actual law or regulation of a state, such law or regulation would prevail.

While the manual is written for state regulators involved in LTCI rate review, it is anticipated that insurers will review this material in order that they make the filing process as expeditious as possible. Therefore, the regulator should not be surprised if an insurer follows the manual directly. Of course, the regulator is responsible for detecting practices that do not comply with the requirements of his or her state’s statutes and regulations. This manual should not be considered to be a limit on appropriate actuarial methodologies.

B. CHANGES IN THE LONG-TERM CARE INSURANCE REGULATION PROCESS

Most state laws and regulations require that premiums for LTCI be such that “benefits will be reasonable in relation to premiums.” The NAIC LTCI Model Regulation that was in effect prior to August 2000 used a minimum fixed loss ratio as the method to determine that a specific set of premiums was reasonable. The NAIC LTCI Model Regulation that was passed in August 2000, and amended in August 2014, changes the standard of reasonableness for LTCI issued after the effective date of new state statutory requirements.

A summary of the changes that were adopted in 2014 include:

- Section 10 defines a minimum composite moderately adverse experience (MAE) margin of 10%. A 10% minimum margin encourages more conservative pricing.
- Section 15 requires the insurer to submit an annual actuarial certification regarding the sufficiency of the current premium rate structure. An annual review of experience encourages an insurer to file a rate increase when needed, rather than delay, and requires a larger rate increase later.
- Section 20 permits the regulator to consider a rate increase that is lower than required under the rate stabilization certification. The drafting note in this section also indicates that a series of increases are permitted. In general, consumers who have filed long-term care increase complaints have stated that they prefer several smaller rate increases rather than one large rate increase.
- Section 20.1 requires the insurer to replace the “58” in the current 58/85 test with the greater of 58 percent and the original lifetime loss ratio with the moderately adverse margin specified in the initial filing. For insurers that price at a loss ratio greater than 58 percent, this change makes it more difficult for the insurer to pass the loss ratio test.
- Section 27 strengthens consumer disclosure requirements at the time of a rate increase.
- Section 28 reduces contingent nonforfeiture benefit triggers for older policies, and lowers the rate increase trigger to 100 percent for policyholders with issue ages 54 and younger. These changes provide greater value to consumers who decide to lapse their policy following a rate increase.
With the changes in the Model Regulation adopted in August 2014, three categories of LTC policies now exist:

1. Pre Rate Stabilized (PS) - these policies were priced using a minimum loss ratio approach and were issued prior to the initial rate stability changes adopted in 2000.
2. Rate Stabilized 2000 (RS 2000) – these policies were issued after the state adopted the initial rate stability model (LTC Model Regulation 641, which was adopted by the NAIC in 2000)
3. Rate Stabilized 2014 (RS 2014) – these policies were issued after the state adopted changes to LTC Model Regulation 641, which the NAIC adopted in 2014.

1. Fixed Loss Ratios

Premiums for LTCI have been determined within a fixed loss ratio structure for decades. The regulatory evaluation of reasonableness using fixed loss ratios is designed to check that premium rates are not too high. The new LTCI Model Regulation moves away from fixed loss ratios applied to initial premiums. Loss ratios are still used by the insurer when determining a rate increase and by the regulator to help evaluate the reasonableness of a rate increase. Before describing these changes, a simplified discussion of fixed loss ratios as a regulatory tool is presented below. The discussion does not address interest discounting, mortality rates or lapse rates.

The two significant consequences of using fixed loss ratios are the following:

- Maximum Initial Allowed Premium
- Fixed Expense Margins as a Percent of Premium

(a) Maximum Initial Premium

A loss ratio equals claims divided by premiums, so a minimum loss ratio standard requires that a minimum portion of the premium will be paid in claims. Claims typically increase over time from issue so a minimum loss ratio is easier to meet over time versus in the initial years from issue. A 60% initial loss ratio requirement means that if the claims are expected to be $600, then the premium cannot be greater than $1,000 (600/1000 = .60). If the premium is greater than $1,000 and the claims are $600, then the minimum loss ratio would not be satisfied (suppose the premium were $1,200, then the loss ratio would be 600/1200 = .50 which does not meet the 60% minimum).

The pricing actuary of an insurer performs the following steps (or similar steps) to develop a premium that is acceptable to the insurer and complies with a minimum loss ratio. Suppose the minimum acceptable loss ratio is 60%.

i. Determine the benefits to be provided.
ii. Analyze the claim costs for the benefits to be provided.
iii. Divide the expected claims by the loss ratio to determine the maximum initial premium ($600/.60=1000).
iv. Determine the final premium based on a variety of business requirements such as profitability, market share, commissions, and insurer expenses.
v. If the resulting premium is greater than $1,000, re-evaluate requirements in step iv.

The first significant consequence of a fixed loss ratio standard is the cap on the initial premium that can be charged. If the insurer believes that the insured is better served by charging a premium higher than the maximum, because of long-term stability of premiums, it would be prohibited from doing so. This is because the actuary must certify that the premium meets the loss ratio standard and the potential circumstances that would lead to the need for higher rates are not within the normal bounds of calculating expected claims.
(b) **Fixed Expense Margins**

Fixed loss ratios produce a fixed expense margin as a percentage of premium. This is illustrated in the following table.

<table>
<thead>
<tr>
<th></th>
<th>A = Original Pricing</th>
<th>B = Re-Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Costs</td>
<td>$600</td>
<td>$1,200</td>
</tr>
<tr>
<td>Loss Ratio</td>
<td>.60</td>
<td>.60</td>
</tr>
<tr>
<td>Premium</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Expense Ratio</td>
<td>.40</td>
<td>.40</td>
</tr>
<tr>
<td>Expense Margin</td>
<td>$400</td>
<td>$800</td>
</tr>
</tbody>
</table>

\[(\text{Expense Margin} = \text{Premium} \times \text{Expense Ratio})\]

The expected annual claims in Column A are $600, so with a 60% loss ratio standard, the maximum premium is $1,000. The portion of the premium available for expenses and profit is 40%, which equals $400.

In Column B, after a few years of experience have come in, the best estimate of the claims are twice the expected amount in Column A or $1,200, so the maximum premium is $2,000 and the maximum expenses and profit are $800. Therefore, since some insurer expenses are fixed (such as salaries and rent), the insurer could increase the profit when claims are higher. The portion of the premium available for expenses and profit is increased when claims are higher after issue than was assumed in the original pricing.

When subject to fixed loss ratios, the certification the actuary provides for LTCI premium filings is that the ratio of expected claims to premiums will satisfy the loss ratio, the premium will not be greater than a maximum and expense margins will increase with claims. This makes it easier for premiums to increase over time, because the maximum allowed premium may be too low to be sustainable over the life of the contract, and the insurer is “rewarded” with higher expense margins if claims turn out to be higher than originally anticipated.

2. **A New Way of Protecting the Consumer**

LTCI has been purchased primarily by consumers who are in their 60s and 70s, so most are on a fixed income. Even if purchased at younger ages, these insureds will spend many of their premium paying years on fixed incomes. Claims under LTCI policies tend to be infrequent until insureds reach their late 70s and become much more frequent as the insureds reach their 80s and 90s.

There have been cases where the premium for LTCI has proven to be inadequate (for any number of reasons), which has caused large rate increases leading to significant loss of LTCI coverage. As a result, seniors have paid premiums for years only to see significant rate increases at the ages when they have increased need for the coverage. Seniors have often lost their insurability and cannot purchase another policy. Also, if a senior cannot afford the increase and lets the policy lapse, he or she loses all the premiums paid. The insurer may benefit by having fewer remaining policyholders to file claims.

The requirements of the new Model Regulation change the insurers’ incentives and should greatly increase the probability that LTCI premiums will remain unchanged for the life of the contract.

3. **Certification of Adequacy**

The new way of regulating RS 2000 and RS 2014 LTCI consists of several steps:

1. The initial loss ratio requirement is eliminated as the test that initial premiums are not
It is replaced by a determination that initial premiums are not excessive because of market competition and that they are not inadequate because of the actuarial certification;

(b2) The economic value to the insurer of an increase in renewal premiums is significantly reduced;

(e3) The required disclosure of past rate increases makes the “rate increase option” less desirable to insurers and provides meaningful disclosure to potential insureds;

(d4) Regulatory oversight increases when a premium increase is filed;

and

(e5) Insurers that persistently offer coverages at inadequate rates can be prohibited from issuing new policies.

(a) Initial Premiums

RS 2000
The Actuarial Certification to be provided with the initial premium filing must certify to the anticipated adequacy of premiums over the life of the contract, even under moderately adverse conditions.

RS 2014
The Actuarial Certification to be provided with the initial premium filing must certify to the anticipated adequacy of premiums over the life of the contract, even under moderately adverse conditions, which is defined as a composite margin not less than 10% of lifetime claims, or specification and/or justification of a lower margin.

(b) Economic Value of Rate Increases Is Reduced

RS 2000
To justify an increase, the insurer must show that the lifetime claims are expected to equal 58% of the lifetime initial premiums plus 85% of the increased portion of the premium. This differs from current standards that allow the expense load to be the same on initial premiums and increased premiums. Now, the expense load on the increased portion of premiums will be limited to 15%.

RS 2014
To justify an increase, the insurer must show that lifetime claims are expected to equal the greater of the original anticipated lifetime loss ratio, including margin for moderately adverse experience, and 58% of the lifetime initial premiums plus 85% of the increased portion of the premium.
Under both RS 2000 and RS 2014, the expense load on the increased portion of premiums will be limited to 15%.

(c) Disclosure of Rate Increases Will Affect Attractiveness of New LTCI
The requirement to disclose past rate increases on similar LTCI business will mean that those insurers without any increases will appear to be better options to applicants than those insurers with rate increases. Insurers are likely to seek alternatives to raising the rates, even if experience is very bad, if rate increases will damage their marketing efforts. The insurer that has had rate increases, but does not expect future ones, must convince the consumer that its pricing is adequate.

(d) Consumer Disclosures
Additional disclosures are required at the time of a rate increase outlining options that are available to consumers in lieu of a rate increase, and the impact of any reduction in benefits on partnership status.
(e) Annual Certification
This is applicable only to RS 2014 policies. Certification differs depending on whether the block is currently marketed. This is an annual certification for all LTCI policies that 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. If this statement cannot be made, the insurer must provide a plan as to how a margin will be established.

(d) Increased Monitoring
For both RS 2000 and 2014, if a rate increase is approved, the insurer must then provide the department annually with the developing experience under the form. If the developing experience shows that the rate increase was not needed, then a portion of it must be undone. If further rate increases are requested, the department can review underwriting and claims adjudication processes or take action for a block that is in a rate spiral.

(e) Marketing Limits
A continued pattern of filing inadequate initial rates (presumably based on a pattern of rate increase requests by an insurer) can lead to the insurer being required to cease offering new LTCI in the state.

C. CHANGING ROLES OF THE REGULATOR, ACTUARY, AND INSURER

To implement these changes, the regulator, the actuary and the insurer must change how they approach LTCI. The initial rate filing contains the proposed premiums, the prescribed documents, Assumptions Template found in Appendix 6 (if applicable) and the Actuarial Certification. The Actuarial Certification includes the actuary’s opinion on the adequacy of the proposed rates as well as other statements and information the regulator should evaluate.

For RS 2014 policies, the insurer must file an Annual Certification certifying the adequacy of premium rates.

In the event of a rate increase, the insurer will need to change the disclosures and the actuary will file a new Actuarial Certification and new projections of future experience. The regulator will review the filed materials, including the Assumptions Template found in Appendix 6, and then will review the performance of premium and claim experience over the next several years in comparison to the projections.

1. Regulator

An understanding of the basic concepts of LTCI is critical for any regulator who reviews policy forms and rates. An excellent source is “A Shopper’s Guide to Long-Term Care Insurance” (Shopper’s Guide) published by the NAIC, which is included as Appendix 6 of this manual. Also, Appendix 7 has definitions of LTCI terms that are not defined in the Shopper’s Guide.

For RS 2014 policies approved after the state adopts the 2014 amendments, the regulator should review the Assumptions Template spreadsheet, which is intended to assist the regulatory actuary in their review of the actuarial assumptions. The purpose of the template is to provide an additional tool for the regulator to achieve a better understanding of the assumptions that make up the initial rates, and the primary assumptions that drive rate increases. Although the regulator may wish to compare assumptions at the company level, which may lead to additional questions for some companies, the assumptions provided in the template are not intended to serve as a basis for rejection or disapproval of a rate filing.

The regulator should review the proposed premium rates based on the benefits provided and, if possible,
compare them to the premiums used by other insurers to see if large differences exist, keeping in mind that factors other than benefits can affect claim cost and premium level. The Actuarial Certification of adequacy should be reviewed for completeness placing special emphasis on any limitations included in it. If the regulator has questions about the rates, the certification, or the insurer’s ability to perform as certified, then further correspondence with the insurer is appropriate. The regulator should also review records of prior rate increases for LTCI within the last 10 years to ensure that they are included in the disclosure documents.

The regulator should review the Annual Certification to ensure compliance with the requirements.

The regulator should review any filing for a rate increase and evaluate the reasonableness of the requested increase. A review of prior rate increases by the insurer may be helpful.

Following a rate increase, the developing experience on the business must be filed annually by the insurer for a minimum of three years. The regulator should then review the comparison of the expected experience with the actual developing experience. If experience continues to deteriorate under a policy form, the regulator should find out what the insurer’s plans are for future rate levels. If the regulator observes a pattern of inadequate pricing by an actuary or otherwise believes that the assumptions are not likely to cover moderately adverse experience, the regulator should consider discussing the issue with other regulators or contacting the Actuarial Board for Counseling and Discipline (ABCD) for advice and consultation.

Because it is expected that there will be fewer increases under this new system, the workload on the regulator should decrease in most cases.

2. Actuary

The focus will be on adequacy of premiums, not satisfaction of a loss ratio (unless the filing relates to a premium increase). The actuary will have an increased need to review all aspects of the insurer operations related to LTCI (see the list below). Future expected claims must be developed based on moderately adverse future conditions. The initial premiums will be developed to be adequate for the insureds’ lifetimes, not to meet a loss ratio. Actuarial Standard of Practice 18 on LTCI requires that various aspects of the expected experience must be considered and included. If at some time in the future the actuary is aware that the company has changed certain practices, or certain pricing assumptions are not being realized, etc., such that the new business rates no longer contain adequate margin, the actuary has an obligation to address the situation.

3. Insurer

Reasonable measures must be taken to ensure that premiums will remain level once a policy is issued. The economics of having fully adequate initial premiums versus relying on rate increases to cover adverse experience have been changed. This will place increased pressure on the insurer to perform well in all areas of LTCI, such as the following:

a. Initial premiums;
b. Benefit structures;
c. Underwriting;
d. Claim adjudication;
e. Marketing;
f. Agent training; and
g. Compliance with state laws and regulations.

Because company practices may change in response to changing market or environmental conditions, or...
today’s expectations may be different from those of years past, it is important for the company to be
cognizant of current rates and their compliance with model standards. The company should, at least
annually, review the assumptions and margins in the current new business rates to ensure adequacy.

D. QUESTIONS AND ANSWERS

1. How is LTCI rating different from rating for medical insurance?

Some people apply rating principles from medical insurance to LTCI, but those principles are often not
applicable to LTCI. Below is a comparison of rating characteristics of the two products.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Medical</th>
<th>Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of claim</td>
<td>High frequency, especially for office visits and prescription drugs.</td>
<td>Low frequency. Historically, insureds have been reluctant to use institutional care. Home health care services are becoming more frequent.</td>
</tr>
<tr>
<td>Average claim amount</td>
<td>Some high cost claims, but larger numbers of low cost claims.</td>
<td>High average claim amounts because benefits usually are for extended time periods.</td>
</tr>
<tr>
<td>Benefit period duration</td>
<td>Claims for a particular illness usually occur within a year or less.</td>
<td>Duration often extends beyond one year.</td>
</tr>
<tr>
<td>Reliability of data</td>
<td>Medical insurance has been available for many years, and data are considered very reliable.</td>
<td>LTCI is relatively new coverage and data for insured populations are still being developed.</td>
</tr>
<tr>
<td>Premium payment period</td>
<td>Premiums are often subsidized by the employer during the working life of the individual. Medicare supplement premiums are usually paid while the individual is on a fixed income.</td>
<td>Most insureds are purchasing this coverage after age 50. Insureds will spend most of their premium paying years on fixed incomes.</td>
</tr>
<tr>
<td>Averaging of premium</td>
<td>Over employer group or block of issued policies</td>
<td>Over each issue age for block of issued policies.</td>
</tr>
<tr>
<td>Premium rating basis</td>
<td>Premiums usually increase each year with age and medical trend.</td>
<td>Premiums are usually sold on an issue-age basis, and are required to be sold on an issue-age basis for ages 65 and older.</td>
</tr>
</tbody>
</table>

Each of the usual medical regulatory considerations should be reviewed carefully to see whether it should be applied. Due to the high cost nature of the claims and the fixed incomes of the insureds, special consideration should be given to the regulation of LTCI to minimize the likelihood of future rate increases.

2. What is the difference between issue-age pricing and attained-age pricing?

Under an attained-age rating structure, individuals pay rates that correspond to the risk at their particular age and do not reflect any pre-funding of risk for older ages. Rates may vary by single ages or age bands.

Premium rates for issue-age policies are determined to “pre-fund” escalating claim costs as the insured
gets older without an increase in premium rates. This means paying more than necessary to cover the risk in the early policy years and less than necessary to cover the risk in the later years. Active life reserves must be established because level premiums are higher than necessary to cover claim costs in the early years of a policy, and lower than necessary to cover the higher claim costs at later ages.

3. What if a state requires prior approval of premium rate increases?

A drafting note following the initial paragraph under Sections 20B and 20.1B of the Model Regulation states: In states where the Commissioner is required to approve

premium rate schedule

increases, ‘shall provide notice’ may be changed to ‘shall request approval.’

E. CAVEAT

While this manual is intended to be reasonably comprehensive, it is impossible to anticipate every possible set of circumstances. This manual is only one of a number of references that should be used in testing compliance of a LTCI premium filing with the state’s laws and regulations. Generally, the state’s regulations (or laws) will be consistent with the Model Regulation, which contains useful drafting notes. In addition, Actuarial Standard of Practice 18 and any practice notes issued by the American Academy of Actuaries (AAA) should be reviewed. Another important resource is judgment. Appropriate judgment is an important element of each and every step of the tests discussed herein. In particular, there are certain to be circumstances wherein a guideline requirement may not apply. This manual should not be considered to be a limit on appropriate actuarial methodologies.

In using judgment, a major concern is “gaming,” that is, complying with the letter of the law, but pushing the limits and definitions beyond common sense. The possibility of gaming should be avoided by insurers and actuaries. They should apply good judgment in complying with a state’s requirements. The regulator should also use judgment in determining whether gaming is taking place.
Section II. WHAT IS LONG-TERM CARE INSURANCE?

A. DEFINITION OF LONG-TERM CARE INSURANCE

As defined in Section 4 of the NAIC Long-Term Care Model Act (Model Act), long-term care insurance means any insurance policy or rider that is advertised, marketed, offered or designed to provide coverage 1) for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid or other basis, and 2) for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

1. What does the definition include?

Long-term care insurance includes contracts (policies, riders, and certificates of coverage) in each of the following formats:

(a) Contracts that provide LTCI under:
   • Stand-alone policies
   • Group and individual annuities
   • Life insurance policies or riders

(b) Contracts regardless of long-term care tax qualification:
   • That are intended to be tax-qualified under the federal Health Insurance Portability and Accountability Act (HIPAA)
   • Those that are not intended to be tax-qualified under HIPAA

(c) Contracts regardless of type of long-term care benefits:
   • Covering institutional long-term care benefits only
   • Covering non-institutional long-term care benefits only
   • Covering institutional and non-institutional care

(d) Other insurance contracts that are advertised, marketed or offered as LTCI

2. What does the definition exclude?

LTCI does not include any insurance contract that is offered primarily to provide:

(a) Basic Medicare supplement coverage
(b) Basic hospital expense coverage
(c) Basic medical-surgical expense coverage
(d) Hospital confinement indemnity coverage
(e) Major medical expense coverage
(f) Disability income or related asset protection coverage
(g) Accident only coverage
(h) Specified disease or specified accident coverage
(i) Limited benefit health coverage

Also, LTCI does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.
B. WHAT ENTITIES MAY ISSUE LONG-TERM CARE INSURANCE?

Long-term care insurance may be issued by:

- Insurers;
- Fraternal benefit societies;
- Nonprofit health, hospital and medical service corporations;
- Prepaid health plans;
- Health maintenance organizations; and
- All similar organizations.

C. COMBINATION PRODUCTS

1. What is a combination product?

A “combination product” is a product that combines LTCI with other products. For example, LTCI may be combined with life insurance, annuities or any of the accident and health products listed in Section A above. The LTCI may be part of the policy itself or may be a rider to the policy.

2. Does the Model Regulation apply to combination products?

LTCI included in combination products is covered by the Model Act and the Model Regulation if it meets the definition of LTCI in the Model Act.

3. What special exceptions exist for combination products?

Because of the nature of combination products and other regulations that may apply, LTCI included in certain combination products is exempt from parts of the Model Regulation. The most notable exemption pertains to Sections 20 and 20.1, Premium Rate Schedule Increases, and Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings, respectively. To qualify for exemption from Section 20 or 20.1, a combination product must meet five conditions similar to those previously required for exemption from Section 19, Loss Ratio, and one new condition that the long-term care benefits provided be “incidental.” For this purpose, “incidental” means that the long-term care benefits provided must be less than 10% of the total value of the benefits provided over the life of the policy.

The five conditions that must all be met are listed here:

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 LTCI law similar to Sections 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 law 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, shall include a description of the type(s) 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.

4. **What requirements apply to combination products that are not excepted under Item 3?**

   Combination products must comply with the Model Regulation. However, if a composite margin lower than 10% of lifetime claims is used, the memorandum should justify the margin by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

D. **QUESTIONS AND ANSWERS**

1. **Does the LTCI Model Regulation apply to disability income policies?**
As indicated above in Section IIA2(f) of this manual, LTCI does not include policies that primarily provide disability income or related asset protection coverage. However, a policy is regulated as LTCI if it satisfies the definition of LTCI, even if it is called disability income. This issue was addressed in a drafting note in Section 3, Applicability and Scope, of the Model Regulation. The applicable model language is shown below.

Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
2. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or
3. Benefits under the policy may commence after the policyholder has reached Social Security’s normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

2. **Does the LTCI Model Regulation apply to riders as well as policies?**

Yes, riders that meet the definition of LTCI are subject to the regulation.

3. **Does the LTCI Model Regulation apply to home health care only riders?**

Yes, the definition of LTCI in the Model Regulation does not differentiate between care that is provided on an institutional basis or a non-institutional basis. Therefore, home health care only riders that meet the definition of LTCI would be subject to the regulation.

4. **How are long-term care benefits determined to be incidental?**

“Incidental” means that the long-term care benefits provided must be less than 10% of the total value of the benefits provided over the life of the policy. The Model Regulation has the following drafting note to help clarify how long-term care benefits may be determined to be incidental.

**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.
Section III. WHEN DO THE NEW REGULATIONS APPLY?

This section of the guidance manual explains the following:

- When the new rating provisions of the NAIC Long-Term Care Insurance Model Regulation become effective;
- What regulators should expect from insurers; and
- What insurers and regulators might do to maximize the value of the new regulations.

This section focuses on the consumer disclosures required by Section 9 of the Model Regulation, the initial form filing requirements of Section 10, the reporting requirements of Section 15, the loss ratio requirements of Section 19, and the rate increase requirements of Sections 20 and 20.1, the benefit reduction requirements of Section 27, and the nonforfeiture benefit requirements of Section 28. An overview of the requirements is given in the chart below. Following the chart, are a series of questions and answers intended to illustrate the more common situations to be expected.

A. EFFECTIVE DATES OF NEW REGULATION
(Appplies to Model Regulation Changes from 2014)

To determine which sections apply, the dates when the policy form was originally available for sale in a state and when a policy or certificate was issued need to be taken into consideration.

<table>
<thead>
<tr>
<th>When-Policy-Form Was Available</th>
<th>When-Policy or Certificate Was Issued</th>
<th>Sec. 9 Consumer Disclosure</th>
<th>Sec. 10* Initial Filing</th>
<th>Sec. 19 Loss Ratio</th>
<th>Sec. 20 Rate Increases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to [6 months after adoption of the amended regulation]</td>
<td>Prior to [6 months after adoption of amended regulation]</td>
<td>N/A</td>
<td>N/A</td>
<td>Applies same as before</td>
<td>N/A</td>
</tr>
<tr>
<td>On or after [6 months after adoption of the amended regulation]</td>
<td></td>
<td>Applies*</td>
<td>Applies to new business if and when rates for new business are increased</td>
<td>N/A</td>
<td>Applies*</td>
</tr>
<tr>
<td>On or after [6 months after adoption of the amended regulation]</td>
<td>Any time</td>
<td>Applies</td>
<td>Applies</td>
<td>N/A</td>
<td>Applies</td>
</tr>
</tbody>
</table>

*Note that some states may adopt modified language or may interpret Section 10 of the LTCI Model Regulation to require the initial filing for any policy or certificate issued on or after the appropriate number of months (i.e., 6 or 12 depending on individual or specified group business) after adoption of the amended regulation regardless of when the policy form was first available.
*If a certificate is issued under certain group policies on or after the date of adoption of the amended regulation, Sections 9 and 20 apply on the first group policy anniversary on or after 12 months after adoption of the amended regulation.

The certain group policies referenced above are those that:

1. Were issued to an eligible group defined in Section 4E(1) of the NAIC Long-Term Care Insurance Model Act. These include policies issued to one or more employers or labor organizations, or to a trust or trustee of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization; and
2. Were in force at the time the amended regulation was adopted.
A. EFFECTIVE DATES OF NEW REGULATION (Applies to Model Regulation Changes from 2014)

<table>
<thead>
<tr>
<th>When Policy or Certificate Was Issued</th>
<th>Sec. 10 Initial Filing</th>
<th>Sec. 15 Reporting Requirements</th>
<th>Sec. 20 Rate Increases</th>
<th>Sec. 20.1 Rate Increases</th>
<th>Sec. 27 Benefit Reductions*</th>
<th>Sec. 28 Nonforfeiture Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 6 months after adoption of amended 2014 regulation</td>
<td>N/A</td>
<td>N/A</td>
<td>Applies</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>On or after 6 months after adoption of the amended 2014 regulation</td>
<td>Applies</td>
<td>Applies</td>
<td>N/A</td>
<td>Applies</td>
<td>Applies</td>
<td>Applies</td>
</tr>
</tbody>
</table>

* The changes to Section 27 apply to any long-term care policy increase implemented on or after the date that is 12 months after adoption of the amended regulation.

B. Examples

The following is a hypothetical example showing how the effective dates of the amended Model Regulation would apply to sections 10, 15, 20, 20.1, 27, and 28.

- The state adopts the amended Model Regulation on July 1, 2015. This means the effective date for most requirements of the amended Model Regulation is 6 months later, on January 1, 2016.

- Insurer A sells LTC policy form LTC 001 in the state (it received approval to sell this policy form on January 1, 2015). The company could continue to sell form LTC 001 in the state on or after January 1, 2016, as long as the moderately adverse margin is equal to or greater than 10% of composite claims. If the pricing composite margin was lower than 10% of composite claims for form LTC 001, Insurer A would no longer be able to sell this policy form in the state.

- Insurer A sold 1,000 LTC 001 policies from January 1, 2015 to January 1, 2016 (with a 10% composite claims margin). These policies would not be subject to the annual rate certification requirements of Section 15, because the annual certification requirement applies only to policies issued after the effective date of the amended model regulation in that state.

- It’s July 1, 2016, and Insurer A sold another 1,000 LTC 001 policies from January 1, 2016, through July 1, 2016. These policies would be subject to the 10% composite claims margin requirements of Section 10, and the annual rate certification requirements of Section 15, because these policies were issued after the effective date of the amended model regulation in that state.

- It’s July 1, 2020, and Insurer A needs a rate increase for policy form LTC 001. From July 2, 2016, through July 1, 2020, Insurer A sold an additional 1,000 LTC 001 policies, so it now has a total of 2,000 policies sold after the effective date of the amended model regulation. The company should have been filing the annual certification for these policies from 2017 through 2020 as required by Section 15 (as noted earlier, the 1,000 policies sold prior to January 1, 2016, would not be subject to the annual rate certification requirements).
• Policies sold prior to January 1, 2016, would be subject to the 58/85 test, including a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience, and that the 10% composite margin is projected to be exhausted. (To emphasize, the reference to the 10% composite margin is that these policies happened to be priced with a composite margin of at least 10%, not because of a regulatory requirement that these policies have a 10% composite margin). The requirements for these policies fall under Section 20.

• Policies sold on or after January 1, 2016, would be subject to the greater of 58%, and the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience. The insurer should include a demonstration that the actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience, and that the 10% composite margin is projected to be exhausted. The requirements for these policies fall under Section 20.1.

• The state approves the rate increase. From Section 27C, Insurer A has the following requirements for reduced coverage for the 1,000 policyholders who bought the policy on or after July 1, 2016, since Section 27C applies to policies issued twelve months after adoption of the amended model regulation:
  ➢ The premium for the reduced coverage shall be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
  ➢ The premium for the reduced coverage shall be consistent with the approved rate table.

• In addition, because the rate increase was implemented at least twelve months after adoption of the amended model regulation, Section 27H requires Insurer A to provide the following for all 3,000 policyholders:
  ➢ An offer to reduce the policy benefits provided by the current coverage;
  ➢ A disclosure stating that all options available to the policyholder may not be of equal value;
  ➢ For partnership policies, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

• For contingent nonforfeiture upon lapse, the 1,000 policyholders who bought the policy prior to January 1, 2016 would be subject to the nonforfeiture triggers that begin with 200% for issue ages 29 and under, 190% for issue ages 30-34, etc.

• The 2,000 policyholders who bought the policy on or after January 1, 2016 (six months after adoption of amended regulation) would be subject to the amended nonforfeiture benefits with a maximum 100% trigger (Section 28D(7)).

• None of the 3,000 polices would be subject to the Assumptions Template in Section IX of the Guidance Manual since policy form LTC 001 was approved on January 1, 2015. The Assumptions Template would apply to policy forms approved on January 1, 2016, and later (i.e., policy forms approved at least 6 months after the amended regulation adoption date of July 1, 2015).
QUESTIONS AND ANSWERS

Each of these questions and answers assumes that your state adopted the new provisions of the NAIC Model Regulation on July 1, 2001, and that Sections 9, 10, and 20 are effective six months after adoption on Jan. 1, 2002. Exceptions for group LTCI are covered in the question about group insurance.

1. An insurer reviews the new regulations and concludes that it would like to continue to use its existing policy form and its current rates beyond January 2002.

(a) Is this permissible?

Yes. There is nothing in the Model Regulation that requires an insurer to change its rates or policy forms.

(b) What must the insurer do?

(1) The insurer may continue to sell its existing policy form using its existing rates.

(2) Before Jan. 1, 2002, the insurer must develop the new consumer disclosure materials required by Section 9 and file those materials in a timely manner.

(3) The new consumer disclosure materials must be used for all policies issued on and after Jan. 1, 2002.

(4) Based on Section 28 of the Model Regulation, Nonforfeiture Benefit Requirements, the insurer must provide contingent benefits upon lapse for all policies issued on or after Jan. 1, 2002.

(c) Is there anything else that the insurer should do?

If the insurer has completed the requirements in Question 1(b) above, the insurer has complied with the law and nothing else is required. However, it would be prudent for the insurer to conduct an actuarial review of its rates and assure itself that it would be in position to comply with Section 20, Premium Rate Schedule Increases, in the event of a future rate increase on the policy form. The rate increase provisions limit increases and provide other consequences if insurers continue to charge inadequate rates.

(d) What can the regulator do to ensure that the insurer conducts this review?

The model does not require an insurer to do such a review. The regulator could remind insurers of potential consequences and encourage those insurers that continue to use older rates and forms to voluntarily file the actuarial opinion required by Section 10 for any forms the insurers continue to sell after a period of time (e.g., one year after the effective date). If the regulator is concerned about the adequacy of the rates, the state’s general statutory authority may allow the regulator to require the filing of an actuarial memorandum and may allow withdrawal of the regulator’s approval of the form for future sales if the actuarial memorandum does not adequately demonstrate adequacy of the rates.

2. Should states require certification under the revised standards on existing forms?

It is widely interpreted that the Model Regulation does not require such filing; however, some states may adopt modified language or may interpret that such filings are required. Even if not required, the regulator may request information under the state’s general statutory authority. As stated in Section 10B of the Model Regulation, the Actuarial Certification required as part of an initial filing applies only to new LTCI.
policy forms “[made] available for sale” at least six months after adoption of the amended regulation. The model provides no authority to require certifications on a retroactive basis for existing policy forms. Question 1 above encourages insurers to review existing forms that it plans to continue to use and encourages regulators to remind insurers of the value of such a review. However, as indicated in Question 1 above, other statutory requirements may apply.

31. An insurer plans to develop new forms and rates. What must the insurer do?

The insurer must file the new policy form and rates with the consumer disclosure materials required by Section 9 and the Actuarial Certification required by Section 10.

42. Because insurers can continue to sell previously approved policy forms and rates after the new regulations are effective, doesn’t this mean that future rate increases could involve some policies that are subject to Section 20 of the Model Regulation, and some policies that are subject to Section 19? If so, what complications does this involve?

Yes. Insurers would be under two standards. If rate increases were needed, an insurer could bifurcate a policy form and determine different rate increases for the older and newer policies. Alternately, an insurer might want to treat the entire form under the newer standard. While the law will vary by state, that treatment may be permitted. Some states’ statutory requirements incorporate the concept of a class, which may affect the way rate increases are handled.

53. Is the effective date for the new regulation different for group insurance?

There is only one difference. If a certificate is issued under certain group policies on or after the date of adoption of the amended regulation, Sections 9 and 20 apply on the first group policy anniversary on or after 12 months after adoption of the amended regulation. The certain group policies referenced above are those that:

a. Were issued to an eligible group defined in Section 4E(1) of the NAIC Long Term Care Insurance Model Act. These include policies issued to one or more employers or labor organizations, or to a trust or trustee of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization; and

b. Were in force at the time the amended regulation was adopted.

64. What if an insurer wishes to apply Section 20 requirements to its entire block of existing business for ease of administration?

An insurer may wish to apply the new requirements of Section 20 to a block of business comprised of some older policies covered by older regulations and some newer policies covered by Section 20. It may be possible to do this without violating the old or new regulations. While the law will vary by state, that treatment may be permitted. The insurer and the regulator should review the state’s unfair trade practices act with regard to unfair discrimination.
Section IV. DISCLOSURE TO CONSUMERS

The NAIC Long-Term Care Insurance Model Regulation includes several requirements intended to assist insurers in providing consumers with adequate information at the time of purchase. This section of the guidance manual is intended to address only the disclosures relating to rating.

A. CONSUMER DISCLOSURE FORMS RELATING TO RATING

The regulation includes two consumer disclosure forms designed to provide information about the insurer’s rating practices and to inform consumers about the rate increase potential of the LTCI that they are purchasing.

1. The Long-Term Care Insurance Personal Worksheet provides the consumer with information about the insurer’s rating practices. It also addresses suitability of purchase, sources of premium payments and the consumer’s ability to afford a rate increase. This form is found in Appendix B of the Model Regulation.

2. The Long-Term Care Insurance Potential Rate Increase Disclosure Form provides consumers with information about initial rates, potential for rate revisions and administrative practices for rate adjustments. It also informs the consumer about his or her rights in the event of a rate increase. This form is found in Appendix F of the Model Regulation. Appendix F was amended to recognize that an additional disclosure requirement for limited pay products is necessary to reflect the additional CBL option available from the changes to Section 28 of the Model Regulation.

3. Rate increase notices shall include:
   a) An offer to reduce benefits;
   b) A disclosure stating that all benefit reduction options are not necessarily of equal value; and
   c) A disclosure stating that some benefit reduction options may result in loss of partnership status.

Both forms, The Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form, are in a standardized format. In general, only the bracketed information should change. However, there may be instances where some deviation from the standard language and/or the bracketed language is necessary to avoid inconsistency, ambiguity or misrepresentation. The only time that deviations in the language should be allowed is when the information provided would be incorrect, ambiguous or inconsistent without such deviation. Examples of instances where the standard language should be modified are found below in Subsection D.

Insurers are required to file the disclosure forms with the initial rate filing, and whenever rates are modified. Insurers that decide to continue the use of an existing policy form after the effective date should file the disclosure documents with the Commissioner at least 30 days prior to their use.

The rate increase history section of the Long-Term Care Insurance Personal Worksheet is intended to provide the consumer with an unbiased look at an insurer’s rating practices. The rate increase history includes information about the policy form that the applicant is applying for and about any similar policy forms. Based on the date of the application, this will include history prior to adoption of the new Model Regulation for at least 10 years.

B. SIMILAR POLICY FORMS

Similar policy forms are defined in the regulation as all LTCI insurance policies and certificates issued by an insurer that have the same long-term care benefit classification as the policy being considered.

For this purpose, benefit classifications are: 1) institutional LTCI benefits only; 2) non-institutional LTCI benefits
only; and 3) comprehensive LTCI benefits.

Group certificates that meet the definition in Section 4E(1) of the Model Act are only similar to other group certificates with the same LTCI benefit classification.

The classification into institutional only, non-institutional only, or comprehensive should be determined based on the total benefits contained in the product provided to the insured. The category should not be determined based on policy format, such as whether the benefit was added via a rider or part of the basic policy. Below is a chart further explaining classification determination. As indicated in the prior paragraph, this chart should be applied separately for Specific Group Business (as defined in Section III B of the manual) and for all other business.

<table>
<thead>
<tr>
<th>Rider</th>
<th>Institutional</th>
<th>Non-Institutional</th>
<th>Shell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional</td>
<td>Institutional</td>
<td>Comprehensive</td>
<td>Institutional</td>
</tr>
<tr>
<td>Non-Institutional</td>
<td>Comprehensive</td>
<td>Non-institutional</td>
<td>Non-institutional</td>
</tr>
<tr>
<td>Institutional &amp; Non-institutional</td>
<td>N/A</td>
<td>N/A</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>None</td>
<td>Institutional</td>
<td>Non-institutional</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**C. RATE INCREASE HISTORY**

When the rate increase history includes forms that have had a premium rate increase, the insurer can provide explanatory information. This information should be short, clear and readily understandable by consumers. The explanation should provide a fair representation of the reasons why rate increases occurred. Insurers should not be prohibited from providing information on the number of policies affected by premium rate increases. The regulator should consider whether such information would be useful to applicants. When provided, the information should represent the insurer’s in force policies at the time of the rate increase. Information that spans a number of years should not be allowed as it may understate the proportion of policies affected by the rate increase.

If the information presented is unclear or appears to be incomplete, the regulator should ask the insurer for additional information.

**D. RATE INCREASE HISTORY EXAMPLES**

Following are generalized examples of the Rate Increase History section of the Long-Term Care Insurance Personal Worksheet. These examples are not comprehensive, but are intended to give general guidance on the appearance and content of this section.

**Long-Term Care Insurance Personal Worksheet**

**Rate Increase History Section**

*Example 1 - Insurer has never increased rates.*

**Rate Increase History**

Insurer X has sold long-term care insurance since 1992 and has sold this policy since 1998. The insurer has never raised its rates for any long-term care policy it has sold in this state or any other state.
**Example 2** - **Insurer has increased rates on a form more than 10 years ago.**

**Rate Increase History**

Insurer X has sold long-term care insurance since 1984 and has sold this policy since 1997. The insurer has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.

**Example 3** - **Insurer has increased rates on a form in the last 10 years. One rate increase was a 10% increase for all cells. The other rate increase varied from 5 to 15%. The insurer may provide an explanation of the rate increase as long as the information is presented in a fair manner. Following are several examples showing explanations that may be acceptable or unacceptable, depending on the state statutory requirements.**

**Rate Increase History (Acceptable per Model Regulation)**

Insurer X has sold long-term care insurance since 1993 and has sold this policy since 1997. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase History</th>
<th>Rate Increase(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993–1996</td>
<td>LTC300</td>
<td>5%–15% rate increase in 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% rate increase in 1998</td>
<td></td>
</tr>
</tbody>
</table>

The rate increase on form LTC300 was caused by home health care benefits often exceeding the amount that the policyholder was charged for the care. This caused claim experience to be higher than anticipated. This plan design is no longer available.

Below are alternative explanations that are equally acceptable and could be substituted for the last paragraph in the above Rate Increase History:

a) In 1996, form LTC300 had 50,000 policies in force out of 125,000 total long-term care policies in force. In 1998, form LTC300 had 43,000 policies in force out of 200,000 total long-term care policies in force.

b) The rate increase on form LTC300 was caused by higher than expected use of home health care benefits. In 1996, form LTC300 had $1,500,000 in annualized premium in force out of $5,000,000 total long-term care annualized premium in force. In 1998, form LTC300 had $1,300,000 annualized premium in force out of $12,200,000 total long-term care annualized premium in force.

c) In 1996, form LTC300 included 25% of our long-term care policies in force. In 1998, form LTC300 included 22% of our long-term care policies in force.

**Rate Increase History (Unacceptable per Model Regulation)**

Insurer X has sold long-term care insurance since 1993 and has sold this policy since 1997. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase History</th>
<th>Rate Increase(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993–1996</td>
<td>LTC300</td>
<td>5%–15% rate increase in 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% rate increase in 1998</td>
<td></td>
</tr>
</tbody>
</table>
The rate increase on form LTC300 was beyond the control of the insurer due to higher than anticipated use of home health care benefits. {Italics added.}

Below are examples of additional explanations that might not be acceptable to a state.

TM The rate increase on form LTC300 was caused by higher than expected use of home health care benefits. In 1996, form LTC300 had $1,500,000 in annualized premium in force. Our insurer has sold $40,000,000 in annualized premium since 1996. In 1998, form LTC300 had $1,300,000 annualized premium in force out of $20,500,000 total long-term care annualized premium sold since 1998. {Italics added.}

TM Form LTC300 represents only 3% of our insurance business. {Italics added.}

Example 4 - Insurer has increased rates on more than one form in the last 10 years. On one form, the increase was on the home health care rider only. The insurer may note that the increase affected only the home health rider. The increase percentage should be determined by looking at the total policy premium (base policy plus home health rider).

Rate Increase History

Insurer X has sold long-term care insurance since 1988 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC001</td>
<td>1988–1996</td>
<td>20% rate increase in 1993</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% rate increase in 1997</td>
</tr>
<tr>
<td>LTC002</td>
<td>1995–present</td>
<td>0%–5% rate increase in 1998</td>
</tr>
</tbody>
</table>

On policy form LTC002, the base plan rates were not changed. Only rates on the home health care rider were increased. The rate increase amounts shown above for policy form LTC002 indicate the change in the total premium rate, not just the change in the premium rate attributable to the health care rider.

Example 5 - Insurer has increased rates in five states in the last 10 years. This increase must be disclosed in all states.

Rate Increase History

Insurer X has sold long-term care insurance since 1993 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC00A</td>
<td>1996–present</td>
<td>15% rate increase in 1998</td>
</tr>
</tbody>
</table>

Policy form LTC00A is sold in 38 states. Rates were increased in 5 state(s).


Example 6 - Insurer increased rates on a form. After monitoring experience, the insurer decreased rates on the form.

**Rate Increase History**

Insurer X has sold long-term care insurance since 1988 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988–1997</td>
<td>LTC700</td>
<td>15% rate increase in 1993</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>LTC700</td>
<td>0%–10% rate decrease in 1997</td>
<td></td>
</tr>
</tbody>
</table>

After rates were increased on form LTC700, monitoring of experience showed that the increase brought some rates to a level that was higher than necessary. Rates were reduced to reflect this.

Example 7 - Insurer increased rates on a nursing home only form, but has never increased rates on a comprehensive policy or on a non-institutional policy. The disclosure for the comprehensive and non-institutional policies could use the language stating that they have had no increase. For an institutional policy, the increase would have to be disclosed.

**Rate Increase History (Institutional Policy)**

Insurer X has sold long-term care insurance since 1987 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990–1995</td>
<td>LTC001</td>
<td>25% rate increase in 1993</td>
<td></td>
</tr>
</tbody>
</table>

**Rate Increase History (Non-Institutional or Comprehensive Policy)**

Insurer X has sold long-term care insurance since 1987 and has sold this policy since 1997. The insurer has not raised its premium rates on this policy form or similar policy forms in the last 10 years.
**Example 8** - Insurer increased rates on a home health rider, but has never increased rates on an institutional policy or on a comprehensive policy. The disclosure for institutional policy forms that cannot have home health riders could use the language stating that they have had no increase. For a non-institutional or an institutional policy form to which a non-institutional rider may be attached, the increase would have to be disclosed. Additionally, the increase would have to be disclosed for comprehensive policies because institutional policies that have a non-institutional rider attached would be similar to comprehensive policies (see chart in Section IV. B. of the manual).

<table>
<thead>
<tr>
<th>Rate Increase History (Non-Institutional Policy, Comprehensive Policy, or Institutional Policy with Non-Institutional Rider)</th>
</tr>
</thead>
</table>

Insurer X has sold long-term care insurance since 1987 and has sold this policy since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC100</td>
<td>1988–1992</td>
<td>3%–7% rate increase in 1994</td>
</tr>
</tbody>
</table>

The increase on form LTC100 was on a rider providing coverage for home health care. The rates on the base policy were not modified. The rate increase amounts shown above for policy form LTC100 indicate the change in the total premium rate, not just the change in the premium rate attributable to the home health care rider.

**Rate Increase History (Institutional)**

The insurer has sold long-term care insurance since 1987 and has sold this policy since 1997. The insurer has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.
Examples 9 – 11 involve insurers where business has been acquired.

Example 9 - Insurer A has not increased rates on any form except as follows. Insurer A acquired form LTC010 from Insurer B (non-affiliated) in 1999. Insurer B raised rates 30% in 1996. Insurer A raised rates on LTC010 20% in 2000.

Insurer A - Since the rate increase in 2000 was within 24 months of acquisition, Insurer A does not have to disclose it. However, they may if they choose. The insurer may use either of the types of disclosures below. Below are examples of acceptable disclosures for one of Insurer A’s existing policy forms.

**Rate Increase History (Insurer A)**

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has never raised its rates for any long-term care policy it has sold in this state or any other state.

or

**Rate Increase History (Insurer A)**

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010 1995–1998</td>
<td>2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 was originally issued by another insurer. The business was acquired by the insurer in 1999.

Insurer B - All increases must be disclosed, including increases on sold business that are made in the 24 months following acquisition. Below is an example of an acceptable rate increase history for one of Insurer B’s remaining policy forms.

**Rate Increase History (Insurer B)**

Insurer B has sold long-term care insurance since 1988 and has sold this policy since 1998. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010 1995–1998</td>
<td>1996 - 30% increase</td>
</tr>
<tr>
<td></td>
<td>2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 had higher benefit utilization than expected. This business was sold to another insurer in 1999.
**Example 10** - Insurer A has not increased rates on any form except as follows. Insurer A acquired form LTC010 from Insurer B (non-affiliated) in 1999. Insurer B raised rates 30% in 1996. Insurer A raised rates on LTC010 20% in 2000. Insurer A raised rates on LTC010 15% in 2001.

Insurer A - Since Insurer A raised the rates on the acquired business more than once, they must disclose all rate increases that they implemented. Below is an example of an acceptable rate history for one of Insurer A’s existing policy forms.

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LTC010</td>
<td>1995–1998</td>
<td>2000 - 20% increase</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2001 - 15% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 was originally issued by another insurer. The business was acquired by the insurer in 1999.

Insurer B - Must disclose all increases including increases on sold business that are made in the 24 months following acquisition. Does not have to disclose the second increase made by Insurer A. Below is an example of an acceptable rate increase history for one of Insurer B’s remaining policy forms.

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LTC010</td>
<td>1995–1998</td>
<td>1996 - 30% increase</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 had higher benefit utilization than expected. This business was sold to another insurer in 1999.
**Example 11** – Same facts as example 9, except Insurer A had raised rates on one of their own forms more than 10 years ago. This is a case where the bracketed language from the regulation must be modified in order for the insurer to make a factually correct statement. The language “the insurer has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years” should be changed to read “The insurer has not raised its rates for this policy form or similar policy forms it has sold in this state or any other state in the last 10 years.” As in example 9, the insurer may choose to disclose the rate increase.

**Rate Increase History (Insurer A)**

Insurer A has sold long-term care insurance since 1987 and has sold this policy since 1997. The insurer has not raised its rates for this policy form or similar policy forms it has sold in this state or any other state in the last 10 years.

*or*

**Rate Increase History (Insurer A)**

Insurer A has sold long-term care insurance since 1986 and has sold this policy since 1986. The insurer has raised its premium rates on this policy form or similar policy forms it has sold in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Policy Form</th>
<th>Years Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1995–1998</td>
<td>2000 - 20% increase</td>
</tr>
</tbody>
</table>

Policy form LTC010 was originally issued by another insurer. The business was acquired by the insurer in 1999.

**Insurer B would have the same disclosure as in example 9.**

**Examples 12-14 involve combination products.**

**Example 12** – An insurer sells a disability income policy with a long-term care rider. The rates for the disability income base policy were increased by 20%. The insurer has never raised rates on long-term care. In this case, the insurer would not show any rate history since the increase was solely on the disability income policy. The insurer could modify the bracketed language as follows: “The insurer has sold long-term care insurance since 1996 and has sold this policy since 1996. The insurer has never raised its rates for any long-term care policy it has sold …” changes to “The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has never raised its rates for any long-term care policy or rider it has sold.”

**Rate Increase History**

The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has never raised its rates for any long-term care policy or rider it has sold in this state or any other state.
Example 13 – An insurer sells a disability income policy with a long-term care rider. They sell no other long-term care coverage. The rates for the long-term care rider were increased by 30%. Because the increase was on the long-term care rider, the insurer must disclose the rate increase for any policy form or rider developed in the future having similar benefits. The insurer could modify the bracketed language as follows: “The insurer has sold long-term care insurance since 1996 and has sold this policy since 1996” changes to “The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996.”

**Rate Increase History**

The insurer has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LTC010</td>
<td>1996–present</td>
<td>2000 - 30% increase on rider rates</td>
</tr>
</tbody>
</table>

Rider form LTC010 is a rider attached to disability income policies.

Example 14 – An insurer sells a disability income policy that has long-term care benefits in the base policy. The policy is considered a long-term care policy under the regulation’s definition. The rates for the policy were increased by 25%. Regardless of the reason for the rate increase, the insurer must disclose the rate increase for any similar policy.

**Rate Increase History (this policy or any similar LTC policy)**

Insurer X has sold long-term care insurance since 1996 and has sold this rider since 1996. The insurer has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DILTC1</td>
<td>1996–present</td>
<td>2000 - 25% increase</td>
</tr>
</tbody>
</table>

Policy form DILTC1 includes disability income benefits and long term care benefits.

E. **QUESTIONS AND ANSWERS**

1. **What is the difference between institutional and non-institutional long-term care benefits?**

   Generally, institutional benefits are based on each day that the insured is confined to a facility and is receiving services. Non-institutional benefits are usually based on specific services or visits, not days.

2. **When does the rate history start?**

   The rate history is shown for a period extending back 10 years from the date that an application is taken.
3. **Does the regulation require disclosure only of premium schedule increases that occur after the effective date of the regulation?**

No. All premium schedule increases in the last 10 years must be disclosed regardless of whether they occurred before or after the effective date of the regulation.

4. **Does the 10-year time frame date back to when the premium schedule increases were approved or when they were implemented?**

The time frame should be based on the date a premium schedule increase was implemented.

5. **When does an insurer have to file disclosure forms?**

The forms must be filed during the initial filing and any other time that rates are modified in this state or any other state. Where an insurer is filing for premium rate schedule increases in a number of states, it is expected that the disclosures will be updated at least every year. Insurers must also file disclosure forms for any plans that were approved prior to the effective date of this regulation but are going to be marketed after the effective date.

6. **When does an insurer have to provide disclosure forms to an applicant?**

The disclosure forms must be provided to the applicant at the time of application unless the method of application does not allow for it. Methods that do not allow for delivery at time of application include application by mail, electronic application, and interactive voice response (IVR) application. With these methods of application, the disclosure must be provided no later than when the policy or certificate is delivered.

7. **When does an insurer have to provide disclosure forms to a policyholder?**

Every policyholder affected by the premium rate increase must be given updated disclosure forms at the same time as the notification of the rate increase.

8. **Does an insurer have to list every plan code that had a rate increase?**

If an insurer has different plan codes under the same plan series (e.g. LTC001-01, LTC001-02, etc.), the insurer can show the rate increase under that plan series. However, if the rate increase varies by plan code, the insurer needs to disclose the full range of the premium increase. If the plans are substantially different, the insurer should show each plan separately.

9. **Can an insurer list all long-term care forms in its rate increase history including forms with no rate increase?**

No. The rate increase history should include only policy forms where rates were increased. Depending on the state, an insurer may be able to provide an explanation of the increase indicating how much of its long-term care business was affected by the premium schedule increase. However, any information concerning policies or premiums in force should be for the year that the rate increase was implemented.

10. **An insurer raised rates on a home health rider attached to a nursing home only policy. With what types of plans does this increase need to be disclosed?**

Comprehensive plans and other types of plans with non-institutional riders would be required to disclose the increase. For an applicant applying for a long-term care policy with a rider providing non-institutional care, the increase would need to be shown. For an applicant applying for an institutional-only policy with no non-institutional care, the insurer would not be required to disclose the increase.
11. If an insurer increases rates on a home health rider attached to an institutional only policy, how is the rate increase percentage calculated?

The rate increase would be calculated based on the total premium rate. If the average increase on the rider was 15% and the premium rate for the home health rider is 20% of the total premium rate, then a 3% (3% = 15% x 20%) rate increase would be disclosed.

12. If the state permits information relating to the number of policies affected by the rate increase, are there useful rules to apply?

To show what percentage of policies have received rate increases, an insurer may show annualized premium in force or policies in force for both the portion of its LTCI business subject to the rate increase and its total LTCI business. However, the amounts should be only for the insurer’s long-term care business. An insurer cannot express percentages or other numbers that incorporate all of the insurer’s business including policies that provide no long-term care coverage. The numbers for policies in force or annualized premium in force should be shown for the year of the rate increase only. Annualized premiums for a specific rate increase should be based on the in force premiums immediately preceding implementation of the rate increase and should not include the relevant rate increase. An insurer may not show numbers that reflect a span of years. The intention is to provide the consumer with a picture of how much of the insurer’s long-term care business was affected at the time of the rate revision.
Section V. INITIAL FILING

The regulator should determine whether the information presented in filings is consistent with the guidance in this manual to the extent appropriate. Your state may not have adopted all sections of the model. Therefore, reviewing the insurer’s initial filing should be consistent with your state’s statutes and regulations. Each of the items in the filing should meet or exceed minimum standards contained in your state’s statutes and regulations related to LTCI.

A. MATERIALS THAT ACCOMPANY A FILING

In most situations, the filing will include the following, provided in accordance with state filing requirements:

- Policy Form
- Disclosure Materials
- Premium Rate Schedule
- Actuarial Certification
- Actuarial Memorandum

An insurer may file a new set of premium rates to be used for new sales. If the sales will be of an existing policy form, the filing must also include disclosure materials and the Actuarial Certification. Because the state would have already received a copy of the form, the insurer may or may not be required to resubmit a copy of it.

The model provides no authority to require certifications on a retroactive basis for existing policy forms that have no change in premiums for new business. However, the regulator may request information and ultimately withdraw approval of forms and rates under the state’s general statutory authority if appropriate.

B. POLICY FORM

The policy form should be provided in the filing to enable the regulator to review the benefits provided by the policy form and any riders that may be attached. Depending on state laws relating to contracts, the policy form may or may not need to describe contingent benefits upon lapse (CBL). The Model Regulation does not require it. For those states that do, the policy will need to be amended or endorsed to describe the benefit. In either case, CBL is assumed to be available in the event of substantial rate increases, as it will have been disclosed in the Potential Rate Increase Disclosure Form.

C. DISCLOSURE MATERIALS

The LTCI Model Regulation sets out certain required disclosures that are to be provided to consumers at specified times. These disclosures are discussed in Section IV of this manual.

Based on the revised Model Regulation, the following disclosure materials associated with the initial rate filing will be required:

- History of the insurer’s rating practices to be provided in the Rate Increase History Section of the Long-Term Care Insurance Personal Worksheet (Appendix B of the NAIC LTCI Model Regulation; and

- The Potential Rate Increase Disclosure Form (Appendix F of the NAIC LTCI Model Regulation).

The disclosure materials should clearly state that the rates may be adjusted in the future for in force contracts, unless the policy form is noncancelable.
D. PREMIUM RATE SCHEDULE

An initial filing must include a premium rate schedule, which should include rates for all options and riders to be offered by the insurer. The insurer should disclose any premium schedules not being provided along with an explanation of why these schedules were not included. (One such example is a rider that was previously filed, has met all the state statutory requirements, and has not had any rate changes.)

The filing for forms that include LTCI in conjunction with other types of insurance (e.g., life or disability coverage) may include the LTCI coverage as a separate rider. Such a rider would be subject to the LTCI Model Regulation, and the premium rate schedule for that rider would need to be filed.

The LTCI coverage may be a non-separable portion of the policy form. The insurer may provide details to justify that the LTCI benefits are “incidental.” Where there is no such justification, the entire product would be subject to these rules for initial filings, and the premium rate schedule for the entire product would need to be filed.

E. ACTUARIAL CERTIFICATION

The review of the Actuarial Certification involves the review of required materials, the review of the specific language used by the actuary and a review, if necessary, of the actuary’s qualifications. A sample Actuarial Certification is in Appendix 1.

1. Required Materials

The Actuarial Certification will include a number of specified sections. Of particular importance are the five sections identified below that relate to the actuarial work and the actuary’s opinion. The language in the Actuarial Certification addressing the first two of these sections should follow exactly the recommended wording. For the third section identified below, the Actuarial Certification should have the recommended wording but may include a “reliance statement.” The last two sections, describing the contract reserves and premium rate schedule relationships, may have many variations.

(a) In my opinion, the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.

(b) I have reviewed and taken into consideration the policy design and coverage provided.

(c) I have reviewed and taken into consideration the insurer’s current or planned underwriting and claims adjudication processes.

The certification should include statements related to these items. The actuary may include a statement that he or she relied upon someone else employed or representing the insurer for this information. The information that was provided to the actuary should be a document available to the regulator. However, since the resource document may include significant proprietary information, in those cases where the regulator cannot guarantee confidentiality, the regulator may consider consulting other states (with confidentiality rules) or other methods of review to satisfy the state’s requirements for adequate review of insurer filings.

NOTE: The wording for the reliance should apply only to the review of the underwriting and claims adjudication processes.

(d) For RS 2014, the actuarial certification should include a statement that the premiums contain at least a composite moderately adverse margin of 10% of lifetime claims. In situations when a composite margin that is less than 10% may be justified, the actuarial certification must justify the
lower margin and describe methods to monitor developing experience that would be the basis for withdrawal of approval of the lower margin.

A complete description of the basis for contract reserves that are anticipated to be held, along with statements that:

1. The assumptions used for reserves contain reasonable margins for adverse experience, and
2. The net valuation premium for renewal years does not increase.

In addition, the certification should include either

(c) A statement that the reserve requirements have been reviewed and considered, including:
   (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 premiums and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or a complete description of the situations where this does not occur.

(e) Either 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 or a comparison of the premium schedules that are currently available with an explanation of the differences.

Both the contract reserve review and the comparison of premium rates are intended to be broadly based. The draft actuary’s certification in Appendix 1 uses the term “consistently in excess” while the Model Regulation in Section 10B(2)(d)(iv)(I) requires “the underlying gross premiums maintain a reasonably consistent relationship.” While it is not expected that every age, every elimination period, and every benefit option will be analyzed, a simple overall aggregation for the contract reserve review may not be sufficient. There should not be large fractions of the expected new issues where rates would have inadequate margins.

2. Review of the Language Used in the Certification

In addition to the comments about specific sections above, the Actuarial Certification should be read carefully to determine whether it is a clean opinion or a qualified opinion. A qualified opinion often uses wording such as the following: “except for the matter referred to in the preceding paragraph...” This is an indication that the information described in the preceding paragraph modifies the actuary’s opinion and in some manner weakens the certification. The regulator should carefully read any qualifying language and discuss the specific meaning of the qualification with the actuary. Based on the degree and significance of the qualification, the certification may be rejected as not compliant with statutory requirements.

3. Review of the Actuary’s Qualifications

The first thing is to verify that the signatory is a member of the American Academy of Actuaries. Membership in the AAA is a minimum requirement (unless the individual has been otherwise approved by the Commissioner), but it should be noted that not all members are qualified to perform all actuarial tasks. The AAA has qualification standards that a member must satisfy in order to issue a prescribed statement of actuarial opinion, such as an Actuarial Certification under the NAIC LTCI Model Regulation. If the regulator is in doubt about the actuary’s qualification, he may contact the ABCD and request guidance.

The American Academy of Actuaries also has Actuarial Standards of Practice, which apply to various
aspects of the work required to sign the Actuarial Certification.

**F. ACTUARIAL MEMORANDUM FOR RS 2014**

Appendix 5 contains a table summarizing the items to be included in the actuarial memorandum.

For initial filings, the regulatory actuary may wish to request a sensitivity analysis, in the form of projected experience, and loss ratios by calendar year. The analysis should show how a change to each key assumption impacts earned premium, incurred claims, and loss ratios by calendar year, including how a change to each assumption produces a lifetime loss ratio that meets the moderately adverse margin.

See the Assumptions Template in Appendix 6 for a sample format for providing the initial pricing assumption components.

**G. RIGHT TO REQUEST FURTHER INFORMATION**

The regulator normally should be able to satisfy himself or herself with the adequacy of the premium rates, the reserves levels in comparison to the minimum requirements in the state of filing, and the disclosure to be provided. The regulator may need to review additional information about pricing assumptions. The Model Regulation gives the regulator the right to ask the insurer for more information. A state may require that an actuarial memorandum include all of the items listed in Appendix 5 or other items. Additional information concerning selected items from the list in Appendix 5 is provided in Question 1 of Section VI.D.

**G.H. QUESTIONS AND ANSWERS**

1. Why aren't loss ratios referenced in this section of the LTCI Model Regulation?

   Initial premium rate schedules are not subject to any minimum loss ratio standard in order to allow insurers to include margins for adverse experience and to avoid the need to file for rate increases.

2. The LTCI Model Regulation had a 60% loss ratio. Is that no longer used?

   The 60% loss ratio standard still applies to business written prior to the effective date of Sections 10 and 20. It still applies to initial and revised premium rate schedules for that business (see Section 19 of the Model Regulation).

13. What has changed in are the actuary’s responsibilities?

   In the past the actuary provided a certification that the assumptions underlying the premiums produced a benefits-to-premium ratio at or above the minimum loss ratio. Thus, the more aggressive the assumptions, the lower the premium and the easier it was to meet the loss ratio standard.

   Under the new basis in Section 10, The Actuarial Certification contains two very important statements representing the actuary’s opinion. These statements should not vary from the recommended wording. Through these statements the actuary is opining that the premium rate schedule contains sufficient margin to allow for anticipated costs under expected conditions as well as under moderately adverse conditions. The opinion also states that the actuary reasonably expects that no future premium increases will be necessary.

24. What is the importance of the information filed on contract reserves?
The contract reserves provide for pre-funding of higher morbidity costs in the later durations. The contract reserves should be based on assumptions that generally mirror the pricing assumptions except that they contain additional margins. Some assumptions are limited by reserve standards (e.g. interest rates and termination rates). The contract reserve assumptions will create a “net valuation premium” for the first year and for all renewal years. In most cases, this valuation premium for renewal years will be level. The only exceptions are for attained-age based premium schedules under age 65, and when states permit the use of a two-year full preliminary term reserve. The NAIC Health Insurance Reserves Model Regulation includes a requirement for use of a one-year preliminary term reserve. The Actuarial Certification should include information about the reserve assumptions.

The Actuarial Certification also includes a statement about the level of the gross premium (the filed rate schedule). The certification should either state that the gross premium exceeds the sum of the net valuation premium for renewal years plus the average assumed renewal expenses or provide a detailed description of the circumstances where this does not occur. The detailed description may be small changes to the contract reserve assumptions that, if incorporated, would cause the gross premium to exceed the sum of the adjusted reserve premium plus the average assumed renewal expenses. Examples of this approach are included in Appendix 1. If the changes are truly small, the review by the regulator is not much different than if the actuarial certification had included the direct statement. The detailed description may involve a less direct manner of relating gross premium assumptions to contract reserve assumptions. The regulator may wish to request additional information on gross premium assumptions under Section 10C.

### 35. When reviewing the Actuarial Certification, what should the regulator look for?

The regulator should look for the use of: (1) the recommended language; (2) additional “except for” language; and (3) “reliance” language.

If the regulator determines that the recommended language has been modified, or if the regulator has any other concerns with the Actuarial Certification, he or she should discuss the concerns with the certifying actuary. If the regulator is not satisfied, the regulator may wish to consult with other regulators, or contact the ABCD for guidance. The regulator may also wish to review Section F, Right to Request Further Information, and may ask for additional information related to the specific area(s) of concern.

### 46. What does “moderately adverse experience” mean?

For policies issued [insert date that is prior to the date that is six (6) months after adoption of the amended regulation] there is no specific definition in the Model Regulation. Ultimately the actuary must determine a reasonable answer for the particular circumstances of each filing, relying on the guidance that is available. This phrase is used in the Actuarial Standards of Practice (ASOPs) and its reference here is intended to be consistent with those standards. For policies issued [insert date that is six (6) months after the date of the amended regulation] moderately adverse experience is a composite margin that is not less than 10% of lifetime claims. A composite margin that is less than 10% may be justified in uncommon circumstances.

- For initial rate filings, the company should state the margin.
- Interest rate and distribution of business should not be considered as part of the MAE.
- The regulatory actuary should ask how the key assumptions (i.e., morbidity, mortality, and voluntary lapse) impact the composite margin. The regulator may wish to request a sensitivity analysis, in the form of projected experience, which shows how a change to each key assumption impacts earned premium, incurred claims, and loss ratios by calendar year. The demonstration should also show how the change to each assumption produces a lifetime loss ratio that is beyond the moderately adverse margin.
A lower margin may be justified in various ways. For example, an insurer may justify a lower margin based on whether they have past LTC pricing experience. For insurers with past LTC pricing experience, the insurer may rely on actual to expected ratios in the LTC experience exhibit, bill weller.

An insurer may also justify a lower margin for products that are not considered stand-alone LTC product, but must be justified by an appropriate actuarial demonstration.

Finally, the regulator should take into account the credibility of the experience supporting any margin to conclude whether a larger margin may be appropriate.

BILL WELLER TO PROVIDE POTENTIAL REPLACEMENT LANGUAGE.

**75.** What can I do if I think the assumptions are not reasonable for even moderately adverse conditions?

The first thing would be to discuss your concerns with the certifying actuary. That discussion may address your concerns fully. If not, you may want to talk to another state regulatory actuary in another state or who has experience with LTCI consider disapproving the filing if allowed in the state.

If you are unable to satisfy yourself through these approaches, you may contact the ABCD for its counsel on your concerns. To do this, you should write or call a member of the ABCD, which is listed in the yearbook and on the AAA website (www.actuary.org), and outline your concerns.

After all of these efforts, in the event you have not been satisfied, you can ask the ABCD to contact the actuary. If you feel that this is needed, you will be given directions in how to take formal action.

**86.** What if initial rates were too high? How would regulators know?

One of the critical tenets on which the new approach to rate stabilization has been built is that the market for LTCI is competitive. Thus if initial rates are “too high,” the consumer will decide to purchase coverage from a different insurer.

**97.** How are rate guarantees handled under these rules?

Rate guarantees were not specifically addressed in the development of the rate adequacy revisions to the model. It is not likely that a rate guarantee period of 5 years or less would have any effect on the Actuarial Certification. Where the rate guarantee period is longer, the actuary may be asked to address the rate guarantees under Section 10C of the Model Regulation.

**108.** How are limited pay plans handled under these rules?

Limited pay plans were not specifically addressed in the development of the rate adequacy revisions to the model. Most limited pay plans are options with the same benefits but a special higher premium schedule, and they are a very small percentage of sales. The assumptions described by the actuary in defining the reserve basis should be reviewed to assure that the impact of any limited pay options have been taken into account.
For example, the morbidity, mortality and interest assumptions should generally be the same (or very similar) as those used for lifetime pay plans. Persistency of most short limited pay plans (5 or 10 years) is very high reflecting the consumer decision to pay more in the early years. Where the limited pay is to age 65 or 70 and the issue age is under 50, the persistency will be closer to that for lifetime pay products.

Are there any other issues that I should be aware of as a regulator?

LTCI is a developing coverage as companies, consumers and regulators learn more about what is needed and what can be provided on a sound basis. For example, a key concept in today’s products is the place where care is given. Products sold in the 1980s generally provided coverage only for care given in a nursing home. Over the years, coverage has been more frequently provided in other settings: adult day care, assisted living facilities and at home. Now, there are policies that provide coverage without reference to place, wherever care is given.

It is a basic fact of LTCI that each aspect – policy design, initial premiums, underwriting, marketing, claim adjudication, and so on must be sound for the whole package to be sound. There are examples in the history of LTCI where only a single flaw caused significant premium rate increases, disgruntled insureds and lost coverage.

For example, if a new liberal benefit is offered and underwriting has not been reviewed and possibly revised, then claims may be higher than expected. If so, premiums will increase, and potentially, many insureds could lose coverage right when they most need it.

A key point is that all aspects of a LTCI policy need to be considered. All policy aspects should be reviewed to determine whether modifications are needed so that actual claims have a high probability of matching expected claims. This hopefully enables premiums to be stable “for the lifetime of the policyholder.”

What should be considered if an insurer offers unisex rates?

LTCI premium rates may be offered on a unisex basis although the expected experience varies by gender. The insurer’s expected mix of business by gender should be reviewed. Claim and active life reserves may be established using unisex morbidity and mortality subject to meeting minimum reserve requirements. For unisex assumptions, adjustments may be needed to reflect the expected mix of genders at each age.

How does the regulator compare rates of different forms to determine that the company complies with the required standard that new business rates are not less than the premium rate for existing similar forms currently available from the insurer except for benefit differences?

The comparison must be performed on a consistent basis. This means that it may be inappropriate to simply compare the two rate schedules directly. When the premium rate schedule for a new policy form is less than the premium rate schedule for an existing similar policy form also currently available from the insurer, and it is not clear whether this is a reasonable difference attributable to benefits, the regulator may wish to ask the company actuary to use one set of pricing assumptions to evaluate all forms. This is done for each form as if it were a new issue (the duration of the business is not directly considered at this point). This is not for the intent of determining the rate, but simply to determine the benefit differences between the forms. This analysis will give a benefit comparison between forms— say coverage A is 1.15 of coverage B. This relationship is then used to compare the rate schedule relationships. The model provides that the relationship should account for benefit differences. The regulatory actuary may want to consider the new business rates of any affiliates when comparing new business rates.
Following is an example showing a comparison of product benefits used to determine the rate comparison.

Summary of material benefit differences:

<table>
<thead>
<tr>
<th>DETERMINATION OF PLAN RELATIVITIES</th>
<th>Plan A</th>
<th>Plan B</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC benefits</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Waiver of premium</td>
<td>1.0</td>
<td>.92</td>
<td>Plan B does not have PW</td>
</tr>
<tr>
<td>Restoration</td>
<td>1.10</td>
<td>1.0</td>
<td>Plan A has restoration</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.10</td>
<td>.92</td>
<td></td>
</tr>
</tbody>
</table>

Plan A is 19.6% richer (1.10/.92) than Plan B. When comparing premiums at various ages, Plan A premiums should be 19.6% higher than Plan B premiums.

The actuary needs to use judgment in deciding which benefit factors would be additive and which would be multiplicative. A benefit that affects the entire policy, i.e., restoration, should be multiplicative, but two mutually exclusive coverages, i.e., nursing home or home health care services, may be considered to be additive.

12. Are there any other things a regulator should consider when reviewing an initial rate filing?

- If the company has submitted prior rate increase filings on the same or a similar policy form, the company should justify any pricing assumptions that are not at least as conservative as the current best estimate in the prior rate increase filing.

- If the company has submitted a prior rate increase filing on the same or a similar policy form, the company should justify any composite margin that is not at least as conservative as the composite margin in the most recent rate increase filings.
Section VI. RATE INCREASE FILING

The prior chapters of this manual have related to the initial filing of premium rates and disclosures to applicants for long-term care insurance policy forms under the new LTCI Model Regulation. It is anticipated that the new rules for developing premium rate schedules will allow insurers to include greater margins and reduce the potential need for rate increases. However, the Model Regulation does provide for the filing, review and approval of premium rate increases, as well as the monitoring of ongoing experience in the event of a rate increase for policy contracts issued subject to the new Model Regulation. For RS 2014 policies, the Model Regulation requires annual actuarial certification certifying that the premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule is sustainable over the life of the policy with no future rate increases anticipated. The certification varies depending on whether the product is currently being marketed or no longer marketed.

This chapter covers the information to be filed and the basis for the regulator’s review of premium rate increase submissions under the new Model Regulation. Later chapters provide information relating to monitoring experience, including the annual actuarial certification, additional regulatory oversight and potential regulatory actions for significant rate increases.

A. MATERIALS THAT ACCOMPANY A RATE INCREASE FILING

The information to accompany a filing for a rate increase is defined in Sections 20, for RS 2000, and 20.1, for RS 2014, of the Model Regulation. The information includes:

- **New Premium Rate Schedule**
- **New Disclosure of Rate Increase History** document that reflects the filed increase. The insurer should also provide a list of all similar policy forms that are available for sale in which applicants will be informed of this rate increase.
- **New Actuarial Certification**
- **Actuarial Memorandum** justifying the new rate schedule which includes:
  - Lifetime projection of earned premiums and incurred claims that illustrate the rate schedule’s compliance with the loss ratio standards. These projections should be based on the valuation interest rate;
  - Disclosure of how reserves have been accounted for if the rate increase triggers contingent benefit upon lapse;
  - Disclosure of why the rate increase is necessary, including which pricing assumptions were not realized and why; and
  - Statement that the policy design, underwriting, and claims adjudication practices have been taken into consideration.

1 There are different rules for “exceptional increases.” These are explained in a separate section at the end of this chapter.
• A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing and the composite margin is projected to be exhausted.

• *Rate Comparison 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…” The regulatory actuary may want to consider the new business rates of any affiliates when comparing new business rates.

1. **New Premium Rate Schedule**

The complete new rate schedule should be filed, including rates for all variations in elimination periods and benefit periods. The percentage increase for each issue age should be provided from both the existing rate (to review the changes to disclosure documents) and the original rate. These percentages should be compared to the levels that trigger Contingent Benefit upon Lapse (CBL). See below for additional issues if CBL is triggered.

2. **New Disclosure of Rate Increase History**

Section 9 of the Model Regulation outlines the disclosure documents that each insurer must provide to all applicants. One part of this is a history of any rate increase on similar policy forms that has occurred within the 10-year period prior to the application date. This disclosure will need to be updated to reflect the actual rate increase that results from the filing. The Commissioner should establish the time frame within which the insurer must change its disclosure documents after the approval of any rate increase.

If a state approves a rate increase that the insurer will phase in over more than one year, each phase of the rate increase should be disclosed.

3. **Actuarial Certification**

The Actuarial Certification required at the time of a rate increase is different from the annual rate certification requirement under Section 15I of the Model Regulation. The Actuarial Certification required to accompany a rate increase filing under Sections 20B(2) or 20.1B(2), as applicable, of the Model Regulation should be reviewed for the specific language used by the actuary. The insurer may propose an increase that is less than what is required to make the actuarial certification; however, the certifying actuary should discuss the basis for any subsequent rate increase.

It is possible that the certifying actuary will not be the same person as the one who signed the original certification. A change in the actuary of record should be explained. A sample Actuarial Certification for a rate increase is in Appendix 2.

4. **Actuarial Memorandum**

The review of the actuarial memorandum relating to a rate increase will be more extensive since it contains additional information, actual experience, a loss ratio demonstration, and an explanation of the original assumptions that were not realized in support of the requested rate increase, and a re-established moderately adverse margin (refer to Appendix 5).

The actuarial memorandum should be reviewed for completeness. The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions. The insurer should provide justification for any change in assumptions. The assumptions used for the loss ratio demonstration should be consistent with prior actuarial experience,
adjusted for known changes in such items as underwriting or claims adjudication that have been made or are anticipated by the insurer. The assumptions for future claims used in the loss ratio demonstration required under Section 20B(3)(a) and Section 20.1B(3)(a) of the Model Regulation should include the actuary’s margins for moderately adverse claims and persistency experience.

The morbidity assumption and reported morbidity experience may not be credible for any LTCI policy form by itself. Combining experience of different forms with similar benefits may result in more credible historical claims as the basis for future claim costs.

Any assumptions that deviate from those used for pricing other forms currently available for sale should be disclosed and justified. For policies that were approved after the 2014 amendments, the Assumptions Template should be completed.

The lifetime projection of earned premiums and incurred claims (including margin for future adverse experience) shall illustrate that the lifetime loss ratio requirement will be satisfied with the filed rate schedule increase. This lifetime must include annual values for at least the five years preceding and three years following the increase. A simplified loss ratio demonstration (not including any detail or justification of assumptions) is in Appendix 4. Please note that this is not the only method or format for providing the required projection and values. The handling of projected lapses that qualify for CBL is described later.

In evaluating compliance with Sections 20 and 20.1 of the Model Regulation, the regulatory actuary should consider the following:

Under 20.1B(3)(a), the lifetime loss ratio using lifetime projections of earned premium and incurred claims should be based on:

• the revised premium rates;
• new best estimate assumptions (no MAE);
• the current mix of business; and
• the valuation interest rate.

One way of showing that the margin is exhausted under 20.1B(3)(f) is to compare loss ratios. The actual lifetime loss ratio using actual past experience and projected experience using new best estimate assumptions with no MAE and current mix of business should be greater than the actual lifetime loss ratio using actual past experience and projected experience using original assumptions with original MAE adjusted for the current mix of business. The calculation should be based on the current valuation interest rate.

In demonstrating compliance with 20.1C, the accumulated value of historic expected claims under 20.1C(2)(ii) should be based on:

• original assumptions with original MAE; and
• current mix of business.

In calculating future expected incurred claims under 20.1C(2), use:

• current mix of business; and
• current best estimate assumptions, including the current MAE.
In demonstrating compliance with 20.1C(2), the lifetime loss ratio referenced in 20.1C(2)(a)(ii) and 20.1C(2)(c)(ii) should be based on:
- current mix of business at time of initial rate filing;
- original assumptions; and
- original MAE.

A simplified loss ratio demonstration (not including any detail or justification of assumptions) is in Appendix 4. Please note that this is not the only method or format for providing the required projection and values. The handling of projected lapses that qualify for CBL is described later.

The memorandum should clearly show that it uses the interest rate(s) required to be used by Section 20C(4) or 20.1C(5), as applicable, of the Model Regulation to demonstrate that the new premium rate scale meets the loss ratio requirements. Any net excess of the expected earnings over the valuation rate would be considered as a part of the provision for moderately adverse experience in the new rates; however, the regulatory actuary may wish to consider whether it is appropriate to include the interest rate assumption in the moderately adverse margin.

The persistency assumption for the future (for both claim costs and premiums) should take into account:

(a) The amount of the proposed rate increase;
(b) The impact of reserves transferred to fund any CBL benefits (triggered proportions of the total in force business subject to rate increases should be shown as well as the percentage for each triggered age or age group that are expected to accept the CBL offer);
(c) Historical renewal lapse rates; and
(d) The actuary’s margin for adverse persistency experience.

The memorandum should describe the analysis done by the actuary comparing prior assumptions with experience. This analysis should cover all important assumptions showing the positive as well as adverse deviations from the expected. The amount of the original pricing margin that is lost when the new assumptions are used should be estimated. Any actions the insurer has taken or is planning to take to offset even greater rate increases should be noted to the extent the actions were relied on by the actuary in developing the new rates.

The memorandum should contain a statement that the policy design (benefits and benefit triggers, etc.), underwriting (to the extent it is still anticipated to affect claim costs) and claims adjudication practices have been taken into consideration by the actuary in the development of assumptions and projections.

For certain group business or particular policy forms it may be necessary to have the same rate for both new issues and in force business. In these cases the actuary’s projections will need to apply the loss ratios to the business subject to a rate increase to show the rate as if there were no new business. A separate rate for new business would be developed consistent with the anticipated loss ratio at issue of the original policy form and the revised assumptions. These two rates would then be combined into a single rate. Actual new business results should then be reviewed as part of the review of projected results for the three-year period following the rate increase.

For additional information, refer to the rate increase column in the chart in Appendix 5.

The regulatory actuary may also wish to request a sensitivity analysis, in the form of projected experience, and loss ratios by calendar year. The analysis should show how a change to each key assumption impacts earned premium, incurred claims, and loss ratios by calendar year, including how the change to each
assumption produces a lifetime loss ratio that meets the re-established moderately adverse margin.

5. Rate Comparison Statement

Section 20B(4) or 20.1B(4), as applicable, of the Model Regulation requires that a rate increase filing provide the following: “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…”

It should be noted that the new business premium rates are not subject to the minimum loss ratio requirements that are applicable to rate increases.

In most situations the insurer will be able to provide a statement that rates after the rate increase are not greater than the new business rates. The regulatory actuary may want to consider the new business rates of any affiliates when comparing new business rates. In some cases, the differences in benefits will be large enough that this comparison cannot be verified by simply comparing the rates. The insurer should provide information justifying significant variations.

In some circumstances the policy forms subject to the rate increase will end up with rates higher than new business rates of another policy form for the same issue age. This will generally result when the future premiums for older policy forms are a much smaller proportion of total premiums while new or newer policy forms will collect more premiums that include the rate increase. The insurer should be able to justify this result to the regulator by including a comparison of the resulting renewal rate with new business rates at the higher (current) age for sample insureds. Although this circumstance demonstrates one reason why the requested rate increase rates would be higher than new business rates, it may not be a sufficient reason to allow the deviation from the standard. A closed, reducing block of business that has been in force for many years is likely to have this circumstance, which may be the result of initial under-pricing and insurer inaction. For closed, reducing blocks of business in particular, the regulatory actuary should consider whether or not the rate resulting from the requested increase is excessive for the remaining insureds.

Where the rate increase is applicable to a policy form that is currently being offered, the renewal rates will be limited by the loss ratio standards. The insurer may wish to use higher rates for new sales (which are not subject to loss ratio minimums). Assuming that new sales of the policy form (at rates higher than the renewal rates) are allowed after the rate increase, the insurer will need to eliminate the experience of these new issues for purposes of comparing actual to projected experience following the rate increase. It should be noted that the experience for these new issues should be included when determining future rate increases.

6. Notice to Policyholder

The insurer must provide notice of an upcoming premium rate schedule increase to all policyholders prior to implementation of the increase. The regulatory actuary should review this notice along with Section IX of this manual.
B. ADDITIONAL ASPECTS IF CONTINGENT BENEFIT UPON LAPSE IS TRIGGERED

As noted earlier, the new rates are to be compared to the original rates and the ratio compared to the table for triggering CBL provisions under Section 28 of the Model Regulation. For any issue age where the percentage equals or exceeds the table value, the insurer also will need to provide those policyholders with an explanation of their options and the date the CBL option expires. Note that for RS 2014 policies, the triggers found in the table are amended by Section 28D(7).

Due to the increased popularity of limited pay long-term care insurance, [in 2005] the NAIC expanded the contingent benefit upon lapse provision to address an identified need to improve the value of contingent benefits for limited pay policies. An additional test of a substantial premium increase and separate reduced paid-up benefit calculations were added for these policies in Section 28 of the Model Regulation. These new provisions become effective six months after their adoption. The insurer will need to provide policyholders with an explanation of their options and the date the CBL option expires should this test be triggered.

There are several aspects to be considered:

1. Approval of the process for informing policyholders of their CBL option;
2. Determination of the proportion of policyholders receiving a rate increase for which the CBL is triggered; and
3. Adjustments made in the actuarial memorandum for CBL and the monitoring of actual versus expected use of CBL following the rate increase.

Sections 28D(5) and D(6) of the Model Regulation provide specifics for the notification of policyholders of their rights at the time of a rate increase. Since it is possible that some but not all policyholders subject to a rate increase will trigger the CBL, the regulator should review the different materials to be provided in each situation.

If an insurer phases in an approved rate increase over more than one year, the full increase should be used in determining whether a contingent nonforfeiture benefit upon lapse is triggered.

Sections 20G and H, or Sections 20.1G and H, of the Model Regulation become effective if the CBL is triggered for the majority of the policyholders (anything over 50%) subject to the rate increase. The regulator should determine the percentage of policyholders for which the CBL is triggered. The determination of this percentage shall include limited pay policies that trigger the additional substantial premium increase test following the effective date of this provision.

Section 20B(3)(b) and 20.1B(3)(b) of the Model Regulation provides an exception to the normal rule that active life reserves are not to be reflected in the demonstration that the lifetime loss ratio projection is satisfied. The expected number of changes from premium paying insured (full benefit) to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected value of all future payments for those under CBL, including comparable margins for adverse experience, should be recognized as immediate benefits in the rate increase calculation subject to a maximum of the total active life reserve held for these insureds. A separate reserve for CBL insureds in this amount should be established and the insurer should adjust the active life reserve for premium-paying policies to reflect this transfer. During the three years when projections are monitored, the reserve should include an examination of the number of policyholders who actually accepted the CBL offer. The reserve established for any additional CBL insureds should be reflected as additional benefits in the updated projections. If the number of CBL insureds is lower, the excess reserve for CBL benefits established at the time of the rate increase should reduce total benefits in the updated projections. The actual claims experience of CBL insureds after the transfer is not to be combined with the experience to be monitored.
C. EXCEPTIONAL RATE INCREASES

Section 4A of the Model Regulation defines exceptional increases. Most rate increases will not be exceptional. If an insurer files a rate increase as an exceptional increase, it should provide justification for one of the two possible bases upon which the insurer may rely.

The regulator should review the justification provided before reviewing the remainder of the rate increase request, since the limitations are different. Approval of the basis for the review should be based on a finding that either:

1. The insurer has reflected a change in federal or the state's laws or regulations applicable to LTCI; or
2. The insurer has documented a rationale for increased and unexpected utilization (higher number of claims or longer periods for insureds in claim status) that affects the majority of insureds with similar products.

There are additional issues the regulator may wish to consider as part of this review.

Would it be beneficial to request a review by an independent actuary or to coordinate with other states? This could be especially important in making a determination under 2 above.

Are there offsets to increases that result from the new laws, regulations or even the basis for higher utilization? If so, the insurer should reflect any potential offset.

Insurers are required to file much of the same information for an exceptional increase (new premium rate schedule, new rate history disclosure) as for a non-exceptional increase, with a few slight modifications. There is a difference in the actuarial filing. The certification would be slightly different in wording. (See Appendix 3 for a sample.) The actuarial memorandum would be shorter. There is no requirement to justify differences from initial assumptions or to provide lifetime projections. Instead, the actuary should demonstrate that future claim costs (resulting from the causes the insurer has used to justify the need for an exceptional increase and from any relevant expected changes in insurer experience) are 70% of the future projected additional premium. Experience to date and the future projections of premiums from the original rate (with the expenses and claims to be covered) are not to be included in the demonstration. However, the regulator may request such experience and other information to evaluate the appropriateness of the insurer’s estimate of potential offsets to higher claim costs.

D. QUESTIONS AND ANSWERS

1. What would be a common list of information a regulator might expect to see in an actuarial memorandum for a rate increase?

A state may wish to require that an actuarial memorandum include some or all of the items listed in Appendix 5 and complete the Assumptions Template in Appendix 6. Selected items from that list are discussed below.

(a) Morbidity
   The overall pattern of claim costs for LTCI is well known – claim costs increase with increasing age – but there is no industry standard morbidity table.

(b) Lapse
   If the LTCI policy does not contain a nonforfeiture provision, the pricing will reflect a “lapse-supported” pricing methodology. The more insureds that leave the block, either by death or
voluntary termination), the lower future costs will be. This means that the assumptions that the insurer makes about future expected lapses (voluntary) and deaths are critical to the pricing of LTCI. The lower the expected lapses and deaths, the more conservative the pricing.

Most current filings have ultimate (after the first 5 years or so) lapse rates of 4% or less. This means that fewer than 4% of the insureds that remain will drop their policy. If this assumption is higher than 3%, then the insurer should be questioned about the source of its assumption. Remember that the higher this number, the lower the premium and therefore, the less conservative it is.

(c) **Mortality**

The mortality assumption (death rates) is critical for the same reason that the voluntary lapse rate is critical. If more insureds are assumed to die than actually do, then the premiums could be inadequate. The NAIC Health Insurance Reserves Model Regulation requires the use of an annuity mortality table. The use of a life mortality table would be less conservative.

(d) **Interest**

Section 20C(4) and 20.1C(5) of the Model Regulation requires that the interest rates used for discount purposes in determining rate increases be the maximum valuation interest rate for contract reserves as specified in the states’ equivalent to the NAIC Health Reserves Model Regulation. Since this rate may vary from year to year, Section 20 and 20.1 allows the use of an average interest rate if the manner in which it has been determined is disclosed. The regulator should review the filing to determine compliance with the moderately adverse standard based on all assumptions, including the interest assumptions, which may be different from those used for testing loss ratio compliance.

(e) **Reserves – Policy and Claim**

The reserves, both policy and claim, should be reviewed by the regulatory actuary for reasonableness and adequacy. The regulatory actuary may wish to consider how the assumptions for active life reserves compare to the corresponding assumptions underlying the projections used to justify the rate increase. If the policyholders are being required to pay additional premiums now to fund the future increased costs of reduced terminations, for example, then the rate increases should be used to fund the additional reserves needed for those increased costs.

2. **How are active life reserves utilized under the revised model?**

Normally, active life reserves are not included in the rate increase analysis. Section 20B(3)(b) and 20.1B(3)(b) provides an exception to this rule by allowing a transfer of the active life reserves to be reflected as a claim for those insureds transferred from the active life pool to the CBL paid-up pool. The expected number of changes from premium paying (full benefit) insured to CBL insured (with a reduced or shortened benefit period) should be a part of the actuarial memorandum. The projected benefits for those under CBL should be recognized at the time of the rate increase, and the insurer should adjust the active life reserve for these potential benefits. During the three years when projections are monitored, the review should include an examination of the number of policyholders who actually accepted the CBL offer. Any difference
between the reserve needed for continuing full coverage and the reserve for CBL coverage for the additional (or lower) number of CBL insureds should be reflected in the updated projections.

3. **What differences in the rate increase filing should be expected when an insurer sells both continuous-pay and limited-pay products?**

The regulator should review the experience to determine whether limited-pay premium experience has been combined with the experience for continuous-pay policies. In general, limited-pay policies may not have credible experience on their own. Rate increases can only be charged to those insureds paying current and future premiums. This means that projected future costs that incorporate higher claim cost assumptions will need to be separated into those for paid-up policies and those for premium paying policies. If these increased costs are combined, the continuous-pay plans would be subsidizing paid-up insureds, and may be considered “unfair discrimination.”

4. **What other differences should the regulator review between continuous-pay and limited-pay products?**

Limited-pay products have two CBL options. The first (or normal) option is the same as for continuous-pay products and is required if the policy is issued without nonforfeiture benefits. The second (or added) option is a reduced paid-up benefit that applies only to limited-pay products and is required even if the policy includes a SBP nonforfeiture benefit.

The added CBL option recognizes the gradual change from premium paying to paid-up status of these products. It is triggered 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.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

Actual benefits from this CBL option are a reduced paid-up policy where the periodic payment is reduced (versus the normal CBL, which reduces the maximum paid when a claim occurs). The reduced amount is determined by 90% of the ratio of (a) to (b) where:

(a) is the number of months of premiums paid to the date of lapse, and
(b) is the number of months in the original premium-paying period.

The added CBL option can only be exercised if the ratio of (a) to (b) is 40% or more and the lapse date is within 120 days of the first due premium following the date of the rate increase.

5. **Is it possible for both CBL options to be triggered by the same rate increase for a limited-pay policy?**

Yes. The policyholder will then have the choice of the “normal CBL” or the “added CBL” and the Model Regulation provides that, if the policyholder does not make a choice, the added CBL is the automatic option.
6. What should be considered if an insurer offers unisex rates?

For policies with unisex rates, rate increases should continue to be based on unisex rates. Claim and active life reserves may have been established using unisex morbidity and mortality but adjustments may be needed to reflect the actual mix of claims and in force policies.

7. In Section 4A(4) of the Model Regulation, the definition for exceptional increase references “potential offsets.” What are some examples of “potential offsets”?

Consider the example of a state passing a new requirement that all LTCI policies cover home health services, even if policies previously provided only institutional care.

(a) If a policy has a maximum benefit period expressed in years, not dollars, to which all benefits (non-institutional and institutional) are subject, a potential offset would occur because benefits paid under lower cost non-institutional benefits (e.g., home health care) would reduce the amount of time remaining for higher cost institutional benefits.

(b) If an insurer retains the same benefit triggers (e.g., Activities of Daily Living) for home health as for institutional care, costs attributable to increased utilization for home health care (which could be anticipated to be higher than utilization for institutional care) could be offset somewhat by the fact that per visit home health care charges are lower than institutional charges.

8. What happens if the regulator believes that the requested rate increase is too high?

The regulator should review the assumptions in the actuarial memorandum and the Assumptions Template for reasonableness. For example, the insurer could be projecting lapse rates or mortality rates that are significantly lower than what was used in the original pricing assumptions. The regulator should examine which assumptions are reasonable, the original assumptions or the assumptions in the rate increase filing. The filing may be subject to the state’s filing review and approval process. The regulation does not guarantee that the requested increase will be approved. Other state statutory requirements may apply.

The regulator should discuss his or her concerns with the actuary. That discussion may resolve your concerns. If not, you may want to talk to another state actuary who has experience with LTCI.

If you are unable to satisfy your concerns through these approaches, you may contact the Actuarial Board for Counseling and Discipline for its counsel on your concerns; consider disapproving the filing if allowed in your state, or approving a lower increase than has been requested.

9. If an insurer wishes to offer the CBL to policyholders when the actual rate increase would not trigger the requirements to offer CBL, is this okay?

So long as the method for determining those policyholders to be offered CBL is not discriminatory and includes all those policyholders who must be offered CBL (based on the resulting rate exceeding the initial rate by the percentage specified in the Model Regulation), the company is allowed to make the offer.

Therefore, the phrase “the majority of policies are eligible for contingent benefits upon lapse” in Sections 20G, 20.1G, and Section 20H(1)(c), and 20.1H(1)(c) should be interpreted to mean only those who must be offered CBL based on the Model Regulation. Otherwise, companies would not be encouraged to expand the number of policies to be offered CBL in the event of a rate increase.

The phrase “adjust rates to reflect how reserves have been incorporated” in the event CBL is triggered means that reserves.

Regulator Use Only
Sections 20B(3)(b) and 20.1B(3)(b) should be interpreted to mean that CBL has been offered to a policyholder or certificate holder and the offer is accepted (or deemed accepted by the failure to pay further premiums during the 120-day offer period).

10. Can a regulator request more annual values of the lifetime projection than just the five preceding and three projected years?

The basis of the model relies on professional judgment and certifications. However, in those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. To reduce the time frame, such requests may be part of the filing requirements for that state.

It is recommended that a state performing a detailed review request that the historical experience and projections of future experience provided by the company both include detail for each (calendar) year. This level of detail could illustrate the pattern of emerging experience being assumed. It is also helpful to request the originally anticipated pricing experience by calendar year. It may be insightful to see the difference of actual versus pricing experience.

11. Can a regulator request projected experience under the assumption that premium rates are not increased?

In those states where the regulator will perform an extensive review before approving rate increases, the model provides the authority for the regulator to request additional information needed for such a review. It may be of interest to see the projections with and without the requested rate increase. The result is not always intuitively obvious of the result. The rate increase will affect persistency as well as claim experience assumptions.

12. Is pooling of experience required or permitted?

As noted previously, morbidity experience will likely be pooled to increase the credibility of the company’s experience. Unless state law requires it, pooling is not required; however, it is encouraged that forms with similar benefits be pooled. When reviewing pooled experience, the reviewer needs to be careful to not jump to conclusions that the rate increase supported by an analysis of the aggregate data is an increase to be applied uniformly over all policy forms. This is generally not the case and in most cases the company will not be asking for a uniform increase. In such situations the reviewer should ask the company to evaluate the benefit differences between forms on a constant morbidity basis. This should show the relativity between the benefits of the different forms. The rates between forms may be increased on a non-uniform basis so as to establish a closer relationship of the premiums to these theoretical relationships and to measure compliance with the required standard that new business rates are not less than premium rates for existing forms, except for benefit differences. Note that some in-force policy forms (not currently for sale) may be excluded from a rate increase and still comply with the model.

13. How does the regulator compare rates of different forms to determine that the company complies with the required standard that new business rates are not less than the premium rate for existing forms except for benefit differences?

The comparison must be performed on a consistent basis. This means that it may be inappropriate to simply compare the two rate schedules directly. When the premium rate schedule for a new policy form is less than the premium rate schedule for an existing similar policy form also currently available from the insurer, and it is not clear whether this is a reasonable difference attributable to benefits, the regulator may wish to ask the company actuary to use one set of pricing assumptions to evaluate all forms. This is done for each form as if it were a new issue (the duration of the business is not directly considered at this
point). This is not for the intent of determining the rate, but simply to determine the benefit differences between the forms. This analysis will give a benefit comparison between forms— say coverage A is 1.15 of coverage B. This relationship is then used to compare the rate schedule relationships. The model provides that the relationship should account for benefit differences.

Following is an example showing a comparison of product benefits used to determine the rate comparison.

Summary of material benefit differences:

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC benefits</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Nursing home</td>
<td>1.0</td>
<td>1.0</td>
<td>No difference in coverage</td>
</tr>
<tr>
<td>Waiver of premium</td>
<td>1.0</td>
<td>.92</td>
<td>Plan B does not have PW</td>
</tr>
<tr>
<td>Restoration</td>
<td>1.10</td>
<td>1.0</td>
<td>Plan A has restoration</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.10</td>
<td>.92</td>
<td></td>
</tr>
</tbody>
</table>

Plan A is 19.6% richer (1.10/.92) than Plan B. When comparing premiums at various ages, Plan A premiums should be 19.6% higher than Plan B premiums.

The actuary needs to use judgment in deciding which benefit factors would be additive and which would be multiplicative. A benefit that affects the entire policy, i.e., restoration, should be multiplicative, but two mutually exclusive coverages, i.e., nursing home or home health care services, may be considered to be additive. The regulatory actuary may want to consider the new business rates of any affiliates when comparing new business rates.

14. What should the regulatory actuary consider when establishing a new margin established at the time of the rate increase?

Although the Model Regulation requires the company-insurer to re-establish a moderately adverse margin at the time of the rate increase, the Model Regulation does not provide for a specific moderately adverse margin. The regulatory actuary should carefully consider the following when establishing a new margin at the time of the rate increase:

a) When the actuary-insurer establishes a margin of, for example, 3% of claims, the risk of extinguishing the margin through minor fluctuations in one or more assumptions is greatly increased. This seems contrary to the spirit of rate stability legislation, which requires the company to establish an adequate margin, so that future rate increases are not necessary.

b) When the actuary-insurer establishes a margin of, for example, 20% of claims, although future increases may be less likely, the company-insurer increases the probability of charging excessive rates, and for policy forms that are open to new sales, charging rates that are not competitive.

c) For policies no longer marketed, the regulatory actuary should consider whether the current best estimate assumptions in the rate increase filing are more conservative than the pricing assumptions of the new business. If this is the case, the insurer should justify the more conservative assumptions.
d) For policies no longer marketed, the regulatory actuary should consider whether the new composite margin used in the rate increase filing exceeds either the original composite margin or the margin for new business. If this is the case, the insurer should justify the higher margin.

e) For policies no longer marketed, if future earned premium is less than past earned premium on a present value basis, the regulatory actuary may wish to consider limiting the moderately adverse margin. For example, if the ratio of lifetime earned premium to future earned premium is 3:1, then the new margin should not be more than one third of the lesser of the new business margin or the original margin.

15. For RS 2014 policies, how does the regulatory actuary determine that the 40% lifetime claims margin has been exhausted?

The Model Regulation requires that, for initial filings, the composite margin should not be less than 10% of lifetime claims. One way to interpret this requirement is to use the lifetime loss ratio as a proxy for lifetime claims. For example, if the insurer assumes a composite margin of 10% of lifetime claims, the insurer must demonstrate that the lifetime loss ratio, based on best estimate assumptions, exceeds the pricing lifetime loss ratio, along with the 10% composite margin. If the product was priced to achieve a lifetime loss ratio of 60% based on best estimate pricing assumptions, the insurer would absorb the moderately adverse experience for any deterioration in the lifetime loss ratio between 60% and 66%. If experience develops so that the expected lifetime loss ratio exceeds 66%, the insurer would have exhausted its composite margin, and would be eligible to file for a rate increase under the requirements of the Model Regulation.

A change in distribution from what was expected should not be used in testing whether a margin is exhausted. All demonstrations that the margin is exhausted should be based on the current mix of business at the valuation interest rate.

Section A4 (Actuarial Memorandum) provides additional guidance.

16. Does the Model Regulation permit the insurer to file a rate increase without the actuarial certification set forth in Section 20B (2)(a) and Section 20.1B (2)(a)?

Yes, the revised Model Regulation permits the insurer to file for a rate increase without the certification that no further rate increases are anticipated. The insurer must provide the premium rate schedule necessary to make the certification, and the rate increase filing must satisfy all other requirements of the applicable section. In addition, the commissioner must determine that it is in the best interest of policyholders.

17. What should the regulatory actuary consider when reviewing a request for a subsequent rate increase if the prior rate increase was less than the certifiable rate increase?

This can happen in more than one way: (1) the insurer could request a rate increase that is less than the certifiable amount; or (2) the state could limit the rate increase to an amount that is less than the certifiable rate increase. In either situation, the regulatory actuary should consider whether the basis for reviewing subsequent rate increases should be the rate increase that was actually approved or the rate increase that the actuary could certify.
18. What should be the regulatory actuary consider when reviewing a request for a series of rate increases?

If the state approves the entire series and does not require the insurer to file each subsequent phase of the rate increase, the full approved amount should be considered for contingent nonforfeiture and disclosure of rate increase history. For the annual report, the insurer would be required to file updated annual projections after each rate increase of the series, and updated annual projections each year for three years after the final increase of the series.

If the state approves the entire series and does require the insurer to file each subsequent phase of the rate increase, the state should consider whether the first rate increase or the entire series should serve as the basis for contingent nonforfeiture, disclosure of rate increase history, and annual reporting.
Section VII. MONITORING EXPERIENCE

The Long-Term Care Insurance Model Regulation requires monitoring of experience following a rate increase. The monitoring is required to ensure that rates are not increased more than is necessary. Since the rate increase is based on a lifetime loss ratio, the anticipated level of future claims plays a role in determining the amount of rate increase necessary.

The following outlines the experience that the regulator should see at each point in the process. It also attempts to provide some guidance on how to determine if the experience adequately matches the original projection.

For RS 2014, Section 15I requires an annual actuarial certification providing a statement of the sufficiency of the current rate schedule. The chart in Appendix 5 outlines the requirements for items to be included in the annual actuarial certification. Sections C1 and C2 provide sample actuarial certifications.

A. AT TIME OF FILING FOR A RATE INCREASE

When an insurer files for a rate increase, it is required to provide a lifetime projection of earned premiums and incurred claims. This projection must include annual values for at least the five years preceding and at least three years following the valuation date. These annual values will be used to monitor whether future experience adequately matches the projected experience.

The projections must include the development of the lifetime loss ratio (unless it is an exceptional increase). This information needs to include enough detail to demonstrate compliance with the loss ratio requirements of the regulation. This means that insurers will need to show the accumulated and discounted premiums separately for the original premium, the exceptional increase premium and the premium from a non-exceptional rate increase. The information should demonstrate that the accumulated claims plus the discounted claims are more than the sum of the following:

1. For RS 2000 policies, issued {insert date that is prior to the date that is six (6) months after adoption of the amended regulation} 58% of the accumulated and discounted original premium;
2. For RS 2014 policies, approved {insert date that is 6 months after adoption of the amended regulation} the greater of the original anticipated lifetime loss ratio, including margin for moderately adverse experience, and 58% of the accumulated and discounted original premium; 
3. 70% of the accumulated and discounted exceptional increase premium; and
4. 85% of the accumulated and discounted premium from a non-exceptional rate increase.

B. AFTER FILING FOR A RATE INCREASE

All insurers must submit annual filings for review during the three years following a rate increase. The information included in this filing will be similar to that in the rate increase filing except that it will have additional years of actual experience replacing projected experience. Regulators should look at the actual durational loss ratios following the rate increase and compare them to what was anticipated in the rate increase filing. If an insurer has a rate increase on a form where new business is still being sold, the regulator may want to request that experience be shown separately for the business in force at the time of the rate increase and for the new business since the rate increase. This will make it easier to see how actual experience compares with expected experience.

When comparing the durational loss ratios to what was expected, the regulator should not expect that experience will be at the level of the expected loss ratios. The experience should be somewhat below those levels. This is due to the requirement that the actuary must certify at the time of the rate increase filing that the rates are adequate
Regulators also should compare the actual earned premiums and incurred claims to the expected premiums and claims that were included in the rate increase filing. If the difference in actual experience and projected is in opposite directions (i.e., premiums are higher and claims are lower), the regulator may want to request additional information. For example, the insurer could be asked to do revised projections by adding the expected margins for adverse claims to actual claims which allows for an improved comparison since these margins are a part of the projected incurred claims. If the regulator determines that actual experience does not adequately match projected experience the insurer may be required to implement a premium rate schedule adjustment, a benefit increase or other measures to reduce the difference between actual and expected values. If the regulator is unsure whether actual experience adequately matches expected experience, the insurer may be required to submit annual filings for a period of time beyond the three-year requirement.

Note that for a policy form where any premium rate increased by more than 200%, the insurer must submit a filing every five years following the end of the required period.

If the insurer receives approval for a rate increase that is phased in over more than one year, implements a series of rate increases under the requirements of Section 20 or Section 20.1, and for example, the insurer implements the increase in three stages, the insurer would be required to file updated annual projections after the first rate increase of the series, updated annual projections after the second rate increase of the series, and updated projections each year for three years after the final increase of the series.

C. Annual Certification

For RS 2014 policies, issued on or after [insert date that is six (6) months after adoption of the amended regulation] Section 15I of the Model Regulation requires the insurer to annually certify to the adequacy of the premium rates for policies currently being marketed, and for policies that are no longer marketed. An annual review of experience will encourage the insurer to file a rate increase when needed, rather than delay, and require a larger rate increase later.

The chart in Appendix 5 outlines the requirements for items to be included in the actuarial memorandum accompanying the annual certification. In addition to the items outlined in Appendix 5, the actuarial memorandum should include:

- a detailed explanation of the data sources and review performed by the actuary prior to making the certification;
- a complete description of experience assumptions and their relationship to the initial pricing assumptions;
- a description of the credibility of the experience data; and
- an explanation of the analysis and testing performed in determining the current presence of margins.

Sections 1 and 2 provide Appendix 6 and Appendix 7 below are provide sample certifications for policies currently being marketed, and for policies that are no longer marketed, respectively.

For rate schedules currently marketed, if the insurer cannot certify that the premium rate schedule is sufficient to cover costs under moderately adverse experience, the insurer must provide a plan of action to reestablish the margin so that the ultimate premium rate is sufficient. The plan must be filed within 60 days of the date of the certification and must include a time frame to reestablish the margin.

For rate schedules no longer marketed, if the insurer cannot certify that the premium rate schedule continues to be sufficient to cover costs under best estimate assumptions, the insurer must provide a plan of action to reestablish the margin so that the ultimate premium rate is sufficient. The plan must be filed within 60 days of the date of the
1. Sample Annual Actuarial Certification for Policies Currently Marketed

Sample Annual Actuarial Certification for Existing Long-Term Care Insurance Premium Rate Schedule
In Accordance with Section 15 of the NAIC Model Regulation
For a Product(s) that is Currently Being Marketed
(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing and reviewing long-term care insurance premiums.

In my opinion

{the premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated. Based on my review of recent experience of the policies involved through [year-end applicable], in my opinion the future margins remain equal to or greater than those originally filed.}

{the premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated. The policies involved are too new to have adequate recent experience to review, however, in my opinion the future margins remain equal to or greater than those originally filed.}

Note: If margins are sufficient but not equal to or greater than those originally filed, the actuary should amend this statement accordingly and must file the actuarial memorandum (even if out of sequence with the normal every third year filing requirements) describing the basis for the revised margin levels.

{the premium rate schedule(s) [is/are] not sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) may not be sustainable over the life of the [form/forms] with no future premium increases anticipated. Based on my review of recent experience of the policies involved through [year-end applicable], in my opinion the premiums contain some margin but not the future margins equal to or greater than those originally filed.}

{the premium rate schedule(s) [is/are] not sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) may not be sustainable over the life of the [form/forms] with no future premium increases anticipated. Based on my review of recent experience of the policies involved through [year-end applicable], in my opinion the premiums contain no future margin with respect to existing policies or new policies.}
In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary. Actuarial assumptions are [provided/available] in a separate actuarial memorandum.

Except where the opinion language above the “Note” is used, the certification should include the fact of and date when the appropriate officer of the company was notified with respect to the need for the company to develop and implement a plan of action to re-establish adequate margins, such as:

I have made my opinion known to [name], the [position] in charge of Long-Term Care Insurance operations for [company] on [date].

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]

[Date of Certification]

2. Sample Annual Actuarial Certification for Products that are No Longer Marketed

Sample Annual Actuarial Certification for Existing Long-Term Care Insurance Premium Rate Schedule
In Accordance with Section 15 of the NAIC Model Regulation
For a Product(s) that is Not Being Marketed

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing and reviewing long-term care insurance premiums.
In my opinion

{the premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) are sustainable over the life of the [form/forms] with no future premium increases anticipated. Based on my review of recent experience of the policies involved through [year-end applicable], in my opinion the premiums contain future margins equal to or greater than those originally filed.}

{the premium rate schedule(s) [is/are] not sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) may not be sustainable over the life of the [form/forms] with no future premium increases anticipated. Based on my review of recent experience of the policies involved through [year-end applicable], in my opinion the premiums contain some margin but not the future margins equal to or greater than those originally filed.}

{the premium rate schedule(s) [is/are] not sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) is not sustainable over the life of the [form/forms] with no future premium increases anticipated. Based on my review of recent experience of the policies involved through [year-end applicable], in my opinion the premiums contain no future margin.}

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary. Actuarial assumptions are [provided/available] in a separate actuarial memorandum.

When the last opinion language is used, the certification should include the fact of and date when the appropriate officer of the company was notified with respect to the need for the company to develop and implement a plan of action to re-establish adequate margins, such as:

I have made my opinion known to __________, the __________ in charge of Long-Term Care Insurance operations for _____ on __________.

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]

[Date of Certification]
Section VIII. RATE INCREASE CONSEQUENCES

The NAIC Model Regulation includes three new provisions that give the Commissioner new regulatory tools to deal with large single or cumulative increases, rate spirals, and insurers that persistently file inadequate initial premium rates. Two of the three new provisions have a requirement that a majority of the policies or certificates to which a rate increase is applicable be eligible for contingent benefit upon lapse. This condition is included as a measure of a rate increase that is considered significantly large enough to warrant the action indicated.

A. REVIEW OF ADMINISTRATION AND CLAIM PRACTICES AUTHORIZED

If a majority of the policies or certificates to which a rate increase is applicable are eligible for contingent benefit upon lapse, an insurer must file a plan for improved administration or claims processing that is designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases. The plan is subject to Commissioner approval.

As an alternative to filing a plan, an insurer may demonstrate that appropriate administration and claims processing have been implemented or are in effect.

If the insurer fails to satisfy one of these requirements, the Commissioner may impose the conditions applicable following a determination that a rate spiral exists (see next section).

B. OPTION TO ESCAPE RATE SPIRALS BY CONVERTING TO CURRENTLY SOLD INSURANCE

Section 20H(1) of the Model Regulation requires that the following three criteria be met before a rate spiral may be considered to exist:

1. The rate increase is not the first rate increase requested for the specific policy form or forms;
2. The rate increase is not an exceptional increase (See Section VI C for exceptional rate increase); and
3. The majority of the policies or certificates to which the increase is applicable are eligible for contingent benefit upon lapse.

If these three criteria are met, the next step in determining whether a rate spiral exists is for the regulator to review the following for all policies included in the filing:

1. Projected lapse rates; and
2. Past actual lapse rates during the 12 months following each increase.

The regulator may determine that a rate spiral exists if significant adverse lapse:

1. Has occurred;
2. Is anticipated in the filings; or
3. Is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase.
If the regulator determines 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.

The offer shall:

1. Be subject to the approval of the Commissioner;

2. Be based on actuarially sound principles, but not be based on attained age. One acceptable approach is for the insurer to demonstrate that the combination of a higher issue age and lower duration, versus the original issue age and higher duration, is appropriate under the new form to match the active life reserve held under the original policy form. This active life reserve for the new form would approximate the transfer of the actual funding from the original form while reflecting the future benefits and premiums of the new form.

3. Provided that maximum benefits under any new policy accepted by an insured be reduced by comparable benefits already paid under the existing policy.

When an insurer is required to provide this offer, the insurer must maintain separate experience of the replacement insureds (those under the form with the rate spiral) and the original insureds (those insureds under the form with which the rate spiral insureds are combined). Future rate increases on the combined business are limited to the lesser of:

1. The increase based on the combined experience; or

2. The increase based solely on the experience of the original lives plus an additional flat 10%.

This limits the adverse impact that the replacement insureds may have on the original insureds with both the original and the replacement insureds receiving the same percentage increase. This two-part limit on rate increases may cause the actuary to qualify the actuarial certification. In this case, the regulator should determine what measures the insurer is taking to avoid future rate increases.

In determining the above limitations to a rate increase, it is important to note that in performing this analysis the assumptions used in the two projections may not necessarily be the same. As an example, the utilization assumption used in future years may be different for the original lives than what was used for the combined experience, which includes replacement insureds that may have been subject to different underwriting standards.

C. COMMISSIONER MAY PROHIBIT ISSUE OF NEW POLICIES

If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates, then in addition to the remedy provided in B above, the Commissioner may take one of the following more severe steps:

1. Prohibit the insurer from filing and marketing comparable coverage for a period of up to five years. This penalty will essentially put the insurer out of the long-term care business in the state.

2. Prohibit the insurer from offering all other similar coverage thus limiting the marketing of new applications to the form subject to the recent increase.

These penalties are intended as a last resort in dealing with a situation that cannot otherwise be rectified.
Section IX. POLICYHOLDER NOTICE REGARDING RATE INCREASE

Tyler McKinney’s subgroup will insert language here.
Sample Actuarial Certification
for
Long-Term Care Insurance Initial Premium Rate Schedule
In Accordance with Section 10 of the NAIC Model Regulation

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing long-term care insurance premiums.

Attached are the premium rate schedule(s) to be used for new sales of the policy forms and riders as specified therein.

In my opinion the initial premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated.

I have reviewed and taken into consideration the policy design and coverage provided.

I have reviewed and taken into consideration the insurer’s [current/planned] underwriting and claims adjudication processes. {I have relied upon information provided to me by [name and title of insurer officer] for a written description of these processes.}

The premiums contain at least a composite moderately adverse margin of 10% of lifetime claims.

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary, and have provided a copy of the supporting documentation to the insurer.

The premium rate schedule(s) [is/are] consistently in excess of the sum of the net valuation premium for renewal years and the average renewal expenses assumed in the pricing.

{Example of an alternative to above statement paragraph} The premium rate schedule(s) [would be consistently in excess of the sum of the net valuation premium for renewal years and the average renewal expenses assumed in the pricing if:

(i) the maximum termination rates allowed by the NAIC Health Insurance Reserves Model Regulation were used in place of the 2% rate assumed in the actual reserve basis, and
(ii) the maximum interest rate allowed by the NAIC Health Insurance Reserves Model Regulation was used in place of the 3.5% rate assumed in the actual reserve basis.

[Attached is a description of the valuation basis for contract reserves which generates the net valuation premium for renewal years. / The basis for contract reserves has been previously filed and there is no anticipation of any changes.]

The premium rate schedule(s) [is/are] consistently equal to or in excess of the premium rate schedule for other
similar policy forms (except for reasonable differences attributable to benefits) which [name of insurer] will be making available to the same broad class of applicants.

Example of an alternative to above statement paragraph: Attached is a comparison of the premium schedules for similar policy forms that [name of insurer] will be making available to the same broad class of applicants. Significant differences in the premium schedules are explained.

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]
Sample Actuarial Certification for
Long-Term Care Insurance Premium Rate Increase
In Accordance with Section 20 of the NAIC Model Regulation

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing long-term care insurance premiums and filing for increases in long-term care insurance premiums.

Attached are:
1. The premium rate schedule(s) to be used for renewals of the policy forms and riders as specified therein. Where necessary, separate schedules of higher premium rates to be used for new sales of the policy forms and riders are noted.

2. An actuarial memorandum, also signed by me, which provides:
   a) the assumptions on which this certification is based;
   b) the adjustments to prior assumptions with an explanation of the reasons previous assumptions were not realized;
   c) a lifetime projection of the prior premium rate schedules and incurred claims plus future expected premiums and claims which demonstrates that the revised premium rate schedule meets the loss ratios standards and necessary details of this state; and
   d) disclosure of the manner, if any, in which reserves have been recognized.

In my opinion the revised premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated.

I have reviewed and taken into consideration the policy design and coverage provided, and the insurer’s [current/planned] underwriting and claims adjudication processes. [I have relied upon information provided to me by [name and title of insurer officer] for a written description of these processes.]

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary. Based on these assumptions, or statutory requirements where necessary, the premium rate filing is in compliance with the loss ratio standards of this state.

[Attached is a description of the new valuation basis for contract reserves which generates the net valuation premium for renewal years. / The basis for contract reserves has been previously filed and there is no anticipation of any changes.]

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]
APPENDIX 3. SAMPLE ACTUARIAL CERTIFICATION – EXCEPTIONAL RATE INCREASE

Sample Actuarial Certification
for
Long-Term Care Insurance Exceptional Premium Rate Increase
In Accordance with Section 20 of the NAIC Model Regulation

(For an actuary who is an insurer employee)

I, [name of actuary], am [title] of [name of insurer] and a member of the American Academy of Actuaries. I meet the Academy’s qualification standards for rendering this opinion and am familiar with the requirements for filing long-term care insurance premiums and filing for increases in long-term care insurance premiums.

Attached are:

1. The premium rate schedule(s) to be used for renewals of the policy forms and riders as specified therein. Where necessary, separate schedules of higher premium rates to be used for new sales of the policy forms and riders are noted.

2. An actuarial memorandum, also signed by me, which provides:
   a) the assumptions on which this certification is based;
   b) the adjustments to prior assumptions consistent with the established basis for this to be approved as an exceptional increase;
   c) a projection of the future additional premiums based on the rate schedule increases and future additional incurred claims which demonstrates that the increase in the premium rate schedule meets the loss ratios standards and necessary details of this state; and
   d) disclosure of the manner, if any, in which reserves have been recognized.

In my opinion the revised premium rate schedule(s) [is/are] sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule(s) [is/are] reasonably expected to be sustainable over the life of the [form/forms] with no future premium increases anticipated.

I have reviewed and taken into consideration the policy design and coverage provided, and the insurer’s [current/planned] underwriting and claims adjudication processes. {I have relied upon information provided to me by [name and title of insurer officer] for a written description of these processes.}

In forming my opinion, I have used actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary. Based on these assumptions, or statutory requirements where necessary, the premium rate filing is in compliance with the loss ratio standards of this state.

[Attached is a description of the new valuation basis for contract reserves which generates the net valuation premium for renewal years. / The basis for contract reserves has been previously filed and there is no anticipation of any changes.]

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]
## APPENDIX 4. SAMPLE LOSS RATIO DEMONSTRATION FOR A HYPOTHETICAL RATE INCREASE

**Insurer XYZ**  
**Policy Form LTC2001**  
**Actual and Projected Experience**

<table>
<thead>
<tr>
<th>Experience Period</th>
<th>Original Earned Premiums</th>
<th>Increased Earned Premiums</th>
<th>Incurred Claims</th>
<th>Original Incurred Claims</th>
<th>Increased Incurred Claims</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-2003</td>
<td>$10,000,000</td>
<td>$0</td>
<td>$1,194,225</td>
<td>$13,563,842</td>
<td>$0</td>
<td>$1,604,225</td>
</tr>
<tr>
<td>2004</td>
<td>$4,000,000</td>
<td>$0</td>
<td>$826,096</td>
<td>$4,982,093</td>
<td>$0</td>
<td>$1,028,922</td>
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<tr>
<td>2005</td>
<td>$3,720,000</td>
<td>$0</td>
<td>$960,337</td>
<td>$4,412,711</td>
<td>$0</td>
<td>$1,139,163</td>
</tr>
<tr>
<td>2006</td>
<td>$3,459,600</td>
<td>$0</td>
<td>$1,143,185</td>
<td>$3,908,401</td>
<td>$0</td>
<td>$1,291,486</td>
</tr>
<tr>
<td>2007</td>
<td>$3,217,428</td>
<td>$0</td>
<td>$1,328,952</td>
<td>$3,461,727</td>
<td>$0</td>
<td>$1,429,859</td>
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<tr>
<td>2008</td>
<td>$2,992,208</td>
<td>$0</td>
<td>$1,347,159</td>
<td>$3,066,101</td>
<td>$0</td>
<td>$1,380,427</td>
</tr>
<tr>
<td><strong>Subtotal Actual Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td>$33,394,875</td>
<td></td>
<td>$7,874,082</td>
</tr>
<tr>
<td><strong>Projection Period</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>$2,782,753</td>
<td>$631,685</td>
<td>$1,365,615</td>
<td>$2,715,689</td>
<td>$616,461</td>
<td>$1,332,704</td>
</tr>
<tr>
<td>2010</td>
<td>$2,587,961</td>
<td>$587,467</td>
<td>$1,384,324</td>
<td>$2,405,325</td>
<td>$546,009</td>
<td>$1,286,630</td>
</tr>
<tr>
<td>2011</td>
<td>$2,406,803</td>
<td>$546,344</td>
<td>$1,403,289</td>
<td>$2,130,431</td>
<td>$483,608</td>
<td>$1,242,150</td>
</tr>
<tr>
<td>2012-2020</td>
<td>$15,335,385</td>
<td>$3,481,132</td>
<td>$13,527,106</td>
<td>$10,972,085</td>
<td>$2,490,663</td>
<td>$9,414,724</td>
</tr>
<tr>
<td>2021-2050</td>
<td>$14,754,202</td>
<td>$3,349,204</td>
<td>$59,164,021</td>
<td>$5,393,467</td>
<td>$1,224,317</td>
<td>$16,477,534</td>
</tr>
<tr>
<td><strong>Subtotal Projected Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td>$23,616,996</td>
<td>$5,361,058</td>
<td>$29,753,741</td>
</tr>
<tr>
<td><strong>Total Actual &amp; Projected Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td>$57,011,871</td>
<td>$5,361,058</td>
<td>$37,627,824</td>
</tr>
</tbody>
</table>

Minimum Present Value Incurred Claims = 58% of (4) $57,011,871 plus 85% of (5) $5,361,058 = $37,623,784

Dual Loss Ratio Test met since total incurred claims (6) $37,627,824 exceeds the minimum.

Col. (1) Earned Premiums from Original Premium Schedule only  
Col. (2) Increased portion of Premium with 22.7% increase implemented on 1/1/2009  
Col. (3) Incurred Claims (Do NOT include Policy Reserves)  
Cols. (4)-(6) Accumulated/Discounted values of columns (1)-(3) to 1/1/2009 with 5% valuation interest rate

*For policies approved {insert date that is 6 months after adoption of the amended regulation} the greater of the original anticipated lifetime loss ratio, including margin for moderately adverse experience, and 58% of the accumulated and discounted original premium

**The above example assumes that: (1) the original anticipated lifetime loss ratio including the margin for moderately adverse experience is less than 58%; and (2) the historical expected claims are greater than the actual incurred claims.
**APPENDIX 5. ACTUARIAL MEMORANDUM CHECKLIST**

---

### Appendix 5: Checklist For Actuarial Memorandum that applies to Rate Stability Policies

<table>
<thead>
<tr>
<th>New Rate Filings</th>
<th>Annual Rate Certification</th>
<th>Rate Increase Request</th>
<th>Rate Increase Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scope and Purpose</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Summary of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Benefits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Renewability</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Marketing Methods</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Issue Age Limits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. History of Rate Adjustments</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>f. Open or Closed Block</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>g. In or Out of the Market, including affiliates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Partnership Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Premium Modal Factors</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Premium Classes</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Expected Average:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Annual Premium</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Issue Age</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Premium Discounts</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Distribution of Business</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Nationwide Business by Percentage</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Distribution of State Business by Inforce Count</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>c. Distribution of Nationwide Policyholder Actions after Rate Increase by Percentage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Underwriting</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Statements Regarding Consideration of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Policy Design</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Underwriting</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Claims Adjudication Practices</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Moderately Adverse Margin</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

© 2009 National Association of Insurance Commissioners
<table>
<thead>
<tr>
<th>Appendix 5: Checklist For Actuarial Memorandum that applies to Rate Stability Policies (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10. Actuarial Assumptions:</strong></td>
</tr>
<tr>
<td>a. Morbidity</td>
</tr>
<tr>
<td>b. Voluntary lapse rates</td>
</tr>
<tr>
<td>c. Mortality</td>
</tr>
<tr>
<td>d. Expenses</td>
</tr>
<tr>
<td>e. Commissions</td>
</tr>
<tr>
<td>f. Interest</td>
</tr>
<tr>
<td>g. Area Factors</td>
</tr>
<tr>
<td>h. Contingency and Risk Margins</td>
</tr>
</tbody>
</table>

| **11. Experience**                                            |
| a. Past, Future and Lifetime, including claim liability and claim reserves | X | X | X |
| b. Demonstration that the margin is exhausted                  | X |
| c. Description of the Credibility of the Experience Data       | X |

| **12. Loss Ratios – at maximum valuation interest rate**      |
| a. Minimum Requirement (58/85 test)                           | X | X | X |
| b. Anticipated lifetime loss ratio                             | X | X | X |

| **13. Rate Increase Analysis**                                |
| a. Why a rate adjustment is necessary (including calculation) | X |
| b. Which pricing assumptions were not realized and why        | X |
| c. Other actions taken by the insurer that may have been relied upon by the actuary | X |
| d. Disclosure of how reserves have been incorporated into increase whenever the rate increase would trigger contingent benefit upon lapse | X |
Appendix 5: Checklist For Actuarial Memorandum that applies to Rate Stability Policies (Continued)

<table>
<thead>
<tr>
<th>New Rate Filings</th>
<th>Annual Rate Certification</th>
<th>Rate Increase Request</th>
<th>Rate Increase Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Description of Basis for Active Life Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Method</td>
<td>X</td>
<td>X, +</td>
<td></td>
</tr>
<tr>
<td>b. Morbidity</td>
<td>X</td>
<td>X, +</td>
<td></td>
</tr>
<tr>
<td>c. Lapse</td>
<td>X</td>
<td>X, +</td>
<td></td>
</tr>
<tr>
<td>d. Mortality</td>
<td>X</td>
<td>X, +</td>
<td></td>
</tr>
<tr>
<td>e. Interest</td>
<td>X</td>
<td>X, +</td>
<td></td>
</tr>
</tbody>
</table>

+ Insurer should describe any changes from original or prior rate increase assumptions.

Notes and Instructions for Appendix 5

1. **Scope and Purpose**
   - **Initial Filings** – A general statement that the memorandum consists of materials in support of the development of the initial rates, and reference to the policy form(s) and rider form(s) to which the filing applies.
   
   Annual Rate Certification – A statement that the filing is meant to comply with the annual rate certification requirements of the regulation applicable to the state, and reference to the policy form(s) and rider form(s) to which the filing applies.
   
   Rate Increase Request – A statement referencing the proposed rate increase, a statement addressing the reason(s) for the rate increase, and reference to the policy form(s) and rider form(s) to which the rate increase applies.
   
   Rate Increase Monitoring – A statement that the filing is meant to comply with the annual reporting requirements following a rate increase, and reference to the applicable state regulation.

2. **Summary of:**
   a. Benefits - A summary of all benefits offered, including riders.
   b. Renewability – Address whether the contract is guaranteed renewable or non-cancelable.
   c. Marketing Methods – Indicate whether the policy is sold via an agency system, direct response, or any other method.
   d. Issue Age Limits – Provide the minimum and maximum issue ages for the policy form(s).
   e. History of Rate Adjustments – Indicate whether the policy form(s) has had previous increases, and if so, provide the year of the rate increase, and the percentage increase.
   f. Open or Closed Block – Indicate whether the company still sells the policy form in the filing state. If the policy form is no longer being sold, indicate the date that the company ceased new sales in that
state, and address whether the form is sold in any other states. Distinguish between individual and group policy forms in the description.

g. In or Out of the Market – Indicate whether the company, including affiliated companies, currently sells long-term care insurance in the filing state, and if not, provide the date that it exited the market. If the company does not sell stand-alone long-term care insurance, but does sell other types of long-term care insurance, such as LTC riders attached to life or annuity products, make a statement to that effect in the narrative of the actuarial memorandum. Distinguish between individual and group policy forms in the description.

h. Indicate whether the subject policy form is a long-term care partnership form.

3. Premium Modal Factors
   For initial filings, provide the factors for annual, semi-annual, quarterly, and monthly premium payment options.

4. Premium Classes
   For initial filings and rate increase filings, list all available issue ages, benefit periods, elimination periods, and inflation options. Also address whether the rates are unisex or gender specific.

5. Expected Average:

   a. Annual Premium
      For initial filings, provide the expected nationwide average annual premium based on the anticipated distribution of business.

      For rate increase filings, provide the average nationwide, or state specific, annual premium prior to the rate increase, and the average nationwide, or state specific, annual premium following the rate increase. The regulatory actuary may consider requesting actual to expected ratios.

      For the annual rate certification and rate increase monitoring filings, provide the average annual nationwide premium based on the current distribution of business, including an aggregate actual to expected analysis.

   b. Issue Age
      For initial filings, provide the expected average nationwide issue age.

      For rate increase filings, annual rate certification filings, and rate increase monitoring filings, provide the actual average nationwide issue age, including an aggregate actual to expected analysis.

6. Premium Discounts

   Provide all premium discounts including spousal, domestic partner, or family.

7. Distribution of Business
   The following tables provide examples of possible formats that a regulatory actuary may want to use to review the insurer’s distribution of business.

   a. Nationwide Business by Percentage
      For initial filings, provide the expected distribution of nationwide business. Provide the expected
distribution of business by gender, underwriting class, benefit period, issue age, elimination period, inflation protection benefit, and marital status.

For rate increase filings, provide the actual distribution of nationwide business. Provide the actual distribution of business by gender, underwriting class, benefit period, issue age, elimination period, inflation protection benefit, and marital status.
### Distribution of Nationwide Business by Percentage

<table>
<thead>
<tr>
<th>Gender</th>
<th>Distribution</th>
<th></th>
<th>Elimination Period</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>%</td>
<td></td>
<td>0 days</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>%</td>
<td></td>
<td>60 days</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>90 days</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>180 days</td>
<td>%</td>
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<table>
<thead>
<tr>
<th>Underwriting</th>
<th>Distribution</th>
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</thead>
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<tr>
<td>Preferred</td>
<td>%</td>
<td></td>
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<td></td>
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<tr>
<td>Standard</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Inflation Protection</th>
<th>Distribution</th>
<th></th>
<th></th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>No Inflation</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5% Simple</td>
<td>%</td>
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</table>

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Distribution</th>
<th></th>
<th></th>
<th>%</th>
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<tbody>
<tr>
<td>2 years</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>%</td>
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</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Distribution</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Single</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>%</td>
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</table>

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Distribution</th>
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<tbody>
<tr>
<td>&lt; 40</td>
<td>%</td>
<td></td>
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<td></td>
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<tr>
<td>41-44</td>
<td>%</td>
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<tr>
<td>45-49</td>
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<td>50-54</td>
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<tr>
<td>-----</td>
<td>-</td>
<td>-</td>
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</table>
### b. Distribution of State Business by In-force Count

#### Distribution of State Business by Inforce Count

<table>
<thead>
<tr>
<th>State</th>
<th>Inforce Count</th>
<th>Annualized Premium</th>
<th>Eligible for CNFB</th>
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</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alaska</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Arizona</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Arkansas</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>California</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Colorado</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Connecticut</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Washington, D.C.</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Delaware</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Florida</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hawaii</td>
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<tr>
<td>Virginia</td>
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</tr>
</tbody>
</table>
c. Distribution of Policyholder Actions after Rate Increase by Percentage

Provide a breakdown of policyholder actions after the rate increase by percentage of policyholders. These policyholder actions include:

- Cancel the policy and not eligible for the contingent nonforfeiture benefit
- Lapse the policy and eligible for the contingent nonforfeiture benefit
- Pay the full rate increase
- Elect benefit reduction option (for example, reduce the monthly or daily benefit, reduce the benefit period, increase the elimination period, or reduce the inflation protection benefit).
- Other

For rate increase filings, the information provided should be for expected nationwide policyholder actions that will occur within one year of the effective date of the rate increase.

For annual reports, the information provided should be for actual state specific policyholder actions.

<table>
<thead>
<tr>
<th></th>
<th>Washington</th>
<th>West Virginia</th>
<th>Wisconsin</th>
<th>Wyoming</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
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</tr>
</tbody>
</table>

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Distribution of Nationwide Policyholder Actions After Rate Increase by Percentage

<table>
<thead>
<tr>
<th>Action</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancel the Policy and not eligible for the contingent non forfeiture benefit</td>
<td></td>
</tr>
<tr>
<td>Lapse the policy and eligible for the contingent nonforfeiture benefit</td>
<td></td>
</tr>
<tr>
<td>Pay the Full Rate Increase</td>
<td></td>
</tr>
<tr>
<td>Elect benefit reduction option</td>
<td></td>
</tr>
<tr>
<td>(for example, reduce the monthly or daily benefit, reduce the benefit period, increase the elimination period, or reduce the inflation protection benefit)</td>
<td></td>
</tr>
<tr>
<td>Reducing Benefit Period; Reducing Inflation Protection; Increasing Elimination Period)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

8. **Underwriting**

For initial filings, provide a description of the underwriting process, and list the underwriting classes. For annual rate certifications and rate increase filings, address any changes to the initial underwriting process or underwriting classes.

9. **Statements Regarding Consideration of:**
   a. Policy Design
   b. Underwriting
   c. Claims Adjudication Practices
   d. Moderately Adverse Margin

For initial filings and rate increase filings, provide a statement that the actuary considered each of these items in the development of the premium rates.

For annual rate certifications, for underwriting and claims adjudication, the actuary should describe any changes from the initial basis. If there were no changes, the actuary should make a statement to that effect.

10. **Actuarial Assumptions**

The actuary may want to consider using the format outlined in the Assumptions Template for reviewing the actuarial assumptions associated with new rate filings or rate increase requests. For annual rate certifications, rate increase requests, or rate increase monitoring, the regulatory actuary may want to consider requesting actual to expected ratios.
a. Morbidity – A description of the data relied upon by the actuary for morbidity assumptions. The memorandum should also address whether the actuary assumed any morbidity improvements in pricing. Rate increase filings, annual rate certifications, and rate increase monitoring filings should address any changes to the pricing morbidity assumption, and provide an actual to expected analysis.
b. Voluntary Lapse rates – Provide a table(s) of voluntary lapse assumptions, and a description of the data relied upon by the actuary in the development of the voluntary lapse rates. Rate increase filings, annual rate certifications, and rate increase monitoring filings should address any changes to the pricing voluntary lapse assumptions, and provide an actual to expected analysis.
c. Mortality – Provide the mortality table and a table of mortality selection factors, as applicable. Rate increase filings, annual rate certifications, and rate increase monitoring filings should address any changes to the pricing mortality assumption, and provide an actual to expected analysis.
d. Expenses – Identity all expense components. This includes premium taxes, administrative claims expenses, and maintenance expenses. Rate increase filings, annual rate certifications, and rate increase monitoring filings should address any changes to expenses, and provide an actual to expected analysis. Some states are required by regulation to make the determination that rates are reasonable, adequate, and not excessive. Since expenses may be an important component in making that determination, it is at the discretion of each individual state whether to require the company to provide expense information.
e. Commissions – For initial rate filings, provide a complete commission schedule.
f. Interest – Provide the assumed investment earnings rate. Rate increase filings, annual rate certifications and rate increase monitoring filings should address any changes to the pricing investment earnings rate or the valuation interest rate.
g. Area Factors – Indicate whether area factors are used, and if so, provide area factor tables.
h. Contingency and Risk Margins

11. Experience

It is at the discretion of each individual state whether it wants state specific experience. States with a small number of policyholders may wish to require only nationwide experience.

a. Past, Future, and Lifetime, including claim liability and claim reserves

For initial filings, provide projected experience, including the expected lifetime loss ratio under best estimate assumptions.

For rate increase filings, provide complete loss ratio demonstrations, including the expected lifetime loss ratio, and a comparison of actual to expected experience, both with and without the proposed rate increase, with and without interest, by calendar year and duration year for both state and nationwide experience. Also provide a demonstration that the applicable loss ratio test is met.

For rate increase monitoring filings, provide actual and projected experience along with a comparison of how actual results compare to projected results from the previous rate increase filing.

b. Demonstration that the margin is exhausted

For rate increase filings, provide a demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite
12. Loss Ratios – at maximum valuation interest rate

a. Minimum Requirement (58/85 test)
   For rate increase requests and rate increase monitoring, the loss ratio requirements differ depending on whether the policy is issued as an RS 2000 or an RS 2014 policy.

b. Anticipated lifetime loss ratio
   For initial rate filings, provide the anticipated pricing lifetime loss ratio. For rate increase requests and rate increase monitoring, provide the lifetime loss ratio after the rate increase.

13. Rate Increase Analysis
   The actuary should address the following:
   a. Why a rate adjustment is necessary (including calculation)
   b. Which pricing assumptions were not realized and why
   c. Other actions taken by the insurer that may have been relied upon by the actuary
   d. Disclosure of how reserves have been incorporated into the increase whenever the rate increase would trigger a contingent nonforfeiture benefit upon lapse

14. Description of Basis for Active Life Reserves:
   a. Method
   b. Morbidity
   c. Lapse
   d. Mortality
   e. Interest

   The actuary should provide a description of the reserve basis, and a description of the reserve calculation methodology under each assumption. The actuary should also disclose assumed improvement or deterioration in morbidity or mortality, as applicable.

   For rate increase filings, the actuary should describe any changes in assumptions from the original basis.
APPENDIX 6. ASSUMPTIONS TEMPLATE INSTRUCTIONS

The Assumptions Template spreadsheet is intended to assist the regulatory actuary in his/her review of the actuarial assumptions related to any long-term care policy issued in this state on or after the state has made the changes to Section 10 and adopted Section 20.1. The insurer is encouraged to complete the Assumptions Template when it submits an initial rate filing or a rate increase filing. A standard format for submitting actuarial assumptions should aid the regulatory actuary in the review of the rates, and help to expedite the review process.

Instructions related to how the template should be completed, and when the applicable spreadsheet tab should be completed follow. Footnotes have also been included in each spreadsheet for additional guidance. The purpose of the template is to provide an additional tool for the regulator to achieve a better understanding of the assumptions that make up the initial rates, and the primary assumptions that drive rate increases. Although the regulator may wish to compare assumptions at the company level, which may lead to additional questions for some companies, the assumptions provided in the template are not intended to serve as a basis for rejection or disapproval of a rate filing. Before completing the template, please review the following:

   Granularity of Data – The template has been designed to provide for a high degree of granularity in the assumptions. The expectation is that companies should have most, if not all, of the requested data available. However, in cases in which the company does not have the assumptions to this level of granularity, the company should indicate this with “not available” or “not applicable” in the appropriate cell. If the company indicates that an assumption is not available for a specific cell, it should provide an explanation. If the company believes that the data provided may need some additional information in order to be interpreted correctly, it should note on each such spreadsheet, the areas where supplemental information is provided in other parts of the filing.

   Examples:

   For tabs that request data broken by Nursing Home and Nursing Home with Home Health Care, and the coverage type for this policy is Nursing Home only, then the company would leave the Nursing Home with Home Health Care table blank.

   If a tab asks for male and female factors, and the company only has unisex factors, the same factors should be entered in male and female cells.

   Applicability of Data – For initial filings, the company should enter its pricing assumptions in the template, and should not consider margins when entering the data. For rate increase filings, the company should enter its best estimate assumptions in the template, and should not consider margins when entering the data. Most assumption spreadsheets assume a base elimination period of 100 days. If the company does not offer the base benefit, it should choose the closest benefit that it offers, and make a statement to that effect in the Additional Information box of the applicable spreadsheet. These points, and other similar issues, are
Confidentiality — To be determined —

The Assumptions Template contains information at a level of detail that a company may consider to be confidential, a trade secret, or otherwise protected from disclosure. If a company decides to provide information it considers protected, the company should clearly mark the information as confidential, a trade secret, or protected from disclosure so that the regulatory actuary knows what information it desires to have protected.

Before requesting information in the assumptions template, the regulatory actuary should be mindful of the state’s laws regarding confidentiality and public information and should abide by them to assure that the protections they afford are extended to a company marking information as protected.

The Assumptions Template consists of a Microsoft Excel workbook with 10 tabs, each of which is described below.

Tab 1 (Product Description)
The Product Description tab contains the following:

- Company and policy form identification information – Enter the company name, product name and policy form number.
- Individual or Group – Indicate whether the policy form is sold to individuals or to groups.
- Tax or Non-Tax Qualified – Indicate whether the policy form is offered as tax-qualified, non-tax qualified, or both.
- Partnership or Non-Partnership - Indicate whether the policy form is offered as a partnership policy.
- Elimination Period Options - Enter all elimination period options available under the policy form.
- Daily Benefit Amount Range – Enter the minimum and maximum daily dollar benefit available under the policy form.
- Premium Payment Period – Enter all available premium payment period options. This may include lifetime pay only, or other options such as 10-pay or paid-up at age 65.
- Coverage Type – Enter all available coverage types available under the policy form. This may include comprehensive only, or other options such as home health care only or nursing home only.
- Benefit Period Options – Enter all available benefit period options, such as 2 years, 3 years, 4 years, 5 years, 10 years and lifetime.
- Inflation Protection Options – Enter all available inflation protections options, such as 5% compound inflation, 5% simple inflation, or future purchase option.
- Enter the company contact person, phone number, email address, and indicate whether the filing is being submitted by a third party.
- If the company considers the information confidential, check the applicable box.
• The choices offered under description may not be exhaustive; please provide appropriate descriptions if any is not found in the provided sample.
1. Morbidity, Mortality and Voluntary Lapse:
   - For “Data Source,” indicate whether the company relied upon a company experience study, an industry study, or both, and reference the study(s). Also provide the experience period that the study encompasses, and the blocks of business that were used in the experience study or the industry study.
   - For “Description,” provide detail on the data and describe the process used to derive the assumption. Also provide adjustment factors for improvement or deterioration, as applicable.
   - For “Supporting Information,” proceed to the referenced tab(s) to provide additional information.

2. Interest Rates
   Provide the interest rate assumption used to calculate present values. This is assumed to be the maximum valuation interest rate (or average valuation rate for the block). In addition, provide the assumed investment earnings rate or rates under “Description.” Provide the source of the data used to derive the investment earnings rate under “Data Source.”

3. Expenses
   Provide, as a percent of the average annual premium, the aggregate renewal annual expenses assumption, and the aggregate first year expense assumption. Additional information regarding expenses is entered in tab 10.
**Tab 3 (Attained Age Claim Cost)**

### Claim cost per $10 of Current Nursing Home Daily Benefit

**Elimination Period = 100 days**

(Enter for the most prevalent underwriting class)

<table>
<thead>
<tr>
<th>Gender (Male/Female)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status (Married/Single)</td>
<td>[Lifetime]</td>
<td>[5 year]</td>
</tr>
<tr>
<td>Benefit Period (Onset of Necessity available)</td>
<td>[Comprehensive]</td>
<td>[Annually]</td>
</tr>
<tr>
<td>Attained Age</td>
<td>[Comprehensive]</td>
<td>[Annually]</td>
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</tbody>
</table>

### Claim cost per $10 of Current Nursing Home and 100% Home Health Care Daily Benefit

**Elimination Period = 100 days**

(Enter for the most prevalent underwriting class)

<table>
<thead>
<tr>
<th>Gender (Male/Female)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status (Married/Single)</td>
<td>[Lifetime]</td>
<td>[5 year]</td>
</tr>
<tr>
<td>Benefit Period (Onset of Necessity available)</td>
<td>[Comprehensive]</td>
<td>[Annually]</td>
</tr>
<tr>
<td>Attained Age</td>
<td>[Comprehensive]</td>
<td>[Annually]</td>
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<td>66</td>
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</tbody>
</table>

**Notes:**
- Use the claim cost for each gender, marital status, and benefit period.
- Enter claim costs separately for Nursing Home coverage (top table) and/or Nursing Home with 100% Home Health Care coverage (Comprehensive) (bottom table), which is applicable to the policy form(s).
- Provide claim costs for all combinations of gender, marital status, benefit periods, and inflation options.
- Benefit periods used should be the two longest periods offered. If the company offers only one benefit period, provide that amount.
- Enter claim costs separately for Nursing Home with 100% Home Health Care coverage (Comprehensive) and/or Nursing Home (top table), which is applicable to the policy form(s). Note that Nursing Home also includes Assisted Living Facility.
- Claim costs are per $10 of current daily benefit. If the benefit is provided on an “other than daily” basis, describe the manner in which you determine the per day value for claim costs in the Additional Information box at the bottom of the spreadsheet. “Current” means daily benefit in effect at the time of the claim.
- If there are multiple underwriting classes, provide claim costs for the most prevalent underwriting/rating class (prevalent means the class where the company expects the most issues).
- Claim costs entered should reflect attained age cost once selection wears off (ultimate duration claim costs).
- Claim costs entered should reflect all factors other than duration.
- Provide claim costs for all combinations of gender, marital status, benefit periods, and inflation options.
- Benefit periods used should be the two longest periods offered. If the company offers only one benefit period,
enter the claim cost twice for the sole benefit period. If the company does not offer a no-inflation option, leave the corresponding fields blank.

- If the company does not offer a 100 day Elimination Period, enter the claim cost for the closest available Elimination Period (e.g., 90 day EP if available).
- If the company does not have a nursing home only policy, it does not need to complete the top table. The company should make a statement to that effect in the Additional Information box.
Tab 4 (Claim Cost Selection Factor)

### Selection Factors for Nursing Home for the underwriting class used in Tab 3

<table>
<thead>
<tr>
<th>Gender</th>
<th>Marital Status</th>
<th>Issue Age</th>
<th>Duration</th>
</tr>
</thead>
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<td></td>
<td>1</td>
<td>2</td>
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<tr>
<td>Female</td>
<td>Married</td>
<td>65</td>
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<td>75</td>
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<td>Male</td>
<td>Married</td>
<td>65</td>
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<td>75</td>
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</tbody>
</table>

### Selection Factors for Nursing Home and Home Health Care for the underwriting class used in Tab 3

<table>
<thead>
<tr>
<th>Gender</th>
<th>Marital Status</th>
<th>Issue Age</th>
<th>Duration</th>
</tr>
</thead>
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<tr>
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<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>Married</td>
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<tr>
<td>Male</td>
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<td>75</td>
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</tr>
</tbody>
</table>

**Notes:**

a) Enter selection factors derived from underwriting year-off only.

b) Claim Cost Selection Factor data should be entered for initial rate filings and rate increase filings.

c) If the company does not have a nursing home only policy, it should not complete the top table.

d) Indicate any additional information below, if applicable.

**Additional Information**

- Enter selection factors separately for Nursing Home coverage (top table) and Nursing Home with 100% Home Health Care coverage (Comprehensive) (bottom table). Note that Nursing Home also includes Assisted Living Facility.
- Selection factors reflect the effect of underwriting in early durations.
- Use the underwriting/rating category which is the basis for the claims costs in Tab 3.
• If the company does not have a nursing home only policy, it does not need to complete the top table. The company should make a statement to that effect in the Additional Information box.
### Claim Incidence for Nursing Home Daily Benefit (Including Assisted Living Facility)

**Elimination Period = 100 days**

For the underwriting class used in Tab 3

<table>
<thead>
<tr>
<th>Gender</th>
<th>Marital Status</th>
<th>Benefit Increase Option</th>
<th>Incidence Factor</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>10</th>
<th>15</th>
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**n Incidence for Nursing Home (Including Assisted Living Facility) and 100% Home Health Care Daily Benefit**

**Elimination Period = 100 days**

For the underwriting class used in Tab 3

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**Nature:**

a) Enter the claim incidence factor after application of any selection factors.

b) Use the underwriting rating category which is the basis for the most prevalent claim costs in Tab 3.

c) The company may not offer flat 600 EP, enter acceptable per-use-claim EP offered (e.g., 90/44).

d) For initial rate offering enter the most current price. For future rate offering enter current, but estimate assumption.

e) Lifetime benefit not offered, enter data for the longest benefit period offered.

f) Indicate any additional information below, if applicable.

**Additional Information**

- Enter the claim incidence factor for each cell, for Nursing Home Benefit and/or Nursing Home Benefit with Home Health Care (Comprehensive). Note that Nursing Home also includes Assisted Living Facility.
- Include incidence rates only for the base coverages (facility, home health care), ignoring other ancillary benefits (e.g. waiver of premium, benefit restoration, benefit sharing, nonforfeiture, return of premium) whether included in the policy or added by rider.
- Use the underwriting/rating category which is the basis for the claims costs in Tab 3.
- Use the longest benefit period used in Tab 3.
- If the company does not offer a 100 day Elimination Period, enter the claim incidence assumption for the closest available Elimination Period (e.g., 90 day EP if available).
### Tab 6 (Claim Continuance)

#### Claim Continuance for Nursing Home Daily Benefit (Including Assisted Living Facility)

**Elimination Period = 100 days**

For the underwriting class used in Tab 3

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<th>Gender</th>
<th>Marital Status</th>
<th>Benefit Increase Option</th>
<th>Attained Age at time of Claim</th>
<th>Duration of Claim (Yrs)</th>
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#### Claim Continuance for Nursing Home (Including Assisted Living Facility) and 100% Home Health Care Daily

**Elimination Period = 100 days**

For the underwriting class used in Tab 3

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<th>Benefit Increase Option</th>
<th>Attained Age at time of Claim</th>
<th>Duration of Claim (Yrs)</th>
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**Notes:**
- Enter the claim continuance factor as a decimal indicating the fraction of time to remain on claim at the end of each period.
- Use the underwriting rating category which is the basis for the most prevalent claim rate in tab 3. Use the longest benefit period used in tab 3.
- If the company does not offer 100% EP enter assumption for the largest EP offered (e.g., 90-10).
- Use initial rate file and enter the best estimate pricing assumption. For subsequent filings enter current, best estimate assumption.
- If lifetime benefits are not offered enter data for the longest benefit period offered.
- Indicate any additional information below, if applicable.

### Additional Information

- Enter the claim continuance factor for each cell, for Nursing Home Benefit and/or Nursing Home Benefit with Home Health Care (Comprehensive). Note that Nursing Home also includes Assisted Living Facility.
- Use the underwriting/rating category which is the basis for claim costs in Tab 3.
- Use the longest benefit period used in Tab 3.
- If the company does not offer a 100 day Elimination Period, enter the claim incidence assumption for the closest available Elimination Period (e.g., 90 day EP if available).

**Tab 7 (Salvage Factor)**

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**Notes:**
- a) For any category that is not applicable, enter "N/A".
- b) Salvage factors should be entered for initial rate filings, and rate increase filings.
- c) If the company does not have a nursing home policy, it does not need to complete the "Nursing Home only" table.
- d) Indicate any additional information below, if applicable.

**Additional Information**

- Enter the salvage factor for each duration, daily benefit, and inflation combination for nursing home only, and nursing home with home health care.
- Use the underwriting/rating category which is the basis for the claims costs in Tab 3.
- If the company does not have a nursing home only policy, it does not need to complete the “Nursing Home only” table. The company should make a statement to that effect in the Additional Information box.
Tab 8 (Mortality Selection Factors)

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Notes:

a) Enter selection factors derived from underwriting wear-off only.
b) Mortality Selection Factor data should be entered for initial rate filings, and rate increase filings.
c) Indicate any additional information below, if applicable.

Additional Information

- Enter the mortality selection factor for each cell.
- Enter the selection factor derived from underwriting wear-off only.
- Use the underwriting/rating category which is the basis for the claims costs in Tab 3.
# Tab 9 (Voluntary Lapse)

## Voluntary Lapse for the Underwriting Class used in Tab 3

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Notes:
1. Voluntary Lapse factors should be entered for initial rate filings, and rate increase filings.
2. For rate increases and annual reports, for closed blocks of business, provide the lapse assumption for all durations, even if all policies are not in early durations.
3. Indicate any additional information below, if applicable.

Additional Information

- Enter the voluntary lapse assumption for each cell.
- Use the underwriting/rating category which is the basis for the claims costs in Tab 3.
Tab 10 (Expenses)

**Expenses**

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<th>Commission Schedule, as a % of Premium</th>
<th>Policy Year</th>
<th>As a Percentage</th>
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<th>First-year Expense, as a % of Premium</th>
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<th>Renewal Expense, as a % of Premium</th>
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<th>Claim Administration Expense, as a % of Claims</th>
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<th>Premium Tax, as a % of Premium</th>
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Note: Indicate any additional information below, if applicable.

**Additional Information**

- Provide, as a percent of the average annual premium, the aggregate first and renewal year, premium tax, and commission expense assumptions.
- Claim administration expenses should be entered as a percentage of claims.
- The company should indicate in the additional information box whether commissions are paid on the increase portion of the premium.
APPENDIX 67. SHOPPER’S GUIDE TO LONG TERM CARE INSURANCE

Insert shopper’s guide here.

APPENDIX 87. ADDITIONAL LTCI PROVISIONS

In recent years, many companies selling LTCI have developed and offered many other varied riders and additional benefits to the base LTCI plan. Below is a description of some of these offerings not explained in the Shopper’s Guide.

1. **Adult Day Care Programs**

   Like home health care, policies may provide reduced coverage for services received in an adult day care facility. Adult day care programs provide care on a daily basis to individuals who do not require confinement in a nursing home. Typical adult day care benefits include: nursing care; therapeutic, social, and educational activities; and constant supervision because of Alzheimer’s or a similar disease.

2. **Dependent Spouse Home Care**

   The Dependent Spouse Home Care provision will allow the policyholder’s spouse to concurrently receive home health care coverage during the same visit by the same provider, if such home health care is being provided for the policyholder. Under this benefit, the dependent spouse is named as a secondary insured under the policy and is therefore eligible to receive benefits that would be payable under the policy. If this is a tax-qualified policy, the spouse (secondary insured) must meet HIPAA’s benefit trigger requirements (i.e., ADL or cognitive impairment trigger, plan of care and licensed health care practitioner certification). Coverage is extended to the dependent spouse if:
   
   (a) The reason the dependent spouse receives care is primarily for the policyholder’s benefit;
   (b) The care is provided during the same visit; and
   (c) The care is provided by the same provider.

   The purpose of this benefit is to protect the financial interests of the married couple. In the case of this benefit, home care provided to the dependent spouse, which would not otherwise be covered, can be paid through private insurance; thus reducing the out-of-pocket expenses of the policyholder.

3. **Weekly Home Health Care**

   The Weekly Home Health Care provision changes the daily benefit for home health care services to a weekly benefit. It provides the policyholder with access to seven times their home health daily benefit with no restriction of a daily cap. Quite often, an individual receives intensive nursing services, the cost of which exceeds the daily benefit amount. Here, the individual would have access to the entire weekly amount to pay for such services or visits. Any excess would remain in the policy limit.

4. **Flex Fund**

   This provision allows the policyholder to use their Flex Fund Benefit Amount for a variety of long-term care expenses that are not otherwise covered under the policy while he or she is living at home. Some of the benefits payable under this provision may be covered charges under the policy, such as covered care
and services used to satisfy the elimination period. Additionally, charges incurred in excess of the home health care daily benefit could be reimbursed.

5. **Enhanced Elimination Period**

The Enhanced Elimination Period provision liberalizes how days are credited toward the elimination period. Rather than require the satisfaction of possible multiple elimination periods (if separated by periods of care), this provision would provide that each date of service would satisfy the elimination period regardless of whether it was accumulated under separate claims.

6. **Spousal Survivorship/Waiver**

The Spousal Survivorship/Waiver provision waives the policyholder’s premium in the event that his or her spouse dies or goes on claim after a defined period (e.g., 10 years) without any claims. The main conditions for benefits under this provision are as follows:

   (a) Both spouses must have had their policies in force for a defined period of time (e.g., 10 years) during which no benefits were paid.

   (b) If such is the case, then in the event of the death of one’s spouse, no further premiums are due under the survivor’s policy.

   (c) Furthermore, in the event that one spouse goes on claim after satisfying the elimination period, no further premium is due for either the non-claiming spouse or the spouse on claim for the duration of the spouse’s claim.

The purpose of this benefit is to protect the financial interests of the married couple. Under this benefit, when one spouse goes on claim or dies, the healthy or surviving spouse has additional financial concerns that must be addressed. This benefit would alleviate a significant cost for this spouse via the waiver provision.

7. **Limited Payment Plans**

   (a) **Single Premium**
       The single premium payment endorsement revises the renewability section of the policy. The insured person pays a one-time premium and the insurer may not charge further premium, regardless of insurer experience.

   (b) **Specified Number of Years**
       Another endorsement revises the renewability section of the policy so that premiums are paid for a specified number of years (e.g., 10 years). This allows participants to pay their premiums in full in the specified number of years. During the premium paying period, the policy will be noncancelable as long as premiums are paid when due or within the grace period. At the end of the specified time period, if each required renewal premium has been paid, the policy will be automatically renewed for life with no further premium payments required.

   (c) **Paid-Up at 65**
       The paid-up at 65 endorsement revises the renewability section of the policy to allow applicants to pay their premiums in full by age 65. Often, premium rates are guaranteed to not increase during an initial period (e.g., 5 years) from the effective date of coverage. The policy will be automatically renewed for life with no further premium payments required if each required renewal premium has been paid up to the anniversary of the effective date of coverage on or after the insured’s 65th birthday.