NAIC Guidance Manual for Rating Aspect of the Long–Term Care Insurance Model Regulation
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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 Model Regulation* (#641)—referred to as Model Regulation in this manual—that was adopted by the NAIC in August 2000, and amended in August 2014 as well as 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 long-term care insurance (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 LTCI 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 then request 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 (LTC) 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% 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 maintains the portion of original premiums to be used for benefits plus the higher portion of any rate increase in rate increase filings.

- 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% for policyholders with issue ages 54 and younger. These changes provide greater value to many 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 the Model Regulation 641, which the NAIC adopted in 2014.

There may be situations, whether or not premium rates are changing, where a policy form re-filing is not required with respect to new business issued under a policy form after a specified date. If the specified date is after the date the state adopted changes to The Model Regulation, which the NAIC adopted in 2014, this may result in one policy form having both RS 2000 policies and RS 2014 policies. The lack of the requirement to refile the policy form does not exempt the policies issued after the specified date from the RS 2014 requirements.

1. Fixed Loss Ratios

Premiums for LTCI were 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 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>0.60</td>
<td>0.60</td>
</tr>
<tr>
<td>Premium</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Expense Ratio</td>
<td>0.40</td>
<td>0.40</td>
</tr>
<tr>
<td>Expense Margin</td>
<td>$400</td>
<td>$800</td>
</tr>
</tbody>
</table>

(Expense Margin=Premium x 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 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

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 excessive. 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;

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

(3) The required disclosure of past rate increases make the “rate increase option” less desirable to insurers and provides meaningful disclosure to potential insureds.

(4) Regulatory oversight increases when a premium increase is filed.

(5) 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, and containing 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 for Pre Rate Stabilized (PS) policies that allow the expense load to be the same on initial premiums and increased premiums.

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 LTCI

The requirement to disclose past rate increases on similar LTCI business means 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 to all policies issued when the 2014 changes are in effect. Certification differs depending on whether the block is currently marketed or for a closed block. When full margins are believed to remain, the annual certification for an open block for all LTCI policies would state 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. When some margins remain (but not necessarily full margins), the annual certification for a closed block would state that the premium rate schedule continues to contain some margin. If this statement cannot be made, the insurer must provide a plan as to how a margin will be established.

Non–cancellable LTCI products are not subject to the requirements of this section once they are no longer marketed. Combination LTCI products are also not subject to this requirement if the LTCI product component is non–cancellable and they are no longer marketed.

(f) Increased Monitoring

For both RS 2000 and RS 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.

Non–cancelable LTCI products are not subject to these requirements. Combination LTCI products are also not subject to this requirement if the LTCI product component is non–cancelable.

(g) 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. ROLES OF THE REGULATOR, ACTUARY AND INSURER

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 actuarial certification is to be accompanied by an actuarial memorandum containing support for the certification. Some of the information in the memorandum may be considered confidential by the company. (See later discussions on confidential information.)

For RS 2014 policies, the insurer is required to file an actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries (Academy) certifying to the continued adequacy of premium rates. An actuarial memorandum is required to be submitted with the certification no less than once every three years.

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 7 of this manual. Also, Appendix 8 has definitions of LTCI terms that are not defined in the Shopper’s Guide.

For new filings of RS 2014 policies (i.e. to be issued after the state adopts the 2014 amendments), the regulator should review the Certification, Memorandum and the Assumptions Template spreadsheet which are intended to assist the
regulatory actuaries in their review of the filing and 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 state’s requirements that follow Section 15.I. of the Model Regulation.

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.

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.

3. Insurer

Reasonable measures must be taken so that premiums will remain level once a policy is issued even if actual experience is moderately adverse to expected. The insurer must perform well in all areas of LTCI, such as the following:

- Initial premiums;
- Benefit structures;
- Underwriting;
- Claim adjudication;
- Marketing;
- Agent training; and
- Compliance with state laws and regulations.

Because market or environmental conditions may change, or current expectations may be different from those of years past, it is important for the company to be cognizant of current rates and how the current margins relate to the initial expectations. As part of the completion of the requirements of Section 15.I. including the Annual Certification, the company should review the assumptions and margins in the current new business rates to ensure either continued adequacy under the current premiums or re-establishing adequacy under a Plan of Action.
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 Academy 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 Insurance Model Act (Model Act), LTCI 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?

LTCI 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 annuity contracts or riders on such annuity contracts
   - Group and individual life insurance policies or riders on such life insurance policies

(b) Contracts regardless of LTC tax qualification:
   - Those that are intended to be tax-qualified under Internal Revenue Code (IRC) Section 7702B and the federal Pension Protection Act (PPA)
   - Those that are not intended to be tax-qualified under IRC Section 7702B and the PPA

(c) Contracts regardless of type of LTC benefits:
   - Covering institutional LTC benefits only
   - Covering non-institutional LTC 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 LTC.

B. WHAT ENTITIES MAY ISSUE LONG-TERM CARE INSURANCE?

LTCI may be issued by:

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

C. COMBINATION PRODUCTS

1. What is a combination product?

A “combination product” is an LTCI product sold in combination with life insurance policies and annuities, where the LTCI product component is regulated as LTCI. Such products fall into two major categories:

**Accelerated Death Benefits Sold with Individual or Group Life Insurance Policies.** These products allow for the tax-free acceleration of the death benefit to pay for qualified LTC service if an insured meets the activities of daily living (ADLs) and cognitive impairment triggers for LTCI eligibility.

The accelerated death benefit may be included in the policy or it may be added to the policy by a rider.

In today’s marketplace, the accelerated death benefit that is regulated as LTCI is sold in combination with the following life insurance products: term, whole life, universal life, indexed life, and variable life.

**LTC Benefits Sold with Individual or Group Life Insurance Policies or Individual or Group Annuity Contracts.** The combination of LTC benefits with life insurance policies or annuities is subject to tax preferential treatment under the PPA, and the LTCI components must meet the Model Act’s definition of LTCI. Consumers who purchase these combinations get two separate benefits under one product. A life/LTCI combination product provides for a death benefit if the insured dies and LTC benefits if the insured needs LTCI. An annuity/LTCI combination product provides for scheduled periodic payments upon annuitization and LTC benefits if the insured needs LTCI. The life policy and annuity contract are subject to the state life insurance and annuity laws and regulations, respectively. The LTCI component of the combination is subject to the state LTCI laws and regulations.

The LTC benefits sold with life insurance policies or annuity contracts may be included in the policy/contract or may be added to the policy/contract by a rider.

In today’s marketplace, the life/LTCI combination is sold with the following life insurance products: term, whole life, universal life, indexed life and variable life. The annuity/LTCI combination is sold with the following annuity products: fixed, indexed, variable and single premium immediate annuity.

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.
3. What special exceptions exist for life insurance and annuity 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 word “policy” should be interpreted as having the broad meaning of “policy, contract, or rider, as applicable.”

(a) The most notable exemption pertains to Sections 20, Premium Rate Schedule Increases, and Section 20.1, Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings, respectively. To qualify for exemption from Section 20 or Section 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 LTC benefits provided be “incidental.” For this purpose, “incidental” means that the LTC 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 LTC set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than LTC 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 LTC Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than LTC 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 LTC 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

(b) A description of the effect of the LTC policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in LTC claim status.

(b) Additional exceptions are included in the Model Regulation for life insurance policies or riders that fund LTCI benefits through the acceleration of the death benefit, as follows:

Section 13. Offer of Inflation Protection, Item C.
Section 14. Replacement, Item F.
Section 18. Reserve Standards, Item A.
Section 19. Loss Ratio, Item C.
Section 24. Suitability, Item A.
Section 26. H. Availability of New Services or Providers, Item H.
Section 27. Right To Reduce Coverage and Lower Premiums, Item F.
Section 28. Nonforfeiture Benefit Requirements, Item A.
Section 34. Requirements to Deliver Shopper’s Guide, Item B.

The exception language in each section cited above is not identical, but the intent is the same.

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

The LTCI components of combination products that meet the Model Act’s definition of LTCI must comply with the Model Act and 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 LTC services;

2. The disability income policy is advertised, marketed or offered as insurance for LTC 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 LTC 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 LTC benefits determined to be incidental?

“Incidental” means that the LTC 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 LTC 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 LTC 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, 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.

#### A. EFFECTIVE DATES OF NEW REGULATION

( Applies 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.

**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. 28 Nonforfeiture Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to [6 months after adoption of amended 2014 regulation]</td>
<td>Portions Apply</td>
<td>Subsection I does not apply</td>
<td>Applies</td>
<td>N/A</td>
<td>Subsection D(7) does not apply</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>
</tr>
</tbody>
</table>

In addition, state requirements that follow the changes to Section 27.A and C. will apply to any rate increase filed for a policy issued more than twelve months after the effective date of the changes. The state’s requirements that follow Section 27.H. will apply to any rate increase filed more than twelve months after the effective date of the changes, regardless of the original filing basis as RS2000 or RS2014.

#### B. EXAMPLES

The following is a hypothetical example showing how the effective dates of the amended Model Regulation would apply to Section 10, Section 15, Section 20, Section 20.1, Section 27, and Section 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 six months later, on Jan. 1, 2016.
- Insurer A sells LTC policy form LTC 001 in the state (It received approval to sell this policy form on Jan. 1, 2015). The company could continue to sell form LTC 001 in the state on or after Jan. 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 continue to sell this policy form in the state unless the company justified, and the state approved, a margin lower than 10% pursuant to Section 10B(2)(d)(ii).
• Insurer A sold 1,000 LTC 001 policies from Jan. 1, 2015 to Jan. 1, 2016 (with at least 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 is July 1, 2016, and Insurer A sold another 1,000 LTC 001 policies from Jan. 1, 2016, through July 1, 2016. These policies would be subject to the minimum 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 is 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 Jan. 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 margin is projected to be exhausted. (To emphasize, full composite margin in these polices, whether more or less than 10% of claims, must be exhausted). 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 full margin (now subject to the minimum 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:
  o 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.
  o The premium for the reduced coverage shall be consistent with the approved rate table.

• In addition, because the rate increase was implemented at least 12 months after adoption of the amended Model Regulation, Section 27H requires Insurer A to provide the following for all 3,000 policyholders:
  o An offer to reduce the policy benefits provided by the current coverage;
  o A disclosure stating that all options available to the policyholder may not be of equal value;
  o 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 Jan. 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 Jan. 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)).

• The use of the Assumptions Template for this rate increase filing for all 3,000 policies would be of more limited value since policy form LTC 001 was approved on Jan. 1, 2015. The Assumptions Template is most useful when reviewing rate increase filings where the Template was included with the initial filing for policy forms approved on Jan. 1, 2016, and later (i.e., policy forms approved at least six months after the amended regulation adoption date of July 1, 2015).

C. QUESTIONS AND ANSWERS

1. 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 and actuarial memorandum required by Section 10.

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2. 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 20.1 of the Model Regulation, some policies 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 multiple 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 newest applicable 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.

3. 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, Section 9 and Section 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.

4. What if an insurer wishes to apply Section 20.1 requirements to its entire block of existing business for ease of administration?

An insurer may wish to apply the requirements of Section 20.1 to a block of business comprised of some older policies covered by older regulations and some newer policies covered by Section 20.1. 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. RS2014 policies are subject to Section 20.1 and the Section 20 requirements may not be sufficient.
Section IV. DISCLOSURE TO CONSUMERS

The 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 LTCI 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. Insurers shall at a minimum provide all of the information shown in the Appendix B "Personal Worksheet" in relevant and readable language, and in the same order. However, it is recognized that insurers may from time to time need the ability to add additional language. Examples of acceptable additional language include but are not limited to:

- insurer contact information and instructions (including reference to a insurer website if applicable)
- answering required questions and sign off for both spouses/partners for a joint application
- supplementary disclosure about the coverage being applied for and/or the right to increase rates.
- expand income/asset ranges to additional and higher ranges without altering the current lower ranges for example:$50k - 100k, $100k - 250k)
- inclusion of definitions to explain terms referenced (i.e., joint applicant, financial plan, assets, etc.)
- add questions for information an insurer wishes to track (i.e., where do you intend to live in retirement, what other coverage do they have that may pay for LTC, do you have a plan in place, etc.)

2. The LTC 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 contingent benefits upon lapse (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.
   
   c) A disclosure stating that some benefit reduction options may result in loss of partnership status.

The LTCI Personal Worksheet and the LTCI 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 LTCI 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 Model Regulation for at least 10 years.

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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 LTC 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>Non–institutional</td>
<td>Comprehensive</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 insurers 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 LTCI Personal Worksheet. These examples are not comprehensive, but are intended to give general guidance on the appearance and content of this section.

**LTCI Personal Worksheet**

**Rate Increase History Section**

**Example 1** – Insurer has never increased rates.

**Rate Increase History**

Insurer X has sold LTCI since 1992 and has sold this policy since 1998. The insurer has never raised its rates for any LTC 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 LTCI 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)**

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC300</td>
<td>1993–1996</td>
<td></td>
<td>5%–15% rate increase in 1996</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 LTC policies in force. In 1998, form LTC300 had 43,000 policies in force out of 200,000 total LTC policies in force.

b) In 1996, form LTC300 had $1,500,000 in annualized premium in force out of $5,000,000 total LTC annualized premium in force. In 1998, form LTC300 had $1,300,000 annualized premium in force out of $12,200,000 total LTC annualized premium in force.

c) In 1996, form LTC300 included 25% of our LTC policies in force. In 1998, form LTC300 included 22% of our LTC policies in force.

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

<table>
<thead>
<tr>
<th>Years</th>
<th>Policy Form</th>
<th>Available for Purchase</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC300</td>
<td>1993–1996</td>
<td></td>
<td>5%–15% rate increase in 1996</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.

- 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 LTC annualized premium sold since 1998. [Italics added.]

- 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 LTCI 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></td>
<td>LTC001</td>
<td>1988–1996</td>
<td>20% rate increase in 1993</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20% rate increase in 1997</td>
</tr>
<tr>
<td></td>
<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 LTCI 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>Years Available for Purchase</th>
<th>Policy Form</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996–present</td>
<td>LTC00A</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 LTCI 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 Available for Purchase</th>
<th>Policy Form</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988–1997</td>
<td>LTC700</td>
<td>15% rate increase in 1993</td>
</tr>
<tr>
<td>1988–1997</td>
<td>LTC700</td>
<td>0%–10% rate increase in 1997</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.

<table>
<thead>
<tr>
<th>Rate Increase History (Institutional Policy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer X has sold LTCI 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).</td>
</tr>
<tr>
<td>Policy Form</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>LTC001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Increase History (Non-institutional or Comprehensive Policy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer X has sold LTCI 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.</td>
</tr>
</tbody>
</table>

**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>
<tbody>
<tr>
<td>Insurer X has sold LTCI 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).</td>
</tr>
<tr>
<td>Policy Form</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>LTC100</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.

<table>
<thead>
<tr>
<th>Rate Increase History (Institutional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The insurer has sold LTCI 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.</td>
</tr>
</tbody>
</table>
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.

率 Increase History (Insurer A)

Insurer A has sold LTCI since 1986 and has sold this policy since 1986. The insurer has never raised its rates for any LTC policy it has sold in this state or any other state.

Or

Rate Increase History (Insurer A)

Insurer A has sold LTCI 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>Policy Form</th>
<th>Years Available for Purchase</th>
<th>Rate Increase 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 – 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 LTCI 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>Policy Form</th>
<th>Years Available for Purchase</th>
<th>Rate Increase History</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC010</td>
<td>1995–1998</td>
<td>1996 – 30% increase</td>
</tr>
<tr>
<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 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.*

**Rate Increase History (Insurer A)**

<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>
<tr>
<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.*

**Rate Increase History (Insurer B)**

<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>1996 – 30% increase</td>
</tr>
<tr>
<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 LTCI 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 LTCI 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 LTC rider. The rates for the disability income base policy were increased by 20%. The insurer has never raised rates on LTC. 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 LTCI since 1996 and has sold this policy since 1996. The insurer has never raised its rates for any LTC policy it has sold ...” changes to “The insurer has sold LTCI since 1996 and has sold this rider since 1996. The insurer has never raised its rates for any LTC policy or rider it has sold.”

Rate Increase History

The insurer has sold LTCI since 1996 and has sold this rider since 1996. The insurer has never raised its rates for any LTC policy or rider it has sold in this state or any other state.
Example 13 – An insurer sells a disability income policy with a LTC rider. They sell no other long-term care coverage. The rates for the LTC rider were increased by 30%. Because the increase was on the LTC 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 LTCI 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 LTCI 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>Policy Form</th>
<th>Years Available</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<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 LTC benefits in the base policy. The policy is considered a LTC 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 LTCI 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>Policy Form</th>
<th>Years Available</th>
<th>Rate History</th>
</tr>
</thead>
<tbody>
<tr>
<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.
Example 15 – An insurer has received approval for a series of three increases of 15% for each of three consecutive years. The insurer must disclose the entire series but need not treat it as three separate increases.

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

<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>2003–2010</td>
<td>2014 – 52%* increase</td>
</tr>
</tbody>
</table>

- The premiums increase by 15% for each of three consecutive years.

E. QUESTIONS AND ANSWERS

1. What is the difference between institutional and non–institutional LTC 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 LTC 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 LTC 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 LTC 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 LTC business. An insurer cannot express percentages or other numbers that incorporate all of the insurer’s business including policies that provide no LTC 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 LTC 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 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 LTCI Personal Worksheet (Appendix B of the NAIC LTCI Model Regulation)
- 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 six 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 three 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. Any information in the this document for which the company requests trade secret or other confidential treatment should be clearly marked and otherwise comply with a State’s rate filing laws, regulations, and other guidance. Determination of what constitutes a trade secret and how such information is treated are made under state law. If a company determines that it has concerns about supplying information requested in the document, it should discuss with the State whether other or more limited information would satisfy the state need for review.

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.

If there is sufficient justification to review and approve a lower margin based on carrier experience, the product design and/or the sensitivities to the baseline pricing assumptions, this should be considered under the Model Regulation. The lower margin may be justified in various ways. For example, an insurer may justify a lower margin because it can demonstrate from its reporting in the NAIC’s LTC Experience Exhibit, that actual experience has been in close approximation to past LTC pricing assumptions for morbidity and persistency. For example, the regulator may want to see that the actual-to-expected ratios for the past four or five years have never varied from 100% (adjusted to appropriately reflect margin in each assumption) by more than one half of the requested lower margin percent. Furthermore, product designs (e.g. combination products) may allow for a lower margin based on the sensitivity of the LTC assumptions when considering the product as a whole.
An insurer may also justify a lower margin for products that are not considered stand-alone LTC products, but must be justified by an appropriate actuarial demonstration. For example, a combination product that requires the use of primary death benefits as payments for LTC services prior to the use of benefits under the LTC rider has a lower claim frequency and smaller likelihood of significant differences from assumptions.

(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.

The comparison of premium rates is intended to be broadly based. The draft actuary’s certification in Appendix 1 uses the phrase “consistently equal to or in excess of the premium rate schedule for other similar policy forms.” It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

(f) A statement that 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.

(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.

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 Academy. Membership in the Academy 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 Academy 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 with variations in key assumptions. The analysis should show how a change in each key assumption impacts earned premium, incurred claims, and loss ratios (possibly separated by policy duration segments), including how the variation to the assumption produces a change in the lifetime loss ratio. Projected experience of variations that are intended to be within moderately adverse experience should show the margins are not exhausted (i.e. no rate increase would be allowed).

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

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Note the comments on page [78][will need to change page number] related to the need to understand the potential for maintaining some of this information as confidential for the insurer.

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. The regulator may also consider whether or not an independent actuary’s review has been done for another state or would be useful. A state may require that an actuarial memorandum include all of the relevant 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.

H. QUESTIONS AND ANSWERS

1. What are the actuary’s responsibilities?

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.

The Actuarial Memorandum that accompanies the Certification for RS 2014 policies will provide sufficient information to understand the actuarial assumptions used to develop the premium rates.

2. 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 (#10) 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 I. 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.

3. When reviewing the actuarial certification, what should the regulator look for?

The regulator should look or 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.
4. What does “moderately adverse experience” mean?

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 ASOPs and its reference here is intended to be consistent with those standards. It is intended to allow considerable actuarial judgment to reflect aspects of the policy form’s projected experience that are more certain (e.g. based on prior experience with similar forms, markets, risk selection and benefits) versus less certain (e.g. new benefits or risk classification, new markets, etc.). For RS2000 policies, there is no minimum requirement for the margin.

For RS2014 policies, there is a minimum margin of 10% of expected claims, although the Regulation allows some flexibility. This minimum is not intended to be a uniform level of margin acceptable under every circumstance. Actuarial judgment is still expected to determine the final level of margin appropriate for the specific circumstance.

- For initial rate filings of RS2014 policies, the company should state the margin.
- Interest rate assumptions different from the discounting at the maximum valuation interest rate should not be considered as part of the MAE.
- Aggregate margins based on significant variations in margins for subsets of the distribution may be insufficient if the distribution is modified. Aggregate margins must still be sufficient under other reasonable distribution assumptions.
- The regulatory actuary should ask how the key assumptions (i.e., morbidity, mortality, and voluntary lapse) impact the composite margin. See the discussion on sensitivity analysis in F above.

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

5. 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 a regulatory actuary in another state or consider disapproving the filing if allowed in the state.

You may also seek the review by an independent actuary. Another state may have already asked for such a review and you should seek to avoid duplication wherever possible. Such reviews are generally done at the company’s expense.

6. 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.

7. 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 five 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.

8. 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 (five 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.

9. 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.”

10. 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.

11. 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.

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 LTCI policy forms under the LTCI Model Regulation. The Model Regulation provides 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 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 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.

Non–cancellable LTCI products are not subject to the requirements of this section. Combination LTCI products are also not subject to this section if the LTCI product component is non–cancellable.

A. MATERIALS THAT ACCOMPANY A RATE INCREASE FILING

The information to accompany a filing for a rate increase is defined in Section 20, for RS 2000, and Section 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:
  - 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.
  - Statement that the policy design, underwriting, and claims adjudication practices have been taken into consideration.
  - 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 There are different rules for “exceptional increases.” These are explained in a separate section at the end of this chapter.

2 A company may revise its pricing assumptions from the original under several circumstances. One is a rate increase request which would provide new assumptions for future filings. Another would be a part of the Annual Certification whereby new sales of a product are at higher rates based on revised assumptions (if allowed by state law) but existing policies’ rates are not increased as some margins still remain. References to “initial” or “original” assumptions are generally intended to mean the most recent prior assumptions, although, where the language is clear, original assumptions are just that regardless of how many times the assumptions may be changed (e.g. Section 20.1 uses the “original lifetime loss ratio” which does not change with rate increase filings).
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 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. See Example 15 of the rate increase history disclosures.

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 Section 20B(2) or Section 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.

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 contains additional information, actual experience, a loss ratio demonstration, 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.

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

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

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• The revised premium rates.
• New best estimate assumptions plus an appropriate re-establishment on margins with respect to future risks.
• The current mix of business.
• The maximum 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 maximum 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 the lesser of original assumptions with original MAE (using the actual mix of business each calendar year) and actual claims.

In calculating future expected incurred claims under Section 20.1C(2), use:
• Current mix of business.
• Current best estimate assumptions, plus an appropriate re-establishment of margins with respect to future risks.

In demonstrating compliance with Section 20.1C(2), the lifetime loss ratio referenced in Section 20.1C(2)(a)(ii) and Section 20.1C(2)(c)(ii) should be based on:
• Current mix of business at time of rate increase filing.
• Original assumptions.
• 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 Section 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/deficiency of the expected earnings over the valuation rate is not to be considered as a part of the provision for moderately adverse experience in the new rates.

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.
(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.

The regulatory actuary may also wish to request a sensitivity analysis similar to the one described in the section on Initial rates [See page 34].

5. Rate Comparison Statement

Section 20B(4) or Section 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 equivalent of the rate increase. The insurer may 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 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 underpricing 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 remaining insureds while still meeting all aspects of the requirements that rates not be excessive, inadequate or unfairly discriminatory. 3

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 state should review this notice along with Section IX of this manual.

3 The NAIC Model Bulletin (APPROVED IN 2013) has language DEALING WITH OLDER CLOSED BLOCKS.
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 LTCI, [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 Section 28D(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 at each of the approved increases.

Section 20G and Section 20H, or Section 20.1G and Section 20.1H, 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 provide 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 review 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:

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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. For RS2014 policies, the regulator can expect a completed Assumptions Template (Appendix 6). Selected items 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 five years or so) lapse rates of 1% or less. This means that less than 1% of the insureds that remain will drop their policy each year. If this assumption is higher than 1%, 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 Model #10 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 require 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 Model #10. Since this rate may vary from year to year, Section 20 and 20.1 allow the use of an average interest rate if the manner in which it has been determined is disclosed.

(e) Reserves – Policy and Claim

The regulatory actuary may wish to request a comparison of the assumptions in projections for the rate increase with the assumptions in the most recent gross premium valuation or asset adequacy testing.

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) provide 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 filings 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 Survivor Benefit Plan (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>

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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 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 Section 20G, Section 20.1G, Section 20H(1)(c), and Section 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 “how reserves have been incorporated” in the event CBL is triggered in Section 20B(3)(b) and Section 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. 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 relative benefit 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.
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 reviewing a new margin established at the time of the rate increase?

Although the Model Regulation requires the 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 reviewing a new margin established at the time of the rate increase:

a) When the 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 insurer establishes a margin of, for example, 20% of claims, although future increases may be less likely, the 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 expect a higher level of scrutiny in justifying 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 expect a higher level of scrutiny in justifying the higher margin.

15. For RS 2014 policies, how does the regulatory actuary determine that the lifetime 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% (calculated using the lesser of the accumulated value of actual incurred claims and the accumulated value of historic expected claims as defined in Section 20.1C(2) of the Model Regulation), 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 maximum 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 (related to that amount of rate increase) that no further rate increases are anticipated. The insurer must provide the amount of rate increase necessary to make the certification (and should be prepared to provide the actuarial certification for this amount of rate increase if asked), and the rate increase filing must satisfy all other requirements of the applicable section. In addition, the commissioner should 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. In this case, the regulatory actuary should seek to understand the reasoning for the company’s lower request. Subsequent increases should be reviewed consistent with that reasoning.

2. The state could limit the rate increase to an amount that is less than the certifiable rate increase. In this situation, the regulatory actuary should review subsequent rate increases reflecting only the rate increase that was actually approved in that state.

18. What should 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 only the initial part of the series and requires the insurer to file each subsequent phase of the series, only the approved rate increases should serve as the basis for contingent nonforfeiture and disclosure of rate increase history. Annual reporting would be based on the actuarial assumptions reflecting the full series of rate increases.
The LTCI 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 policies, Section 15I requires an annual actuarial certification providing a statement of the sufficiency of the current rate schedule. The actuarial memorandum that supports this certification is to be filed every three years. The chart in Appendix 5 outlines the requirements for items to be included in the actuarial memorandum. Sections C1 and C2 provide sample actuarial certifications.

LTC coverage may be provided in the state through a policy form approved and reviewed by the IIPRC. Annual monitoring of experience following a rate increase and review of the annual certification is done by the IIPRC only when the rate increase was not subject to state review and approval.

Noncancelable LTCI products are not subject to the requirements of subsection A and subsection B of this section. Combination LTCI products are also not subject to subsection A and subsection B of this section if the LTCI product component is noncancelable. Both of these product types are subject to subsection C: annual certification when the policies are currently marketed. They are not subject to subsection C: annual certification when the policies are no longer marketed.

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, 58% of the accumulated and discounted original premium.
2. For RS 2014 policies, the greater of the original anticipated lifetime loss ratio, including margin for moderately adverse experience, and 58% of the accumulated and discounted original premium. (For RS 2014 policies, the accumulated claims are the lesser of the actual incurred claims and the historic expected claims).
3. 70% of the accumulated and discounted exceptional increase premium.
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 under moderately adverse conditions.

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 (e.g., 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, 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, Section 151 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 then request 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.
- An explanation of the analysis and testing performed in determining the current presence of margins.

Section 1 and Section 2 below are sample certifications for policies currently being marketed, and for policies that are no longer marketed, respectively.

For rate schedules of policy forms currently marketed (see Section 1 below), 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.
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 LTCI 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 ________, the ________ in charge of LTCI operations for _______ on ________.

[Signature of Actuary]
[Name of Actuary (typed or written)]
[Address of Actuary]
[Telephone Number of Actuary]
[Date of Certification]
For rate schedules of policy forms no longer marketed (see Section 2 below), 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 certification and must include a time frame to reestablish adequate margins for moderately adverse experience.

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

Sample Annual Actuarial Certification for
Existing LTCI 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 LTCI 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 LTCI operations for _____ on _____.

[Signature of Actuary]

[Name of Actuary (typed or written)]

[Address of Actuary]

[Telephone Number of Actuary]

[Date of Certification]

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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).
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.
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.
   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.

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 LTC 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.

SECTION IX. POLICYHOLDER RATE INCREASE NOTIFICATION ELEMENTS AT TIME OF A RATE INCREASE

In 2013, the NAIC regulators, industry and consumer representatives began work on setting new parameters relating to long-term care insurance rate increase filings, rate increase implementation, disclosure and enhanced consumer protections. This initiative resulted in the development of a new NAIC Model Bulletin and changes to the NAIC Model Regulation. While both the Bulletin and revised NAIC Model Regulation provisions address actuarial practices, filing and implementation and an enhanced contingent nonforfeiture benefit on lapse, this Section of the Manual focuses on consumer disclosure at time of the rate increase.

Examples of the types of consumer disclosure elements contemplated during the NAIC discussions are provided in this Section. However, the insurer is encouraged to provide as much detail and information as the insurer deems appropriate to clearly disclose any element in the context of how the insurer will administer the implementation of the rate increase.

A. NAIC MODEL BULLETIN – “THE ANNOUNCEMENT OF ALTERNATIVE FILING REQUIREMENTS FOR LONG-TERM CARE PREMIUM RATE INCREASES”

The Model Bulletin addresses policies which were issued prior to the date the state adopted rate stabilization (e.g., the 2000 Model Regulation.) This grouping of policies is generally referred to as “pre-rate stabilization” policies.

The Bulletin requires that the insurer file the policyholder premium increase notification for informational purposes as part of the rate increase submission. This filing is intended to provide Insurance Department staff with advance notice of the content of the notice that the insurer intends to send to all affected policyholders.

The insurer must clearly disclose the following elements in the premium increase notice:

1. the amount of the premium rate increase requested and implementation schedule (e.g., single premium increase applied or phased-in as a series of premium increases);
2. a minimum of 60 days to respond or make a decision about benefit changes to reduce the increase;
3. available benefit reduction/rate increase mitigation options. The insurer should focus on one option in detail and provide direction/contact information as to where the individual may seek information on additional options if available. No mitigation options may be available when the insured has already reached the minimum benefit levels available under the policy;
4. clear disclosure addressing the guaranteed renewable nature of the policy/coverage and that the insured should understand that premium rates may increase again in the future;
5. offer of contingent benefit upon lapse “CBL” (which is administered in accordance with the CBL provisions of the 2014 revised NAIC Model Regulation and Bulletin), as applicable. If a phased-in increase is approved, the full increase should be used in determining whether CBL is triggered at the time of each of the approved increases, as described in Section VI;
6. reference to the availability of State Health Insurance Assistance Program (SHIP) counseling; and
7. reference to the availability of Department/Bureau of Insurance contact information.

As will be described below, revisions to the NAIC Model Regulation added a 6th disclosure element that was not addressed in the Bulletin – specifically, the impact on benefit reduction options on DRA* Partnership status. In the event that a state has adopted a DRA Partnership program in which the insurer participates and the insurer has issued coverage to the policyholder that is intended to qualify for DRA Partnership status, the insurer must also disclose that a reduction in benefits may negate DRA Partnership status if applicable. Examples of benefit reductions that may have an impact on Partnership status include the dropping or reduction in inflation coverage. Due to the different regulatory construct for the 4 grandfathered Partnership states (CA, CT, IN, NY), carriers will work with both the respective insurance department and grandfathered Partnership office in matters of disclosure.

* DRA refers to the Deficit Reduction Act of 2005
B. NAIC MODEL REGULATION

In 2014, revisions were made to the NAIC Model Regulation which also addressed consumer disclosure at the time of the increase. In particular, section 27 “Right to Reduce Coverage and Lower Premiums” was amended to incorporate the required elements in the Bulletin as well as addressing the impact of benefit reduction options on Partnership status and requiring that policyholders be notified that options available to the policyholder may not be of equal value.

C. RATE INCREASE DISCLOSURE ELEMENTS

The following elements should be included in any rate increase disclosure or communication package. Please note that:

- the following examples are intended to provide specific guidance as to the intended content of the required elements;
- they are illustrative only;
- disclosure positioning will likely vary by insurer;
- these elements may be included as part of the increase notification letter or included in an attachment to such letter; and
- the insurer may include as much detail as the insurer believes necessary to relay concise and easy to understand information to the consumer regarding these elements.

**Element 1 - the amount of the increase and implementation schedule**

- Indicate amount of increase. Include current premium and new premium
- Indicate effective date of increase
- Provide additional information regarding any future scheduled increases

**Element 2 Examples – mitigation options**

- Include information on at least one mitigation option in detail
- Include information about the current daily benefit amount if it has increased due to inflation protection
- Include information that in some policies, if contractually agreed upon, dropping inflation protection will revert the daily benefit back to the pre-inflation protection level.
- Include information on how to elect the option and when any election period would expire
- Include instructions on election process and contact information
- Provide direction/contact information as to where the individual may seek information on additional options if available
- Include reference to the availability of State Health Insurance Assistance Program (SHIP) counseling

**Element 3 Examples – reminder that premium rates can increase in the future**

- Include a reminder that the policy is guaranteed renewable, explain what that means and indicate that premium can increase in the future

**Element 4 Examples – the offer of the CBL, if applicable**

- Reference to CBL should only be included if applicable to the individual
- Describe CBL coverage and the election period
- Explain that exercising CBL will result in a paid-up policy
- Disclose that CBL results in significant reduction in policy benefits and careful consideration should be made

**DRA Partnership Status Examples – when a benefit reduction option may cause the loss of DRA Partnership status**

- Disclosure only applicable if a benefit reduction offer would cause loss of DRA status. (Not required when offer would not jeopardize status)
- At time of offer, explain what loss of status would mean to the policyholder including loss of Medicaid asset protection

“Options may not be of equal value” – Each option should be viewed as to whether it is appropriate to the individual’s needs”
Remind policyholder that each option should be viewed in light of the individual’s need and situation
Remind policyholder that they may wish to consult with family members and advisors

Examples of Benefit Mitigation/Reduction Options:

- You may keep your premium at or about its current level by electing available options that may help minimize the effect of the premium increase, including the following:
  - You may choose to reduce your maximum daily or monthly benefit, or
  - You may choose to adjust your benefit period or inflation option.
  - Include information that in some policies, if contractually agreed upon, dropping inflation protection will revert the daily benefit back to the pre-inflation protection level.

  If you reduce your daily benefit of $### to $###, your new premium will be $###.

- We are offering you an option to avoid the premium increase completely by reducing your future annual inflation rate from X% to Y% and keeping all other benefits the same. Please see the enclosed election form for more information on this as well as additional options that will enable you to minimize the premium increase.

Example of SHIP Counseling Language:

We recommend that you review all options available to you (including paying the rate increase and any available benefit reduction options) to determine which option is appropriate to your needs by consulting with you family members and other advisors.

In addition, you may also wish to contact the State Health Insurance Assistance Program (SHIP) located in your state if you need additional counseling on determining your response. Please go to www.shiptalk.org to find the nearest SHIP to you.

In addition, you may also wish to contact your State Department/Bureau of Insurance if you need additional counseling on determining your response. Please go to http://naic.org/state_web_map.htm to find your State Department/Bureau of Insurance.
Drafting Note – The letter below is a sample rate increase notification letter that reflects all 7 elements as detailed in Subsection A of "SECTION IX - POLICYHOLDER RATE INCREASE NOTIFICATION ELEMENTS AT TIME OF A RATE INCREASE." This letter is a sample only. Carriers may submit to the insurance department rate increase notification letters and other disclosure material that include different language, options, format and order as appropriate to reflect carrier rate increase communication and implementation processes. However, carriers are reminded that all 7 elements as appropriate must appear in plain language in the carrier's rate increase notification communications.

Sample Rate Increase Letter

(Consumer groups disclosure notice)

Date

Dear Policyholder

[address]

[policy number]

The premium for your long-term care insurance policy will increase on [date].

This letter is to let you know that the premium for your long-term care insurance policy [XXX] is increasing. This notice will tell you when your premium will increase, how much more you will pay, what choices you have if you don’t want to or can’t pay the full premium increase, and the deadline to tell us what you want to do.

The new premium will be [$$] paid [frequency] beginning on [date]. You will pay this higher premium for the same coverage as long as you keep the policy, unless the premium changes again in the future, or you choose one of the options below to reduce the amount of the increased premium.

The terms of the policy you have now are listed below

<table>
<thead>
<tr>
<th>Premium</th>
<th>$xxx paid [frequency]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period</td>
<td>[duration]</td>
</tr>
<tr>
<td>Daily Benefit</td>
<td>$xxx</td>
</tr>
<tr>
<td>Waiting Period, Elimination Period, Deductible</td>
<td>$xxx</td>
</tr>
<tr>
<td>Inflation Protection</td>
<td>[xx]%</td>
</tr>
</tbody>
</table>

This information will help you decide if you want to pay the higher premium or choose one of the options described below to reduce the amount of the increase.

<table>
<thead>
<tr>
<th>The policy you have now</th>
<th>Choices you can make to reduce the amount of the premium increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Benefit $xxx</td>
<td>Change the amount the policy will pay for each day of your care (daily benefit). Your new daily benefit will be [new daily benefit].</td>
</tr>
<tr>
<td>Waiting Period, Elimination Period</td>
<td>Current Waiting Period, Elimination Period</td>
</tr>
<tr>
<td>Deductible Period, Deductible period, deductible period</td>
<td>will be [xxx] calendar service days.</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Inflation Protection</td>
<td>[xx]%</td>
</tr>
<tr>
<td>Change the amount that your daily benefit increases each year (inflation protection). The new inflation protection for the daily benefit will be [xxx] percent per year.</td>
<td></td>
</tr>
<tr>
<td>Drop your current inflation protection. If you do, your current daily benefit amount will stay the same [$$] for as long as you have your policy.</td>
<td></td>
</tr>
</tbody>
</table>

You also can:

- **Stop paying policy premiums and keep your policy.** Your benefits if you stop paying premiums will be equal to the total amount of premium you have paid since you first bought the policy, which is [$$].
- **Pay the increased premium without making any changes to your policy benefits.** The new premium will be [$$] paid [frequency] beginning on [date].

**Some of these choices will reduce the new premium by more than others.** Please call us at [Company Name] at [Phone Number] for help to make any of these choices. You can also get free help from [local SHIP] to make a choice. You can call [local SHIP] at [Phone Number]. A trusted financial advisor or Elder Law attorney also could be helpful.

[Alternate Partnership language: Some of these choices may mean your policy would no longer meet the requirements of a Qualified Partnership policy that protects your assets under the state’s Medicaid program. Please call [Company Name] at [Phone Number] for more information. You can also get information about this from [local SHIP], your State Department/Bureau of Insurance, or from a trusted financial advisor or Elder Law attorney.]

You must tell us if you want to make any of these choices before [date]. Please return this form by [date]. If we don’t hear from you by [date], we assume you intend to pay the higher premium and keep your policy. If we don’t hear from you and you don’t pay the higher premium by the due date, we will cancel your policy.

[Company name] has the right to increase the premium you pay for this policy in the future.

[Company] plans to increase your premium again. Your new premium will be [$$] beginning on [date] [and on date].

This policy will continue to cover you for as long as you continue to pay premiums.
APPENDIX I. SAMPLE ACTUARIAL CERTIFICATION – INITIAL FILING

Sample Actuarial Certification for
LTCI 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 LTCI 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]

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APPENDIX 2. SAMPLE ACTUARIAL CERTIFICATION – RATE INCREASE

Sample Actuarial Certification for LTCI Premium Rate Increase
In Accordance with Section 20 or Section 20.1 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 LTCI premiums and filing for increases in LTCI 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 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
LTCI Exceptional Premium Rate Increase
In Accordance with Section 20 or 20.1 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 LTCI premiums and filing for increases in LTCI 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 that demonstrates that the increase in the premium rate schedule meets the loss ratios standards and necessary details of this state.

   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 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]

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## 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>Interest Adjusted to 1/1/2009 Earned Premiums</th>
<th>Incurred Claims</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>$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>
</tr>
<tr>
<td>2005</td>
<td>$3,720,000</td>
<td>$0</td>
<td>$960,337</td>
<td>$4,412,711</td>
<td>$0</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>
</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>
</tr>
<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>
</tr>
<tr>
<td><strong>Subtotal Actual Experience</strong></td>
<td><strong>$33,394,875</strong></td>
<td><strong>$0</strong></td>
<td><strong>$7,874,082</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Projection Period</th>
<th>Original Earned Premiums</th>
<th>Increased Earned Premiums</th>
<th>Incurred Claims</th>
<th>Interest Adjusted to 1/1/2009 Earned Premiums</th>
<th>Incurred Claims</th>
</tr>
</thead>
<tbody>
<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>
</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>
</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>
</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>
</tr>
<tr>
<td>2021–2050</td>
<td>$14,754,202</td>
<td>$3,349,204</td>
<td>$5,164,021</td>
<td>$5,393,467</td>
<td>$1,224,317</td>
</tr>
<tr>
<td><strong>Subtotal Projected Experience</strong></td>
<td><strong>$33,394,875</strong></td>
<td><strong>$0</strong></td>
<td><strong>$7,874,082</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Actual & Projected Experience**

| Minimum Present Value Incurred Claims = 58%* of (4) ($57,011,871) plus 85% of (5) ($5,361,058) = $37,627,824
| 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 RS2014 policies 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.

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## Appendix 5: Checklist for Actuarial Memorandum that Applies to Rate Stability Policies

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

<table>
<thead>
<tr>
<th>10. Actuarial Assumptions:</th>
</tr>
</thead>
<tbody>
<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>

<table>
<thead>
<tr>
<th>11. Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Past, Future and Lifetime, including claim liability and claim reserves</td>
</tr>
<tr>
<td>b. Demonstration that the margin is exhausted</td>
</tr>
<tr>
<td>c. Description of the Credibility of the Experience Data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Loss Ratios – at maximum valuation interest rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Minimum Requirement (58/85 test)</td>
</tr>
<tr>
<td>b. Anticipated lifetime loss ratio</td>
</tr>
<tr>
<td>New Rate Filings</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>X</td>
</tr>
</tbody>
</table>

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

14. Description of Basis for Active Life Reserves

a. Method  
   - X

b. Morbidity  
   - X

c. Lapse  
   - X

d. Mortality  
   - X

e. Interest  
   - X

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

* An actuarial memorandum must be submitted with the annual certification at least once every three years.
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 the implementation date of the rate increase applicable to the state.

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 currently sells similar LTCI in the filing state, and if not, provide the date that it exited the market (the company may use a date when it exited the national LTC market or the date it exited the LTC market in the filing state). The regulatory actuary may want to question whether an affiliated company sells LTCI in the filing state. If the company does not sell stand-alone LTCI, but does sell other types of LTCI, 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.

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, list all available underwriting or risk classification variations. Also address whether the rates are unisex or gender specific.

5. Average 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. If there have been previous rate increases where the amount of increase approved varied by state, then show how the currently approved rate schedule in the state of filing compares to the current nationwide average rate schedule.
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. Except for the issue age distribution, the insurer in completing the form should use their specific variations, not the examples shown.

   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 other filings, provide the actual distribution of nationwide business as of the end of the calendar year. 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>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elimination Period</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 days</td>
<td>%</td>
</tr>
<tr>
<td>60 days</td>
<td>%</td>
</tr>
<tr>
<td>90 days</td>
<td>%</td>
</tr>
<tr>
<td>180 days</td>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Underwriting</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred</td>
<td>%</td>
</tr>
<tr>
<td>Standard</td>
<td>%</td>
</tr>
<tr>
<td>......</td>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inflation Protection</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Inflation</td>
<td>%</td>
</tr>
<tr>
<td>5% Simple</td>
<td>%</td>
</tr>
<tr>
<td>3% Compound</td>
<td>%</td>
</tr>
<tr>
<td>4% Compound</td>
<td>%</td>
</tr>
<tr>
<td>5% Compound</td>
<td>%</td>
</tr>
<tr>
<td>......</td>
<td>%</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>State</th>
<th>In-Force Count</th>
<th>Annualized Premium</th>
<th>Percentage Eligible for CNFB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Alaska</td>
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<tr>
<td>Arizona</td>
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<tr>
<td>Arkansas</td>
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<tr>
<td>California</td>
<td></td>
<td></td>
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</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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Illinois</td>
<td></td>
<td></td>
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<tr>
<td>Indiana</td>
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<td></td>
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<tr>
<td>Iowa</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kansas</td>
<td></td>
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<td></td>
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<tr>
<td>Kentucky</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Maryland</td>
<td></td>
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<tr>
<td>Massachusetts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>In-Force Count</td>
<td>Annualized Premium</td>
<td>Percentage Eligible for</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
<td>--------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Mississippi</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Missouri</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Montana</td>
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<td></td>
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<tr>
<td>Nebraska</td>
<td></td>
<td></td>
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<tr>
<td>Nevada</td>
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<td></td>
<td></td>
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<tr>
<td>New Hampshire</td>
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<tr>
<td>New Jersey</td>
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<td></td>
<td></td>
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<tr>
<td>New Mexico</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>New York</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>North Dakota</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ohio</td>
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<tr>
<td>Oklahoma</td>
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<tr>
<td>Oregon</td>
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<td></td>
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<tr>
<td>Pennsylvania</td>
<td></td>
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<td></td>
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<tr>
<td>Rhode Island</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>South Dakota</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Vermont</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
a. Distribution of Policyholder Actions after Rate Increase

Provide a breakdown of policyholder actions during the calendar year for policyholders whose rate was increased in that year. These policyholder actions include:

- Cancel the policy and not eligible for the contingent nonforfeiture benefit.
- Discontinue premium payments and continue coverage under a 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 (provide explanation)

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 each policy.

For annual reports, the information provided should be for actual specific policyholder actions during the calendar year.

<table>
<thead>
<tr>
<th>State</th>
<th>In-Force Count</th>
<th>Annualized Premium</th>
<th>Percentage Eligible for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wyoming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Distribution of Nationwide Policyholder Actions After Rate Increase

<table>
<thead>
<tr>
<th>Action</th>
<th>Number of Policyholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancel the Policy and not eligible for the contingent non forfeiture benefit</td>
<td></td>
</tr>
<tr>
<td>Discontinue premium payments and continue coverage under nonforfeiture benefit</td>
<td></td>
</tr>
<tr>
<td>Pay the Full Rate Increase</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>Other (provide explanation)</td>
<td></td>
</tr>
</tbody>
</table>

Number of Policyholders Subject to Rate Increase during ____

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 prior basis as described by the company. 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 and subsequent rate increase requests for those forms. 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.
   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.
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.

d. Expenses – Normally expense experience is of limited value. The existence of margins (in initial rates or annual certifications) should be sufficient to demonstrate that rates are not inadequate. Expenses should not be the cause of rate increases. Some states are required by regulation to make the determination that rates are reasonable, adequate, and not excessive. Because 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, including any commissions.

e. Interest – For the initial filing, provide the assumed investment earnings rate. Changes to this rate and actual variations from it are not the basis for any rate increase. Rate increase filings, annual rate certifications and rate increase monitoring filings should be based on lifetime values using the maximum valuation interest rate.

f. Area Factors – Indicate whether area factors are used, and if so, provide area factor tables.

g. Contingency and Risk Margins – A description of the margin for moderately adverse experience, including a demonstration that the margin meets the minimum requirement should be provided. The premiums may contain additional amounts to reflect a return on capital invested in the policies or other amounts. Like expenses, these margins are not subject to limitations under the Model Regulation and are thus of limited value.

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

      Annual Rate Certification
      Projected experience should be discounted at the maximum valuation interest rate, and include margins for moderately adverse experience. The state may wish to review the expected lifetime loss ratio under best estimate assumptions.

      Rate Increase Requests
      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, separating the experience of the last five calendar years and the next five years of projected experience. Also provide a demonstration that the applicable loss ratio test is met.

      Rate Increase Monitoring
      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

      A demonstration that the margin is exhausted is required for rate increase requests. The lifetime loss ratio calculated 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 lifetime loss ratio calculated 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 maximum valuation interest rate.

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

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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\(^5\) 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 each assumption of the reserve basis. 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.

\(^5\) In this case, changes to both triggered and offered nonforfeiture benefits should be included.
The Assumptions Template spreadsheet is intended to assist the regulatory actuary in his/her review of the actuarial assumptions related to any LTC 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 changes to those 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. Where the coverage type includes both Nursing Home with Home Health Care and both must be included in the policy, the company would leave the Nursing Home table blank. If the policy form will offer coverage for Nursing Home only and alternative for both, then the two parts of the table should be completed.

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 this elimination period, it should choose the closest elimination period 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 reinforced in the instructions that follow, and in the spreadsheet footnotes.

**Confidentiality** –

The Assumptions Template is a way to provide a useful common source of information across jurisdictions and time periods to satisfy the requirement for a complete description of pricing assumptions. It contains information that a company may claim is exempt from public disclosure as a trade secret or otherwise. Any information in the Assumptions Template for which the company requests trade secret or other confidential treatment should be clearly marked and otherwise comply with a state’s rate filing laws, regulations, and other guidance. Determination of what constitutes a trade secret and how such information is treated are made under state law. If a company determines that it has concerns about supplying information requested in the template, it should discuss with the state whether other or more limited information would satisfy the state need for review.
The Assumptions Template consists of a Microsoft Excel workbook with 10 tabs, each of which is described below.

**Tab 1 (Product Description)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual or Group</td>
<td></td>
</tr>
<tr>
<td>Tax or Non-Tax Qualified</td>
<td></td>
</tr>
<tr>
<td>Elimination Period Options</td>
<td>0, 30, 60, 90, 100 days</td>
</tr>
<tr>
<td>Daily Benefit Amount Range</td>
<td>$50.00 - $400.00 ($10.00 increments)</td>
</tr>
<tr>
<td>Premium Payment Period</td>
<td>Ten-Pay; Paid-Up at 65; Lifetime Pay</td>
</tr>
<tr>
<td>Coverage Type</td>
<td>Comprehensive, Home Health Care, Nursing Home</td>
</tr>
<tr>
<td>Benefit Period Options</td>
<td>2, 3, 4, 5, 10 years and Unlimited</td>
</tr>
<tr>
<td>Inflation Protection Options</td>
<td>Future Purchase option, 5% Automatic Compound Inflation, 5% Automatic Simple Inflation</td>
</tr>
</tbody>
</table>

The company requests that some of this data be kept confidential to the extent possible under state law.

**Note:** The Product Description tab should be completed for initial rate filings and rate increase filings.

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 two years, three years, four years, five years, 10 years and lifetime.
- Inflation Protection Options – Enter all available inflation protection options, such as 5% compound inflation, 5% simple inflation, or future purchase option. Note that at the time of a rate increase, insurers may offer unique inflation percentages in order to allow the policyholder to maintain their premium level. All such values do not need to be shown, but the methodology should be available upon request.
- Enter the company contact person, phone number and email address, and indicate whether the filing is being submitted by a third party.
- If the company considers some of the material in the remaining Tabs to contain trade secret information, the box on this Tab 1 should be checked as an “alert” and the box on Tabs with trade secret information should be checked.
- The choices offered under description may not be exhaustive; please provide appropriate descriptions if any are not found in the provided sample.
Tab 2 (Assumptions)

### Actuarial Assumptions

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
<th>Description</th>
<th>Supporting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbidity</td>
<td>Company Experience Study, Industry Study</td>
<td>Name of Standard Table; Attained Age Claim Cost; Claim Cost Selection Factor; Claim Incidence; Claim Continuance; Salvage Factor; Other Morbidity Adjustment Factors</td>
<td>9 Attained Age Claim Cost 9 Claim Cost Selection Factor 9 Claim Incidence 9 Claim Continuance 9 Salvage Factor</td>
</tr>
<tr>
<td>Mortality</td>
<td>Company Experience Study, Industry Study</td>
<td>Name of Standard Table; Mortality Selection Factors; Actual Life Mortality; Disabled Life Mortality; Other Mortality Adjustment Factors</td>
<td>8 Mortality Selection Factors</td>
</tr>
<tr>
<td>Voluntary Lapse Rates</td>
<td>Company Experience Study, Industry Study</td>
<td>Voluntary Lapse Rates; Other Voluntary Lapse Adjustment Factors</td>
<td>9 Voluntary Lapse</td>
</tr>
<tr>
<td>Interest Rates</td>
<td>Company Experience Study, Industry Study</td>
<td>Valuation Interest Rate</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Company Experience Study, Industry Study</td>
<td>First and Renewal Year; Claim Administration, Premium Tax, and Commissions Expenses</td>
<td>10 Expenses</td>
</tr>
</tbody>
</table>

**Notes:**
- a) Enter best estimate assumptions, without margin.
- b) Provide any additional information below, if applicable.

### Additional Information

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 may be 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>Attained Age</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td></td>
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</tr>
<tr>
<td>80</td>
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</tr>
<tr>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- a) Enter the ultimate claim cost for each cell after all adjustments beyond selection period
- b) “Nursing Home” also includes 100% Assisted Living Facility
- c) If the company does not offer 100 day EP, enter the assumptions for the closest offered EP (e.g., if 100 day EP is not offered, enter the assumptions for 90 day EP).
- d) Attained Age Claim costs should be entered for initial rate filings, and state maximum filings.
- e) If the company does not have a nursing home only policy, it should not complete the top table.
- f) Provide any additional information below, if applicable.

The company requests that the information in this Tab be kept confidential to the extent possible under state law.

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). 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 filing.

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 (EP), 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

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

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Notes:
- a) Enter selection factors derived from underwriting wear-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.

☐ The company requests that the information in the Tab be kept confidential to the extent possible under state law.

Additional Information

- Enter selection factors separately for Nursing Home coverage (top table) and/or 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.
Tab 5 (Claim Incidence)

The claim incidence rates below are for the longest available benefit period, which is _ _ years. (Enter a number or "lifetime" in the box.)

### Claim Incidence 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>
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### Claim 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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<th>Gender</th>
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</tbody>
</table>

Notes:

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

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

c) If the company does not offer 100-day EP, enter assumptions for the closest EP offered (e.g. 90-day).

d) For initial rate filings enter the best estimate pricing assumptions. For subsequent filings enter current, best estimate assumptions.

e) If lifetime benefits are not offered, enter data for the longest benefit period offered.

f) Indicate any additional information below, if applicable.

- The company requests that the information in this Tab be kept confidential to the extent possible under state law.

Additional Information

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• 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 EP, enter the claim incidence assumption for the closest available EP (e.g., 90 day EP if available).
Tab 6 (Claim Continuance)

The claim continuance rates below are for the longest available benefit period, which is _____ years. (Enter a number or “lifetime” in the box.)

### 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 in Years</th>
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### Claim Continuance for Nursing Home Daily Benefit (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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</tbody>
</table>

Notes:
- a) Enter the claim continuance factors as a decimal indicating the fraction assumed to remain on claim at the end of each period.
- b) Use the underwriting/rating category which is the basis for the most prevalent of claim costs in Tab 3. Use the longest benefit period used in Tab 3.
- c) If the company does not offer 100-day EP, enter assumptions for the closest EP offered (e.g. 90-day).
- d) For initial rate filings enter the best estimate pricing assumptions. For subsequent filings enter current, best estimate assumptions.
- e) If lifetime benefits are not offered enter data for the longest benefit period offered.
- f) Indicate any additional information below, if applicable.

The company requests that the information in this Tab be kept confidential to the extent possible under state law.

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- 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 EP, enter the claim incidence assumption for the closest available EP (e.g., 90 day EP if available).
Tab 7 (Salvage Factor)

Salvage Factor for the Underwriting Class used in Tab 3

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<td>201-300</td>
<td>301-400</td>
<td>&gt;400</td>
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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/or 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)**

**Mortality Selection Factor for the Underwriting Class used in Tab 3**

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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.

☐ The company requests that the information in this tab be kept confidential to the extent possible under state law.

**Additional Information**

- Enter the mortality selection factor for each cell.
- Any mortality improvement should be described in the Additional Information box.
- 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:
- a) Voluntary Lapse factors should be entered for initial rate filings, and rate increase filings.
- b) For rate increases and annual reports, for closed blocks of business, provide the lapse assumption for all durations, even if all policies are no longer in early durations.
- c) Indicate any additional information below, if applicable.

Additional Information

The company requests that the information in this tab be kept confidential to the extent possible under state law.

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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) –

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#### Commission Schedule, as a % of Premium

- First-year Expense, as a % of Premium
- Renewal Expense, as a % of Premium
- Claim Administration Expense, as a % of Claims
- Premium Tax, as a % of Premium

**Note:** Indicate any additional information below, if applicable.

☐ The company requests that the information in this Tab be kept confidential to the extent possible under state law.

**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 7. SHOPPER’S GUIDE TO LONG–TERM CARE INSURANCE

Insert shopper’s guide here.
APPENDIX 8. 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 be otherwise 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 LTC 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 not be subject to termination 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.
APPENDIX 9. NAIC LONG TERM-CARE INSURANCE MODEL ACT