2017 Spring National Meeting  
Denver, Colorado

LONG-TERM CARE ACTUARIAL (B) WORKING GROUP  
Friday, April 7, 2017  
1:00 – 3:00 p.m.  
Hyatt Regency Denver—Centennial FGH Third Floor

ROLL CALL

Perry Kupferman, Chair California  
Steve Ostlund Alabama  
Paul Lombardo Connecticut  
Eric Johnson Florida  
Nicole Boyd Kansas  
Marti Hooper Maine  
Kristi Bohn Minnesota  
Rhonda Ahrens Nebraska  
Terry Seaton New Mexico  
William Carmello New York  
Laura Miller Ohio  
Frank Stone Oklahoma  
Johanna Fabian-Marks Pennsylvania  
Andrew Dvorine South Carolina  
Mike Boerner/Jan Graeber Texas  
Tomasz Serbinowski Utah

AGENDA

1:00 – 1:05 p.m.  1. Call to Order/Roll Call—Perry Kupferman (CA)

1:05 – 1:10 p.m.  2. Consider Adoption of its 2016 Fall National Meeting Minutes—Perry Kupferman (CA)

1:10 – 1:20 p.m.  3. Hear an Update from the American Academy of Actuaries (Academy) on Long-Term Care Insurance (LTCI) Working Group Activities—Academy

1:20 – 2:05 p.m.  4. Consider Adoption of the Report of the Long-Term Care Pricing (B) Subgroup—Jan Graeber (TX)

2:05 – 2:45 p.m.  5. Consider Adoption of the Report of the Long-Term Care Valuation (B) Subgroup—Perry Kupferman (CA)

2:45 – 2:55 p.m.  6. Hear an Update from the Society of Actuaries (SOA) on LTCI Research—SOA

2:55 – 3:00 p.m.  7. Discuss Any Other Matters Brought Before the Working Group—Perry Kupferman (CA)

8. Adjournment
1. **Adopted its Summer National Meeting Minutes**

Ms. Parker made a motion, seconded by Mr. Ostlund, to adopt the Working Group’s Aug. 25 minutes *(see NAIC Proceedings – Summer 2016, Health Actuarial (B) Task Force, Attachment Ten)*. The motion passed unanimously.

2. **Heard an Update on SOA Long-Term Care Section Activities**

Ms. Ahrens said the Society of Actuaries (SOA) Long-Term Care Section (Section) continues to invite her to act as a regulator liaison at its monthly meetings. She said the Section recently held a planning meeting to discuss activities for 2017. She said the Section continues to work on planning regulator-only webcasts for 2017. She said the Section is planning a public webinar for January 2017 to discuss the recently completed SOA long-term care (LTC) pricing study, which examines assumptions for morbidity, mortality, lapse rates and interest rates used in long-term care insurance (LTCI) pricing for each of 2000, 2007 and 2014. She said that regulators that wish to volunteer to assist the Section can contact her for more information.

3. **Adopted the Report of the Long-Term Care Pricing (B) Subgroup**

Ms. Graeber said the Subgroup has not met since the Summer National Meeting. She said some Subgroup members have participated in regulator-only calls to discuss specific company LTCI rate increase filings and how each state conducted its review of the filings. She said the Subgroup has a goal of developing an LTCI rate increase review process that is more uniform among the states. She said Mr. Andersen developed a set of recurring questions (Attachment Four-A) asked by regulators during their reviews of LTCI rate increase requests. She said open Subgroup conference calls will resume in early 2017, and the set of questions will be used to guide discussion.

Mr. Andersen said uniformity in LTCI rate increase reviews is important, as it will give regulators, insurers and policyholders a better sense of what they can expect concerning rate increases. He said the set of questions is based on his observations and the observations of other regulators, and is a list of eight items that show the most variability in LTCI rate increase reviews among states. He said the first issue he wants the Subgroup to address is how regulators evaluate morbidity assumptions used in rate increase requests. He said the vast majority of companies requesting rate increases are presenting morbidity assumptions based on studies of industry morbidity. He said there is a wide range in the way regulators and insurers are evaluating how these industry experience studies are evaluated and applied to an insurer’s own block of policies.

Mr. Andersen said there are issues concerning rate increases on small remaining blocks (SRB) of LTCI policies. He said that when a minimum loss ratio test is used for rate increase approval, extremely large rate increases are possible. He said he hopes that states can move towards greater uniformity on how rate increases for SRB are evaluated.

The Subgroup discussed the first of the eight questions: What should a company be required to provide to justify a rate increase based on a consultant’s new industry morbidity study? Mr. Andersen said he understands how a state insurance regulator might either deny any rate increase based solely on an industry morbidity study and how a regulator might approve the full requested rate increase that is based solely on an industry morbidity study, but he also understands the dangers of going to either of these extremes. He said if the entire requested rate increase in such a scenario is approved, but the industry study is not relevant to the insurer’s own experience, the increased rates can be excessive. He said denying any increase in rates in this scenario, but future experience develops that is in line with the industry study, can result in insufficient rates. He said his approach in such a scenario is to determine a balance between the two extremes. He said if an insurer can demonstrate that its experience parallels that in the industry study after the initial balanced rate increase is approved, he will consider approving a greater increase based on the new experience. Mr. Kupferman said if an insurer presents an industry
study as a morbidity basis for an LTCI rate increase, he requires the insurer to explain how the industry study is relevant to the insurer’s own experience. Ms. Ahrens said her experience is that most insurers used some form of industry-wide experience to initially price their LTCI products. She said she asks insurers why they need to use industry studies, and how the industry study data is similar to its own experience. She said newer industry studies can be appropriate, especially if the newer data is more credible than prior study data. Mr. Serbinowski suggested regulators could allow an industry study to be used with a specified reduction in the study morbidity and then provide for an additional future rate increase in the event the insurer’s experienced morbidity is approaching that shown by the study. Mr. Lombardo said Connecticut does not prohibit the use of industry studies for morbidity assumptions, but does give more credence to company-specific experience when reviewing a rate increase request.

Bill Weller (America’s Health Insurance Plans—AHIP) said regulators should ensure that regulations do not prohibit the use of updated morbidity studies, as they are more credible than the respective original morbidity studies. He also said they should ensure regulations do not prohibit the use of improvements to morbidity, such as those that will occur due to possible new Alzheimer’s disease drugs, that have not yet entered into morbidity study data.

Mr. Andersen suggested the Subgroup draft separate discussion papers for each of the eight questions using input from regulators and interested parties and that these papers can be discussed on future Subgroup conference calls. He made a motion, seconded by Ms. Graeber, to expose the eight questions for a 60-day public comment period. The motion passed unanimously.

Ms. Graeber made a motion, seconded by Mr. Ostlund, to adopt the report of the Long-Term Care Pricing (B) Subgroup. The motion passed unanimously.

4. **Adopted the Report of the Long-Term Care Valuation (B) Subgroup**

Mr. Kupferman said the Subgroup has not met since the Summer National Meeting. He presented a proposed draft actuarial guideline (Attachment Four-B) with requirements for performing stand-alone asset adequacy analyses of LTCI blocks, and presented a letter (Attachment Four-C) commenting on the proposal from the American Council of Life Insurers (ACLI) and AHIP.

Mr. Andersen said one reason for requiring stand-alone LTCI asset adequacy testing is that it will allow regulators to see how regulators in other states regulate their LTCI insurers. He said the current formula reserve standard is outdated and can result in overstated or understated reserves, and the proposed requirement will give guidance on how LTCI reserves are to be calculated, giving regulators a more transparent representation of an insurer’s reserve position. He said another reason is stand-alone testing will enable regulators to determine if a block of LTCI policies can be financially supported without reserve contributions from other insurance lines. He said some comments have been received on the draft stating that insurers are not comfortable with additional reserves possibly being required on LTCI blocks as a result of the stand-alone analysis, even if there are reserve deficiencies from other lines that offset the LTCI block’s shortfall. He said the Subgroup should consider aggregating LTCI with other lines in some instances. He said the Subgroup needs to discuss whether additional reserves will be required in the event the stand-alone asset adequacy analysis indicates the need for them. Mr. Lombardo said if additional reserves are required, insurers should not be required to fund the reserves solely through LTCI revenues, but should be allowed to transfer reserves from other product lines.

Mr. Kupferman said Nebraska, Iowa, New York, Pennsylvania and Wisconsin have the greatest number of domestic LTCI companies and that he hopes these states will participate in future discussions about the draft actuarial guideline. Ms. Ahrens said she discovered two property/casualty (P/C) insurers with significant blocks of LTCI and that she wants to ensure that all companies, not just life and health companies, will be subject to stand-alone LTCI asset adequacy analysis. She said it is possible that the stand-alone requirement may become part of the Health Reserves Guidance Manual.

Paul Graham (ACLI) said that asset adequacy analysis differs from reserve adequacy analysis and that asset adequacy analysis is best done on a broad, aggregated basis because assets are generally not purchased to back any particular product line. He said when specific product lines are examined, the focus should be on reserve adequacy. He said the ACLI and AHIP have reviewed existing reserve adequacy guidance and found it to be complete. He said the ACLI and AHIP comment letter includes draft language to be added to the Health Reserves Guidance Manual that will place all existing guidance in one place for reference. Mr. Weller said that there should be a materiality standard that would exempt LTCI blocks below a given size from the stand-alone requirement and that details of the exemption are given in the comment letter.
Mr. Kupferman directed NAIC staff to schedule a conference call to discuss issues identified with the actuarial guideline proposal.

Mr. Ostlund made a motion, seconded by Mr. Seaton, to adopt the report of the Long-Term Care Valuation (B) Subgroup. The motion passed unanimously.

5. **Heard an Update on SOA LTCI Research**

Dale Hall (SOA) said the SOA Section Long-Term Care Think Tank is a group that was formed approximately a year ago to discuss how consumers’ LTC needs are changing, and how LTC delivery systems and insurance products may need to evolve to meet these needs. He said the goal of the Think Tank is to implement some of the ideas it has generated. He said a research project that focuses on new ideas for LTCI products has recently been approved. He said the project has three components: 1) actuarial modeling of savings-based LTCI products; 2) survey of consumers’ attitudes towards such LTCI products; and 3) the tax implications of these products.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
Long-Term Care Pricing (B) Subgroup
Conference Call
February 15, 2017

The Long-Term Care Pricing (B) Subgroup of the of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Feb. 15, 2017. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Paul Lombardo (CT); Lisa Parker (FL); Marti Hooper (ME); Fred Andersen (MN); William Leung (MO); Terry Seaton (NM); Bob Potter (NC); Laura Miller (OH); Andrew Dvorine (SC); and Tomasz Serbinowski (UT).

1. Discussed Comments on Exposure of Discussion Topics

Ms. Graeber said the deadline to submit comments on the set of discussion questions (Attachment One) regarding long-term care insurance (LTCI) rate reviews is Feb. 21. She asked if interested regulators or interested parties need clarification on any of the questions.

Ms. Graeber said a conference call will be scheduled for March 2 to discuss comments received.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
Fred Andersen – Minnesota Department of Commerce

To assist in increasing the understanding of similarities and differences regarding aspects of states’ LTC rate increase review approaches, here are questions I compiled that could be distributed and discussed on future public LTC Pricing Subgroup calls. I tried to rank the questions such that those at the top of the list are most impactful (in terms of general effect on magnitude of rate increases and differences in how states currently handle these aspects). I recommend that the Subgroup discuss these questions in order.

1. What should a company be required to provide to justify a rate increase based on a consultant’s new industry morbidity study?

2. What approaches are appropriate for handling the “shrinking block” issue, i.e., to avoid astronomical rate increases to get back to original loss ratios when the block has significantly shrunk due to mortality, lapses, or claims? Are rules that cap increases effective in addressing this issue? What approaches are used when a company combines a shrunken block with a more established block into one rate increase request? What criteria should be used to defend similarities among forms that would allow or disallow combinations. Is it appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support?

3. Is it preferable for a rate increase to be approved in its entirety (e.g., 60% this year or pre-approved 20% per year for 3 years) or to be approved in stages (e.g., approve 30% now and review again next year for the other 30%)? If in stages, how should this approach be communicated with policyholders?

4. Should deficiencies associated with higher past claims (for those no longer paying premiums) be differentiated from deficiencies associated with past premiums (for those still paying premiums) being insufficient due to updated expectations on lapses, mortality, morbidity, and interest?

5. With LTC, many rate increase proposals are based on assumption changes that significantly increase projected loss ratios, even though yearly actual-to-expected ratios up to the current year based on historical experience may be favorable. How can states get comfortable with 40- or 50-year projections to justify a rate increase?

6. Should lower-than-expected investment returns factor into the justification for a rate increase?

7. What are appropriate approaches for handling waiver-of-premium provisions? For instance, for policyholders currently on waiver of premium, is it appropriate to include those premiums as earned premiums with equal offsetting incurred claims?

8. Is it appropriate to address a deficiency in the disabled-life reserve (associated with current claims) via a rate increase, or do you think the company should fund the additional disabled-life reserves in other ways, such as through company surplus?

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The Long-Term Care Pricing (B) Subgroup of the of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call March 2, 2017. The following Subgroup members participated: Jan Graeber, Chair (TX); Paul Lombardo (CT); Lisa Parker (FL); Fred Andersen (MN); William Leung (MO); Bob Potter (NC); Rhonda Ahrens (NE); David Sky (NH); Terry Seaton (NM); David Ball (OR); Andrew Dvorine (SC); and Tomasz Serbinowski (UT).

1. Discussed Comments on Exposure of Discussion Topics

Ms. Graeber said the Subgroup will discuss comments received (Attachment One) on the set of discussion questions regarding long-term care insurance (LTCI) rate increase reviews. She said the eight discussion questions are issues that insurance regulators have struggled with during rate increase reviews. She said if insurance regulators can reach consensus on the treatment of these issues, companies filing LTCI rate increases will be better able to address regulator concerns with the filings.

Ms. Graeber said discussion will begin with the first question: “What should a company be required to provide to justify a rate increase based on a consultant’s new industry morbidity study?” She said that in Texas, rate increase requests are not based solely on new morbidity studies, and that most companies are using their own company experience and not new consultant studies to justify a rate increase. She said to the extent a company’s own experience is not credible, Texas allows the use of industry morbidity studies adjusted for a company’s circumstances. Ms. Ahrens said even if actual-to-expected experience ratios are close to 1.00, part of the justification a company provides for using industry studies should be the ways in which company experience differs from that in the industry study. She said regulators are at a disadvantage when they do not have access to the complete industry morbidity study and need to verify the credibility of whatever portion of the complete study is used by a company to justify a rate increase. She said the use of peer review of industry morbidity studies may help regulators increase their confidence in the appropriateness of reliance on the studies for rate increase justification.

Mr. Serbinowski suggested that rate increases based on industry studies be phased-in over a given time period instead of implementing the full rate increase in year one, and regulators then can compare the actual morbidity to that projected using the industry studies. Mr. Andersen said Minnesota allows companies to request additional increases based on deteriorating morbidity experienced after the initial rate increase filing. Ms. Ahrens said Nebraska requires companies to implement the full rate increase with the initial filing and only allows additional increases if morbidity deteriorates beyond what was initially projected. She asked Mr. Andersen if Minnesota approves an initial rate increase that is less than the company requests, but allows for the balance of the increase to be implemented in the future if it can be shown that actual morbidity is in line with what the company initially projected. Mr. Andersen said this is correct.

Mr. Potter said when he compares actual company experience presented in a rate increase filing to expected industry study morbidity, he considers not knowing what portion of the range of industry study the company’s experience lies in to be a problem. He said the difficulty is more pronounced in post-rate stabilization blocks than in pre-rate stabilization blocks. Ms. Ahrens and Mr. Serbinowski said they examine both actual experience versus initial pricing assumptions and actual experience versus industry study experience. Mr. Andersen said his understanding is that companies, especially smaller ones, use industry morbidity studies as the basis for initial pricing. Ms. Ahrens said this is her understanding as well. She said that no one can ensure that the conditions that were present when the industry study was done—such as care delivery in nursing homes and in-home health settings, Alzheimer’s disease treatments, and life expectancy—will continue unchanged through the rate projection period. She said because these and other parameters can change over projection periods that may be as long as 60 years, regulators need to ask companies how such changes will affect their projections. She said that the length of the projection periods necessitates regulator monitoring of experience at least every five years to determine whether a rate increase was actually justified or still necessary. She said there is currently no regulatory requirement for companies to demonstrate that the projected deterioration of experience that precipitated a rate increase actually materialized.

Bill Weller (America’s Health Insurance Plans—AHIP) said regulators can compare a given company’s rate increase filing assumptions to assumptions from other companies’ filings to become more comfortable with the reasonableness of the given
Ms. Graeber said there seems to be consensus that regulators should compare actual experience to expected, require companies to explain how they adjusted an industry study to fit more closely to company experience, and monitor emerging company experience relative to projected experience as ways to justify a rate increase based on an industry study. Birny Birnbaum (Center for Economic Justice—CEJ) said that for regulators to determine if an industry study is an appropriate basis for justifying a rate increase, they must have an understanding of the data and methodologies used to develop the study. Mr. Kupferman said his perspective is that he does not question the industry studies, but he does question how a company applies the studies to its own blocks.

Ms. Graeber said the second question is: “What approaches are appropriate for handling the ‘shrinking block’ issue, i.e., to avoid astronomical rate increases to get back to original loss ratios when the block has significantly shrunk due to mortality, lapses or claims? Are rules that cap increases effective in addressing this issue? What approaches are used when a company combines a shrunken block with a more established block into one rate increase request? What criteria should be used to defend similarities among forms that would allow or disallow combinations? Is it appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support?” She said in Texas, regulators use a prospective, present-value approach and do not allow a company to use the 58%/85% loss ratio test to justify a maximum rate increase. She said companies are required to provide projections of premiums and claims associated only with policyholders that are still paying premiums, as this is the only source for additional revenue. She said the projections must not include figures for policyholders that are on claim and not paying premiums. Mr. Potter said he is concerned this approach requires premium-paying policyholders to fund past premium inadequacies. Ms. Graeber said this is not the case, as any shortfall in active life reserves has to be funded from company surplus, not increased premiums.

Mr. Andersen said Minnesota approaches rate increases for such blocks by calculating an “if you knew then” premium that is then adjusted to account for the percentage of original policyholders remaining from the initial block. Mr. Ball said Oregon uses a similar approach, but calculates the adjustment based on percentage of premium remaining. Rod Perkins (American Council of Life Insurers—ACLI) said a key element to this question is how to define “shrinking block” to determine which blocks will be subject to shrinking block rate increase review treatment. Mr. Serbinowski said he thinks the best approach is to use methods that inherently do not require that “shrinking block” be defined. Ms. Graeber said she agrees with Mr. Serbinowski and that the methods used in Texas apply to all blocks, regardless of size or duration in the block’s life cycle. Mr. Leung said Missouri does not allow rate increases to be approved or denied based on anything other than a loss ratio test. Mr. Andersen said states with similar regulations may not be able to use the approach that is used in Minnesota. He said the Subgroup should examine the variation in rules among the states in order to identify areas that can be made more uniform.

Ms. Graeber said the third question is: “Is it preferable for a rate increase to be approved in its entirety (e.g., 60% this year or pre-approved 20% per year for three years) or to be approved in stages (e.g., approve 30% now and review again next year for the other 30%)? If in stages, how should this approach be communicated with policyholders?” She said in Texas, the entire increase is approved, but a company has the option of phasing in the increase over a period of time. She said the company is required to communicate to policyholders the full increase amount, and the schedule for and amount of increases over the time period. Mr. Seaton said New Mexico allows phased-in rate increases but does not approve the entire increase at the outset. He said the company must file the subsequent rate increase requests for review. Mr. Leung said Missouri generally requires phase-in of rate increases greater than 25%, and requires policyholders to be notified of the schedule for and amount of increases.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
1. **What should a company be required to provide to justify a rate increase based on a consultant's new industry morbidity study?**

**ACLA/AHIP**

The new Guidance Manual provides detailed directions regarding morbidity assumptions. Regulators should be able to determine if a set of assumptions (e.g. a consultant’s morbidity table) is within reasonable bounds of what they are seeing as morbidity assumptions for new business or for in-force rate increases (after consideration of any appropriate adjustments). Companies should provide information supporting their use of a specific morbidity table, including a comparison of actual recent incurred claims with expected (applying the new morbidity table to in-force), where appropriate.

Bob Yee

(Note: The opinion expressed below are solely that of Robert Yee himself and not of his employer.)

It is an acceptable actuarial practice to combine sources of data for assumption setting for the purpose of projection of future experience. Credibility weighing and other blending techniques have been used to set assumptions. The SOA Inter-Company Experience is another source of data companies can use in addition to consultant’s data. As well there are other consultants that have data. What is emerging is that more data and expertise are available now than before. As blocks of business age, experience begins to stabilize and data credibility increases.

The company should be able to demonstrate that the consultant’s specific dataset is appropriate, proper weighing technique has been used and the overall resulting assumption is reasonable compared to the company’s own credible experience. The companies and the regulators should be able to agree on assumptions where the combined data is credible. Where actuarial judgement is needed, peer review should be a regular request by the regulators. Some templates to facilitate the agreements between the companies and the regulators may be helpful.

**California**

Prior to adopting a new industry morbidity study there should be a thorough comparison of; policy coverage, underwriting and claims practice differences. A certified actuary should opine on such as; gender mix, impact and mix of marital status, discounts, target markets, issue age distribution, marketing differences, underwriting standards and adherence by underwriters, declination rate, mix by maximum benefit duration and elimination period, type of coverage, claim practices, and use of second medical opinion.

**Colorado**

Carriers should demonstrate that their populations in plans being rated are similar to the underlying study populations, provide proof that the new morbidity table is reflective of the block of business.

One method to check this is Actual / Expected analysis showing that updated assumptions match experience on this block. Carriers need to provide details for how claim severity and duration were developed, all assumptions as to how the Expected value in their A/E calculations were developed.
The Division is not likely to give 100% credibility to a new consultant morbidity study – with lack of credibility evidenced by how often carriers have changed morbidity assumptions and how volatile they are. We have not settled on a final number for applying a credibility % to a consultant’s morbidity study, though only recognizing a portion of the change from the prior morbidity assumptions could be a valid approach.

**Connecticut**
A carrier should still be required to submit their nationwide and state specific experience as well as a detailed explanation of why they believe the consultant’s new industry morbidity study properly reflects the carrier’s current and prospective experience.

**Louisiana**
The company should show how their own company experience maps to the industry morbidity study.

**Texas**
A valid morbidity study is appropriate to justify a rate increase if the company adjusts rates based on a prospective premium shortfall, and the company can demonstrate that the study is appropriate for the block of business.

For a change in the morbidity, or any other assumption, we apply a prospective present value formula. Under this approach, active, premium paying policyholders, based on current assumptions, pay the appropriate premium going forward to fund a prospective deficiency, and not a premium that recoups the past losses of policyholders who no longer pay premium.

We believe the prospective present value approach, along with frequent monitoring of experience, is the best method to produce a stable product long-term.

**Virginia**
The company should present evidence that the characteristics of their block of business are similar to the block underlying the new industry study (demographics, underwriting, marketing, etc.).

**Center for Economic Justice**
What is the role of the profit provision in the proposed rates? What risks are borne by investors? What risks are borne by policyholders? Which of these groups should be responsible for the insurers’ errors in various pricing assumptions regarding lapses/persistency, investment income or mortality?

2. **What approaches are appropriate for handling the "shrinking block" issue, i.e., to avoid astronomical rate increases to get back to original loss ratios when the block has significantly shrunk due to mortality, lapses, or claims? Are rules that cap increases effective in addressing this issue? What approaches are used when a company combines a shrunken block with a more established block into one rate increase request? What criteria should be used to defend similarities among forms that would allow or disallow combinations? Is it appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support?**

**ACLA/AHIP**
The issues detailed above should not be considered independently. We acknowledge the complexity of these issues as they relate to closed blocks. An initial issue for all is to develop a common definition of shrinking or small closed block. The industry is in the process of considering potential approaches to these issues and will continue to work with regulators to develop solutions.

**Bob Yee**

Under the rate filing regulations, companies are free to request rate adjustments at their discretion. The current loss ratio requirement allows companies to ask for very large rate increases. Shrinking blocks are especially susceptible when necessary rate corrections are not granted and the deficits are accumulating. This is an artifact of inappropriate actions from both the companies and the regulators. Companies should be required to periodically report experience to the regulators, every form should be reviewed and its experience development is transparent to everyone. With proper and timely rate adjustments, the shrinking block issue can be mitigated or eliminated.

**California**

California requires companies to combine experience but with adjustment for policy form differences. California prefers insurers request less than result of a strict application of mathematically derived 60/70 loss ratio rule and the 58/85 Rate Stabilization rule because of the tenuous impact on the results of making long claims forecast. We expect subsequent rate filings will be submitted with higher credibility and the initial rate increase effects developing premium and claim experience.

**Colorado**

(a) Colorado reviews measures such as:

1. Remaining % of premium to be collected in the future versus lifetime premium;
2. The % impact to the LT LR from each % of rate increase;
3. The average attained age of policyholders.

A LTC block of business with an average attained age of 80 years old or greater, with only have 5% to 10% of premium outstanding, and with little ability to impact the LT LR may often not be allowed additional rate increases. We have not developed a hard and fast rule for how this is applied, but we are considering criteria around these measures for when to deny or limit a rate increase.

Colorado does not apply any rate caps directly, though as indicated above may limit rate increases based on the specific situation in the case of small remaining blocks with high attained ages. Otherwise we attempt to develop the theoretical needed rate increase after all adjustments we require are applied.

Colorado now requests all carriers to provide the “If-Known” premium analysis, and determines how much higher the original premiums would needed to have been if known assumptions as of today had been implemented at policy origin. This is essentially adjusted against the total rate increase currently requested. Colorado regulations, and Division guidelines, also request carriers to provide a simpler “On-Rate-level” premium analysis which similarly requires carriers to input all historic rate increases back to original sales date so that the current premium is reflected in the LT LR calculation.

The primary question with such analysis is how much of prior losses should the carrier assume liability for, and how much should be allowed to be implemented on policyholders. As one measure, Colorado utilizes a tool from another state which assigns 60% responsibility to the carrier, 40% to policyholders.
However Colorado does not yet have a hard rule, would be inclined to assign 50% to 100% to the carrier depending on the circumstances.

(b) A shrunken block generally should not be allowed to be rated with an established block, would not be desirable. The company should separate out the very different blocks of business so they can be evaluated on each of their merits individually.

(c) No. The 58/85 is a minimum test to meet. Also, it is only a somewhat useful test if it is without margins; with margins it seems to be a case of setting margins to a level which supports the rate increase.

**Connecticut**
Combining similar policy forms if available; combining all policy forms issued in the specific state. We don’t believe it is appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support.

**Louisiana**
It is also our opinion that eventually a company should have to live with their inadequate initial pricing. We are currently closing an existing block to any additional rate increases once the number of remaining lives in our state drops below 30.

We allow closed block combinations provided the blocks share the same approximate issue era. We have in the past instructed companies to separate out the blocks they have combined in a filing. We have also encouraged discussions with the filing actuaries as to how to combine their various business blocks prior to submitting their filing.

**Texas**
We believe that the prospective present value approach described in question # 1 is an appropriate method to calculate the justified rate increase, regardless of the size of the block of business.

We see the 58/85 as a means to show that a rate increase is needed, not as the maximum allowable rate increase.

**Virginia**
Many companies today are requesting rate increases below (sometimes far below) what can be actuarially supported. Artificially imposed rate caps are not entirely successful in addressing this issue unless there is a material change in experience/projections. Shrinking block issues are generally handled on a case-by-case basis with several methods to analyze whether a company is attempting to recoup past losses with an increase. These include: projecting the proposed premium scale from inception of the policies; comparing the present value of future loss under current assumptions with the same measure under all original assumptions for the policies inforce at the projection date.

**Center for Economic Justice**
What is the appropriate goal of the rate increase -- to restore the profitability of the book of business to the original profit target? To some portion of the profit target? To zero profit? To less-than-zero profit, but solvency? To some other standard?
3. Is it preferable for a rate increase to be approved in its entirety (e.g., 60% this year or pre-approved 20% per year for 3 years) or to be approved in stages (e.g., approve 30% now and review again next year for the other 30%)? If in stages, how should this approach be communicated with policyholders?

ACLA/AHIP
The NAIC Long-Term Care Insurance Model Regulation and Model Bulletin provide for “provisional approval” of a series of increases that are actuarially equivalent with the timing and amount of each increase being established at the time of approval. This allows for improved disclosure of the full series of increases so that policyholder can make more informed decisions. We believe only approved future increases should be required to be disclosed; disclosing more than approved increases would be at the option of the company. We recommend assessing whether this approach works over the next several years.

Bob Yee
It is a deceptive practice to grant a smaller rate increase without letting policyholders know the total ultimate increase. Policyholders purchased insurance to protect an unknown event in exchange for known premiums. They have a right to know the degree of premium deficiency so that they can react to it. We need to do a better job in determining the appropriate amount of rate increase, load it with a margin and have the companies guaranteed the premiums for a time period. Otherwise, the policies have little value to the policyholders since they do not know their costs. LTC experience is much better known than before. There is currently sufficient expertise and knowledge to set proper assumptions. Companies should be able to demonstrate the level of needed rate increase and the regulators should be able to agree within a reasonable range.

California
California approves rate increases in stages. The Department must approve the letter to policyholders to ensure a complete understanding by policyholders of estimated future company rate increases, that the increase is based on evolving experience, and has been approved by the Department. The Department prefers experience be re-filed for each increase as credibility develops.

Colorado
Colorado attempts to identify the full amount of rate increases that we believe would be allowed by the state, which may be less than the carrier had proposed. Our internal guidelines are that the rate increases subsequently implemented in any one year should not exceed 15%, so larger pre-approved increases need to be phased in over multiple years.

Carriers must provide policyholder letters in which they demonstrate that they are correctly and transparently indicating to policyholders all current and future needed increases. Typically now Colorado will request the inclusion of a statement that the carrier will not be allowed to come back for any additional rate increases unless future LT LR experience or projections show a significant further deterioration (such as 15% worse or more).

Connecticut
Prefer steady approach to approving rate increases with annual filings submitted to support future rate increases that were not allowed in previous rate filings. The policyholder should be notified of the approved rate increase and any future rate increase that the carrier anticipates submitting for review the following year.

**Louisiana**

Our commissioner currently restricts any approved rate increase to a one-time only basis with an option to file an independent rate increase with actuarial justification in subsequent years.

**Texas**

From a solvency standpoint, we believe it is better to implement the full needed increase as quickly as possible. However, absent solvency concerns, frequent small adjustments to address emerging experience is probably preferable to policyholders.

We have approved phased-in rate increases. Under a phased-in approach, we require the company to fully disclose all increases of the phase-in to the policyholder, and to use the full approved rate increase to determine eligibility for contingent nonforfeiture upon lapse.

**Virginia**

Given the two options it is usually preferable to spread out rate increases over multiple years; unless there is a material change in experience/projections, staged rate increases can be helpful for insureds to budget. Such rate increases should be clearly and understandably communicated to policyholders, and such communication should be reviewed by the Insurance Dept. (preferably for approval). Regarding the up-front approval of multiple increases versus requirement of multiple filings, the Bureau has traditionally approved multiple staged increases at once when the entire increase appears to be justified.

**Center for Economic Justice**

What is the history of the book of business for which the rate increase is sought? Has the insurer created its own death spiral by offering and moving some original policyholders in the book of business other products? If so, should the original and alternative product blocks of business be combined for ratemaking purposes?

4. **Should deficiencies associated with higher past claims (for those no longer paying premiums) be differentiated from deficiencies associated with past premiums (for those still paying premiums) being insufficient due to updated expectations on lapses, mortality, morbidity, and interest?**

**ACLA/AHIP**

We understand this question to differentiate between block-of-business losses that have already occurred (“past losses”) and those that are expected to occur based on revised assumptions. We believe that there would be significant complexity in attempting to determine if any portion (of claims incurred in the many years prior the date of a rate filing) is to be excluded from the block’s experience and lifetime loss ratio. One measure of losses to be excluded from the lifetime loss ratio calculation applies to new policies subject to Section 20.1 C (2) and (3) – i.e. incurred claims that exceed the projected claims under filed pricing or repricing assumptions (including margins in the claims assumptions). This approach is likely impossible to administer to older, closed blocks. We believe that the vast majority of rate increase requests are moderated such that recovery of past losses is not considered.
Bob Yee
At the time of issue, the loss ratio requirement is the underlying contractual agreement between the companies and the policyholders (with regulators acting as their representatives). Regulators approved the initial rate filings. This is no different than in other lines of accidental and health insurance business. Arguably, this agreement should be upheld through the term of the policy. It turns out that this loss ratio requirement is not workable and its application results in very large rate increases for LTC. To resolve the rate increase dilemma, only policyholders’ and companies’ future well-being should be considered (current reserve adequacy notwithstanding).

The appropriate level of rate increase should be based on agreement on the assumptions for projection, insurance companies’ future financial results and margins for adverse deviation. This approach essentially revise the original agreement and delineate the current policyholders’ and companies’ shares of the contractual obligations. Projected loss ratio becomes a metric rather than the determinant of the rate increase. It should be recognized that the companies’ future financial result factor may vary between open and closed book of business.

California
Few, if any, rate filings have indicated past LTC claims were higher than expected. Nearly all rate increase requests were based on lapse and mortality being much lower than in the initial pricing.

Colorado
Yes, ideally they should be identified and differentiated in the analysis. See item #11 in the Colorado LTC Rate Filing Template attached.

There are 2 groups of policyholders no longer paying premium. There are policyholders on limited premium paying policies which will never pay any more premiums on their policy. There are also active claims on Waiver of Premium, where premiums do not have to be paid while on claim which means no premium in the near future and potentially no premium anymore on active claim policies.

Policies with limited premium paying policies where the premium payment period should not be part of the rate increase analysis. These policies and their active and potentially active future claims should be ignored in the analysis. On the other hand, policies which have remaining premium scheduled to be paid should be included in the analysis whether the policies are on active claim or not.

Connecticut
No

Louisiana
The experience of the entire block should be part of a rate increase study since the entire block was part of the original pricing experience expectation.

Texas
Texas sees both of these as past losses. Past losses are insurance risks, and thus sunk costs that the company should not recoup. Companies must find some other way, such as through capital and surplus, to fund the deficiency.

Virginia
Generally speaking, yes, though the Bureau has not previously required this differentiation. Anything that can assist in explaining the sources of required increases is preferred.

Center for Economic Justice
What tools exist for regulators to evaluate the policyholders' response to the large rate increase in order to evaluate the results of the rate increase? How should regulators consider policyholder responses to large rate increases in terms of an actuarial evaluation of the results/impacts of the rate increase? For example, will the rate increase be so great that assumptions about lapses/persistency or the number of policyholder's opting for reduced benefits should be changed?

5. With LTC, many rate increase proposals are based on assumption changes that significantly increase projected loss ratios, even though yearly actual-to-expected ratios up to the current year based on historical experience may be favorable. How can states get comfortable with 40- or 50-year projections to justify a rate increase?

ACLA/AHIP
The new Guidance Manual is intended to provide guidance to regulators regarding what constitutes a reasonable range of assumptions across the industry. With respect to long-term projections, regulators should be able to compare assumptions in rate increase filings to those used for reserve adequacy. Per the Model Regulation, loss ratios below anticipated may allow a state to require reduced rates or increased benefits.

Bob Yee
All projections involve an element of doubt and a level of comfort. LTC experience is much better known than before. There are more data on later durational and older age experience. The LTC insurance knowledge base is growing. What remain unknown are future trends. However, many of the intangibles tend to be favorable even though they cannot be quantified. To be comfortable with the projections, regulators should require more detailed demonstration of experience analysis and assumption setting process from the companies. Independent peer reviews should also accompany every rate filing. Finally, an acceptable method of refunding experience gain should be proposed. Since LTC has a very long time horizon, refunds should go to every policyholder who is affected by the rate increase that generates any future gains.

California
Projections over very long periods of time should; include adequate margin for uncertainty and adverse development in claims experience and legal decisions, be sensitivity tested, use appropriate discount rates, assume conservative investment and reinvestment rates, and assume continuing mortality improvement in the future.
**Colorado**
Colorado requires detailed LT LR spreadsheet calculations be provided, with additional support of claim projections, and a number of adjustments and split outs in order to become “comfortable” with a proposed rate increase. The LTC rate Filing Template attached includes additional support that we require at a minimum for an actuarial review, beyond our basic rate filing regulation requirements. This includes becoming comfortable that the assumptions used the projection are correct for this block of business, checking that the Actual to Projected experience for the main assumptions (morbidity, voluntary lapse, mortality) are similar. In our LT LR spreadsheet analysis we verify that the transition from recent year premiums and claims amounts to the first few projected years premiums and claims amounts looks smooth, verify that the incurred claims have not been loaded with unreasonable IBNR amounts in the last couple of years of experience to attempt to justify a higher rate increase.

**Connecticut**
Not sure it’s possible since the carriers themselves are having significant difficulty with accurate projections, especially towards the tail of those projections.

**Louisiana**
It is my opinion that a LTC reviewing actuary should give less credence to long projection period. What may work is to model the filing and test various cut off points in the projection period.

Also, the company should show how well the actual experience from a new proposed increase matches that projected from the last approved increase.

**Texas**
Need frequent monitoring of actual to expected. If historical AE is less than 1.0, an interesting question would be what the company is doing with the surplus. Is the company creating a future deficiency by releasing the surplus to profit?

**Virginia**
Acknowledging that this is one of the many challenging aspects of rate review, states should review any and all data/assumptions used to justify a rate increase. One suggestion is to “stress test” the point-estimate assumptions by modelling the projections using a range of reasonable assumptions to determine if the rate increase is justifiable. Ultimately, this is the catch-22 of this product line – if we wait until the past experience bears out the deficiency in premium rates before approving a rate increase, it is too late for the rate increase to be effective and the company will experience large losses. If, however, the future estimate turns out to be too conservative, the company will eventually experience large windfalls.

**Center for Economic Justice**
How does a regulator navigate a situation in which the size of the rate increase will be so great to force most policyholders to surrender their policies, but without the rate increase the insurer’s solvency may be threatened? What lessons have regulators taken from the Penn Treaty saga? At what point does is a rate increase unreasonable regardless of the actuarial indication either because of the impact on consumers (i.e., force surrenders due to unaffordability of premiums or force consumers to choose reduced benefits) or because of historical errors by the insurer? What is the role of the guaranty fund system in this type of
situation? When does the rate increase request become a public policy issue for the Commissioner instead of simply a technical review of a rate filing?

6. Should lower-than-expected investment returns factor into the justification for a rate increase?

ACLA/AHIP
Per the NAIC Long-Term Care Insurance Model Regulation and Model Bulletin, actual investment returns would have no bearing on rate increases. We recommend all states uniformly apply the rule regarding the maximum statutory valuation interest rate.

Bob Yee
It is difficult to justify investment return experience as a reason for rate increases. Policyholders have no involvement or little influence on a company’s investment practices as well as the general investment environment. Excess investment returns are not shared by the policyholders.

For all policies issued after rate stability regulation and many prior to the regulation, the discount rate is the statutory valuation interest rate. Thus investment return has no impact on the loss ratio formula. For the other policies, the higher interest assumption enabled the companies to offer the policies at a relatively lower premiums. Unlike adverse claim experience where the policyholders as a group benefited, policyholders should not have to pay for the result of aggressive investment assumption where they are not the beneficiaries.

For these reasons, the companies should not be allowed to use a lower discount rate for the loss ratio calculation.

California
No. Consumers assume insurers have investment expertise. This is one of the major reasons long term insurances and annuities are purchased. Passing investment risk back to the policyholders should have been disclosed prior to sale and would likely have resulted in more self-insurance of the long term care risk by consumers.

Colorado
Colorado requires that a LT LR calculation be provided based on actual historical investment interest rates being applied. Colorado regulations allow us to investigate scenarios of investment interest rates. This is necessary given the typically large amount of premium and small amount of claims in the historic period. Directing issuers to apply actual historic rates more correctly accumulates premium and claims at appropriate rates usually demonstrating that the LT LR are much smaller than what carriers are attempting to base proposed rate increases on. Colorado requests scenarios with future period rates that are more realistic than the current valuation interest rate, though the Division is open to carriers proposing a realistic set of rates to evaluate.

Connecticut
Yes
Louisiana
In my view, a lower than expected investment return could factor into a rate increase justification. However, for recently developed products one would have to question why the initial assumption was not adequate to begin with given that investment returns have been low for some time.

Texas
Under the prospective present value formula, lower-than-expected investment returns are not factored into the calculation.

Virginia
Due to the long tail nature of LTCI, an argument could be made that actual and expected investment returns should play a part in justifying a rate increase. However, since most calculations are based on the valuation interest rate which is fixed at issue, this factor is largely ignored.

Center for Economic Justice
If a large rate increase is approved and such rate increase is phased in over several years, what principles should guide this phase-in? Are consumers served by phasing in, say, a 50% rate increase over 3 years instead of a single 50% rate increase? What type of disclosure to policyholders should be required with a phase-in rate increase?

7. What are appropriate approaches for handling waiver-of-premium provisions? For instance, for policyholders currently on waiver of premium, is it appropriate to include those premiums as earned premiums with equal offsetting incurred claims?

ACLA/AHIP
Currently, company practices vary regarding waiver-of-premium. The approach mentioned in the question would be one acceptable approach, but other approaches could also be acceptable for rate increase filings, and thus HATF should not mandate only one approach for rate increase filings.

Bob Yee
For rate filing purposes, projections of premiums and benefits should only focus on active lives. Presumably, the disabled life reserve is adequate to fund future claim liabilities on current claimants. In most instances, current claimants have a very negligible effect on future benefits and premiums since few recover and claim again. Current claimants’ financial impact should be ignored.

In a ‘total lives’ projection model, it is appropriate to included waived premiums as earned premiums with an offset to incurred claims. In a ‘first principle’ projection model, only cash flows are considered. Thus, there are no premiums from claimants.

California
Waiver of premium is not a material consideration in LTC pricing adequacy so should WP not be included in premium or claims when determining if a LTC rate increase is needed.
**Colorado**
WOP should be removed from premiums, would NOT include those premiums as earned premiums with equal offsetting incurred claims.

**Connecticut**
No

**Louisiana**
In my opinion, WOP should be part of both incurred claims and earned premium.

**Texas**
The prospective present value approach only includes active, premium paying policyholders, so the formula excludes policyholders on waiver of premium.

**Virginia**
We generally prefer that WOP be deducted from premium rather than added to claims experience and/or projections since the loss ratios would be greater than 100% for those folks which may serve to generate a higher rate increase than excluding them entirely. However, as noted before, companies rarely request the maximum increase that can be justified, so this change would rarely impact the approvability of a request on its own.

8. Is it appropriate to address a deficiency in the disabled-life reserve (associated with current claims) via a rate increase, or do you think the company should fund the additional disabled-life reserve in other ways, such as through company surplus?

**ACLA/AHIP**
The most recent disabled life reserve should be used to determine historic incurred claims, just like any paid claim would impact historic incurred claims.

**Bob Yee**
Reserve adequacy, whether it is contract reserve or disabled life reserve, should not be a part of policyholders’ obligations in the revised view of the insurance contracts as described above. Policyholders have no influence on the adequacy of the reserves. Thus, reserves should not be part of the rate increase determination.

**California**
Correction of any claim reserve deficiency is part of updating claims incurred. It should be part of any rate increase justification as an adverse development from initial pricing assumptions.

**Colorado**
Carriers should indicate changes in assumptions from the prior rate filing to the new rate filing in their DLR development, any impact of the changes in the DLR on the LT LR calculation should be documented. Colorado often obtains incurred claims for each historic period split out into:
Actual paid on incurred claims;
(2) estimated Disabled Life reserve claims;
(3) estimated IBNR claims.
Carriers should be able to verify the method used for estimating the DLR and IBNR claims, changes in assumptions. We have not adopted a policy to disallow impacts from changes in DLRs.

Connecticut
Combination of rate increases and surplus, as necessary

Louisiana
A disabled life reserve that is part of the expected claim payments should use best estimate techniques. This then makes it part of incurred claims. It should be released when no longer needed thereby reducing incurred claims. It is our belief that the company should use surplus for any associated reserve deficiency.

Guaranteed renewability does not mean guaranteed profitability.

Texas
We believe the company should fund through company surplus. See response to question #4.

Virginia
Any deficiency in the DLR is inherently included in the justification for a rate increase through the inclusion of claim reserves, presumably based on current assumptions, in the past incurred claims. As such, it would be difficult to exclude this effect.

Additional Questions

9. (Virginia) Is it appropriate to allow a rate increase based on a different mix of business distribution of issued policies than originally priced for? As a simple example, if half of the pricing cells had a expected loss ratio of 40% and half 80% for an average of 60%, should a rate increase be approved if all policies actually sold had an expected 80% loss ratio?

California
A change in mix from initial assumptions should amend the original base pricing target (i.e. raise the 58 in the 58/85) rather than represent a justification for a rate increase.

Colorado
Yes, depending on what pricing cells are being referred to. In Colorado carriers cannot use gender rating, so estimating the mix of males and females is important, both cells may not be originally priced to the 60% target since their rates may be equal. If actual experience deviates from the original assumed mix then the carrier would definitely be allowed to reflect the actual mix at time of re-rating.

Texas
We would not consider a mix of business that is different from the mix assumed at pricing to be valid reason for a rate increase.
10. (New Hampshire) To what extent should remaining policyholders be expected to bear the burden of mispricing? How should the burden of mispricing be parsed between remaining policyholders and the company?

Colorado
Colorado now requests all carriers to provide the “If-Known” premium analysis, and determines how much higher the original premiums would have been if known assumptions as of today had been implemented at policy origin. This is essentially adjusted against the total rate increase currently requested. Colorado regulations, and Division guidelines, also request carriers to provide a simpler “On-Rate-level” premium analysis which similarly requires carriers to input all historic rate increases back to original sales date so that the current premium is reflected in the LT LR calculation.

The primary question with such analysis is how much of prior losses and mispricing should the carrier assume liability for, and how much should be allowed to be implemented on policyholders. As one measure, Colorado utilizes a tool from another state which assigns 60% responsibility to the carrier, 40% to policyholders. However Colorado does not yet have a hard rule, would be inclined to assign 50% to 100% responsibility for original mispricing to the carrier depending on the circumstances.

11. (New Hampshire) What considerations, if any, should be given to pricing requests from reinsurance companies or TPAs... entities that have assumed some ‘risk/reward’ in seeking out premium increases?

Colorado
We seek to understand the reinsurance arrangements at work in a rate filing. If the carrier submitting the rate filing reinsures the block to a reinsurer, and the reinsurer is at solvency risk, we consider the impact it may have on the carrier if the reinsurer went insolvent.

12. (New Hampshire) Should review standards and/or considerations change among companies that are actively selling, SEBO, under supervision or in liquidation?

Colorado
We now typically approach the domiciled state and request to be provided with the IPS of each company writing LTC business in Colorado. We attempt to understand the company’s financial condition, estimate the impact to our Guaranty Fund if the carrier becomes insolvent. We do consider this as part of the analysis for allowing rate increases, the commissioner in Colorado has broad authority to consider such factors.

If the company is actively selling, we need to ensure that the company is not selling new policies with premiums below rate increase requests for the same level of benefits.

13. (New Hampshire) Is there a point when it's actually more beneficial for remaining policyholders to have the company go into liquidation versus allowing further rate increases to be passed through to policyholders? If so, how should this point be evaluated by regulators?

Colorado
Probably yes, we don’t have a fixed rule or measure when this should occur.
The Long-Term Care Pricing (B) Subgroup of the of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call March 9, 2017. The following Subgroup members participated: Jan Graeber, Chair (TX); Perry Kupferman (CA); Paul Lombardo (CT); Eric Johnson (FL); Marti Hooper (ME); Fred Andersen (MN); William Leung (MO); Rhonda Ahrens (NE); Terry Seaton (NM); Bob Potter (NC); Andrew Dvorine (SC); and Tomasz Serbinowski (UT).

1. **Discussed Comments on Exposure of Discussion Topics**

Ms. Graeber said the Subgroup will continue discussion from its March 2 conference call of comments received (Attachment One) on the set of discussion questions regarding long-term care insurance (LTCI) rate increase reviews. She said the discussion will resume with the fourth question, “Should deficiencies associated with higher past claims (for those no longer paying premiums) be differentiated from deficiencies associated with past premiums (for those still paying premiums) being insufficient due to updated expectations on lapses, mortality, morbidity, and interest?” She said Texas does not differentiate between the two, as both are considered to be past losses, and are not allowed to be recouped with rate increases. She said most of those who commented on this question have the same view concerning past claims and premiums. She said of those who disagreed, most are using a lifetime loss ratio approach to determine if a rate increase is justified. Ms. Ahrens said there are many different ways to examine past losses, and perhaps question number four can be subdivided into multiple questions. Mr. Andersen said more insight into how states treat past losses can be gained by asking how a situation where, in a given period, there have been no claims and lapses are lower than initially priced for is to be treated in a rate increase review. Mr. Serbinowski said he is not certain how this question is to be answered.

Ms. Graeber said question five is “With LTC, many rate increase proposals are based on assumption changes that significantly increase projected loss ratios, even though yearly actual-to-expected ratios up to the current year based on historical experience may be favorable. How can states get comfortable with 40- or 50-year projections to justify a rate increase?” She said Texas now asks companies to provide projections with assumptions in the aggregate, along with projections that show results with only changes in one assumption for each assumption used in the aggregate projection. She asked Mr. Andersen to describe how Minnesota does independent assumption testing using sample cells. Mr. Andersen said the future premiums and claims presented in a rate increase filing he reviewed did not correspond to the premiums and claims he expected to develop from the assumptions stated in the filing. He said upon further inspection, it was found the company had a substantial number of polices with waiver of premium upon spousal death riders, which explained the discrepancies. He said when reviewing a rate increase filing, he develops a spreadsheet with the original and revised pricing assumptions, and performs sample calculations at levels of detail finer than fully aggregated, and this aids in understanding how the revised assumptions yield the requested rate increase projection. Mr. Lombardo asked if any regulators have considered requiring companies to file sensitivity analyses for all of their pricing assumptions when requesting a rate increase. He said this could increase regulators’ levels of comfort with long-term projections. Mr. Andersen said this will be considered by the Subgroup.

Ms. Graeber said question six is “Should lower-than-expected investment returns factor into the justification for a rate increase?” She said the consensus of comments received is that deficient investment returns should not be an allowable justification for a rate increase. Mr. Lombardo said he does not want the inability of a company to receive a rate increase due to mispricing investment returns result in company insolvency.

Ms. Graeber said question seven is “What are appropriate approaches for handling waiver-of-premium provisions? For instance, for policyholders currently on waiver of premium, is it appropriate to include those premiums as earned premiums with equal offsetting incurred claims?” She said allowing inclusion of these premiums with offsetting claims can result in an increased loss ratio, which may give inappropriate support for a rate increase. Mr. Serbinowski said he has seen instances where different methods of waiver of premium inclusion can result in substantially different projection outcomes. Mr. Potter said waiver-of-premium elements should be treated consistently between pricing and projections.

Ms. Graeber said question eight is “Is it appropriate to address a deficiency in the disabled-life reserve (associated with current claims) via a rate increase, or do you think the company should fund the additional disabled-life reserves in other ways, such as through company surplus?” She said companies should be able to demonstrate the disabled life reserve (DLR)
deficiency for each of its LTCI blocks, and can offset deficiencies with excess DLR from other blocks or from company surplus. She said the DLR for a deficient block should not be strengthened with proceeds from a rate increase.

Ms. Graeber said the Subgroup will summarize its discussions from its March 9 and March 2 conference calls, and will use the summary as a starting point for future Subgroup discussions.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
1. What should a company be required to provide to justify a rate increase based on a consultant's new industry morbidity study?

ACLI/AHIP
The new Guidance Manual provides detailed directions regarding morbidity assumptions. Regulators should be able to determine if a set of assumptions (e.g. a consultant’s morbidity table) is within reasonable bounds of what they are seeing as morbidity assumptions for new business or for in-force rate increases (after consideration of any appropriate adjustments). Companies should provide information supporting their use of a specific morbidity table, including a comparison of actual recent incurred claims with expected (applying the new morbidity table to in-force), where appropriate.

Bob Yee
(Note: The opinion expressed below are solely that of Robert Yee himself and not of his employer.)

It is an acceptable actuarial practice to combine sources of data for assumption setting for the purpose of projection of future experience. Credibility weighing and other blending techniques have been used to set assumptions. The SOA Inter-Company Experience is another source of data companies can use in addition to consultant’s data. As well there are other consultants that have data. What is emerging is that more data and expertise are available now than before. As blocks of business age, experience begins to stabilize and data credibility increases.

The company should be able to demonstrate that the consultant’s specific dataset is appropriate, proper weighing technique has been used and the overall resulting assumption is reasonable compared to the company’s own credible experience. The companies and the regulators should be able to agree on assumptions where the combined data is credible. Where actuarial judgement is needed, peer review should be a regular request by the regulators. Some templates to facilitate the agreements between the companies and the regulators may be helpful.

California
Prior to adopting a new industry morbidity study there should be a thorough comparison of; policy coverage, underwriting and claims practice differences. A certified actuary should opine on such as; gender mix, impact and mix of marital status, discounts, target markets, issue age distribution, marketing differences, underwriting standards and adherence by underwriters, declination rate, mix by maximum benefit duration and elimination period, type of coverage, claim practices, and use of second medical opinion.

Colorado
Carriers should demonstrate that their populations in plans being rated are similar to the underlying study populations, provide proof that the new morbidity table is reflective of the block of business.

One method to check this is Actual / Expected analysis showing that updated assumptions match experience on this block. Carriers need to provide details for how claim severity and duration were developed, all assumptions as to how the Expected value in their A/E calculations were developed.
The Division is not likely to give 100% credibility to a new consultant morbidity study – with lack of credibility evidenced by how often carriers have changed morbidity assumptions and how volatile they are. We have not settled on a final number for applying a credibility % to a consultant’s morbidity study, though only recognizing a portion of the change from the prior morbidity assumptions could be a valid approach.

**Connecticut**
A carrier should still be required to submit their nationwide and state specific experience as well as a detailed explanation of why they believe the consultant’s new industry morbidity study properly reflects the carrier’s current and prospective experience.

**Indiana**
We do not normally adjust the rates based on this. We may in some cases make them price from inception with the new assumptions and determine a premium at that level. We require that they provide A:E results and if the assumption doesn’t fit their experience, we may make adjustments or ask them to provide a different projection. If there’s a factor that we can’t analyze from historical experience (like changes in future age slopes) we don’t normally adjust for that.

**Louisiana**
The company should show how their own company experience maps to the industry morbidity study.

**Minnesota**
For morbidity, since it is not often clear that experience is fully relevant or credible, we tend to balance between ignoring the non-full credibility data and recognizing full credibility of it. In most cases, the company will get partial “credit” as recognition of new morbidity data and expectations. We have told companies that further rate increases could be approved based solely on morbidity credibility being higher, even if best-estimate morbidity expectations have not changed.

**Nebraska**
We require A/E showing a fit to the industry table for past experience and key statements about why the new industry table is more meaningful for projections than past data might be. Ideally, we would like to see A/E where E is original pricing and E is the new morbidity table, but most companies have trouble recreating their original E because of the way the original assumption is or is not compatible with their current A/E system. We try to give credit for the fact that the projection is related to their experience but their experience may not exactly be able to predict their projection so outside factors and actuarial judgment are often necessary for the projection of future claims. Fit to the new E is helpful for us to establish that the company adequately considered the applicability of the outside source to their current case for projections. We would allow companies to make adjustments to the morbidity for potential future trends and would consider the use of a margin and the pros and cons to the policyholder for such a margin vs waiting for another rate increase if margin is not used but needed in hindsight. We have not seen this type of situation yet. We have seen morbidity improvement used, but we do not require morbidity improvement. And we have seen mortality improvement used as a conservatism and we do not disallow this in order to approve lower rates.

**North Carolina**
We first consider historical trends relative to the original pricing assumptions. If the historical data is limited to only a few early policy durations, and if the historical experience is favorable, we may disapprove the requested rate increase as not being justified, or consider a modification of the company’s projections that limits the projected deterioration in loss ratios so that future loss ratios grade into the original pricing, and perhaps approve a lesser amount than was requested. As noted in the question, the consultant’s study may or may not be relevant to the experience of the company and policy form in question.

**Texas**

A valid morbidity study is appropriate to justify a rate increase if the company adjusts rates based on a prospective premium shortfall, and the company can demonstrate that the study is appropriate for the block of business.

For a change in the morbidity, or any other assumption, we apply a prospective present value formula. Under this approach, active, premium paying policyholders, based on current assumptions, pay the appropriate premium going forward to fund a prospective deficiency, and not a premium that recoups the past losses of policyholders who no longer pay premium.

We believe the prospective present value approach, along with frequent monitoring of experience, is the best method to produce a stable product long-term.

**Utah**

I don't recall a single instance of the rate increase request being reduced based on the disagreement about the current assumptions. In majority of the cases, requested rate increase is much lower than what could be justified by a minimum loss ratio standard. To the extent that the assumption appears overly conservative or does not appear very well supported we may calculate future and lifetime loss ratios based on an alternative assumption (for example using prior filing premium persistency or prior filing calendar year loss ratios). These contribute to our assessment of the need for the rate increase, but are generally not central to our decision-making.

**Virginia**

The company should present evidence that the characteristics of their block of business are similar to the block underlying the new industry study (demographics, underwriting, marketing, etc.).

2. **What approaches are appropriate for handling the "shrinking block" issue, i.e., to avoid astronomical rate increases to get back to original loss ratios when the block has significantly shrunk due to mortality, lapses, or claims? Are rules that cap increases effective in addressing this issue? What approaches are used when a company combines a shrunk block with a more established block into one rate increase request? What criteria should be used to defend similarities among forms that would allow or disallow combinations? Is it appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support?**

**ACLI/AHIP**

The issues detailed above should not be considered independently. We acknowledge the complexity of these issues as they relate to closed blocks. An initial issue for all is to develop a common definition of
shrinking or small closed block. The industry is in the process of considering potential approaches to these issues and will continue to work with regulators to develop solutions.

**Bob Yee**
Under the rate filing regulations, companies are free to request rate adjustments at their discretion. The current loss ratio requirement allows companies to ask for very large rate increases. Shrinking blocks are especially susceptible when necessary rate corrections are not granted and the deficits are accumulating. This is an artifact of inappropriate actions from both the companies and the regulators. Companies should be required to periodically report experience to the regulators, every form should be reviewed and its experience development is transparent to everyone. With proper and timely rate adjustments, the shrinking block issue can be mitigated or eliminated.

**California**
California requires companies to combine experience but with adjustment for policy form differences. California prefers insurers request less than result of a strict application of mathematically derived 60/70 loss ratio rule and the 58/85 Rate Stabilization rule because of the tenuous impact on the results of making long claims forecast. We expect subsequent rate filings will be submitted with higher credibility and the initial rate increase effects developing premium and claim experience.

**Colorado**
(a) Colorado reviews measures such as:
   (1) Remaining % of premium to be collected in the future versus lifetime premium;
   (2) The % impact to the LT LR from each % of rate increase;
   (3) The average attained age of policyholders.
   A LTC block of business with an average attained age of 80 years old or greater, with only have 5% to 10% of premium outstanding, and with little ability to impact the LT LR may often not be allowed additional rate increases. We have not developed a hard and fast rule for how this is applied, but we are considering criteria around these measures for when to deny or limit a rate increase.

   Colorado does not apply any rate caps directly, though as indicated above may limit rate increases based on the specific situation in the case of small remaining blocks with high attained ages. Otherwise we attempt to develop the theoretical needed rate increase after all adjustments we require are applied.

   Colorado now requests all carriers to provide the “If-Known” premium analysis, and determines how much higher the original premiums would needed to have been if known assumptions as of today had been implemented at policy origin. This is essentially adjusted against the total rate increase currently requested. Colorado regulations, and Division guidelines, also request carriers to provide a simpler “On-Rate-level” premium analysis which similarly requires carriers to input all historic rate increases back to original sales date so that the current premium is reflected in the LT LR calculation.

   The primary question with such analysis is how much of prior losses should the carrier assume liability for, and how much should be allowed to be implemented on policyholders. As one measure, Colorado utilizes a tool from another state which assigns 60% responsibility to the carrier, 40% to policyholders. However Colorado does not yet have a hard rule, would be inclined to assign 50% to 100% to the carrier depending on the circumstances.
(b) A shrunken block generally should not be allowed to be rated with an established block, would not be desirable. The company should separate out the very different blocks of business so they can be evaluated on each of their merits individually.

(c) No. The 58/85 is a minimum test to meet. Also, it is only a somewhat useful test if it is without margins; with margins it seems to be a case of setting margins to a level which supports the rate increase.

**Connecticut**
Combining similar policy forms if available; combining all policy forms issued in the specific state. We don’t believe it is appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support.

**Indiana**
We do not allow pricing to lifetime loss ratio based only on future premiums. We require that lifetime loss ratios meet the minimum standard with premiums from inception adjusted to the approved rate level.

**Louisiana**
It is also our opinion that eventually a company should have to live with their inadequate initial pricing. We are currently closing an existing block to any additional rate increases once the number of remaining lives in our state drops below 30.

We allow closed block combinations provided the blocks share the same approximate issue era. We have in the past instructed companies to separate out the blocks they have combined in a filing. We have also encouraged discussions with the filing actuaries as to how to combine their various business blocks prior to submitting their filing.

**Minnesota**
We determine a makeup premium (necessary to get back to the originally priced loss ratio or profit position) and an “if you knew then what you know now”, or “if knew”) premium. We take a weighted average of the two, with additional weight on the lower “if knew” premium as the percentage of policyholders remaining in the block (those who have not died, lapsed, or gone on claim) goes down.

We described other options for capping the premium as the block shrinks in a document presented to the NAIC LTC actuarial working group.

**Nebraska**
Lately, we have been reducing most increase requests to 0% if the future premium collectability is less than 5% unless we did not approve the full amount of a past increase that affected the company's ability to address the shrinking block, especially if we would have approved the past increase under our current review method adopted officially for the first time in the last part of 2015. Where future premium collectability is less than 10%, we are less critical but adjustments depend on the level of increase being asked and the cumulative past increases as well as how much care the company appears to have taken with managing premiums and poor experience in the past. It's highly subjective at the moment, but when premium collectability is less than 5%, it is common for any adverse experience to result in extremely high
justified rate increases (we’ve seen as high as 5,000% increases that would be justified because the company waited too long or because a small change affected the shrunk premium base). We have started to try to identify a portion of past losses that could be removed from the actuals in order to make the lifetime loss ratio more reflective of what an average policyholder who hasn’t claimed by the time they are the current attained age should have reasonably paid. We have some ideas on how to do this using Lifetime Loss Ratio analysis, but we have not found a uniform way to apply it across all filings yet, so a lot of this is simply using the "eye-ball" test.

One idea I would like to explore would be to consider the future portion of the projection as the amount that needs to be funded (PV Claims - PV Premiums) to calculate a block attained age premium but then apply a cumulative past premium that would have been paid by current premium payers to adjust the block attained age premium. This could provide a balance of what a move to a new product would mean for the group but also bring in a way to give credit for past premiums paid in without forcing it to be about reserves (which may or may not have been increased by the company in the past for various reasons that are not within the scope of the rate filing).

North Carolina
We estimate the rate schedule that would have been required at issue in order to achieve the original pricing target or minimum lifetime loss ratio standard. For small remaining blocks we use this estimate as an upper bound. We may make adjustments to the company’s projection or consider the average of the company’s projection and an independently developed trend model based on the historical data, with historical earned premiums adjusted to reflect the current rate level in our state.

Texas
We believe that the prospective present value approach described in question # 1 is an appropriate method to calculate the justified rate increase, regardless of the size of the block of business.

We see 58/85 as a minimum requirement, not as justification for a rate increase.

Utah
We use judgement, but in general we look at the following: impact on the lifetime loss ratio, portion of the lifetime premium that has yet to be paid, and lifetime loss ratio assuming the proposed rate was charged from inception.

We may argue that the rate is unreasonable if the restated lifetime loss ratio is very low (say 20%), if the rate increase has very little impact on the lifetime loss ratio (say decreases it by 0.1%), or remaining future premium is very small percentage of the lifetime premium (say 3%).

Virginia
Many companies today are requesting rate increases below (sometimes far below) what can be actuarially supported. Artificially imposed rate caps are not entirely successful in addressing this issue unless there is a material change in experience/projections. Shrinking block issues are generally handled on a case-by-case basis with several methods to analyze whether a company is attempting to recoup past losses with an increase. These include: projecting the proposed premium scale from inception of the policies; comparing
Arguably, this agreement should be upheld through the term of the policy. It turns out that this loss ratio requirement is not workable and its application results in very large rate increases for LTC. To resolve the rate increase dilemma, only policyholders’ and companies’ future well-being should be considered (current reserve adequacy notwithstanding).

The appropriate level of rate increase should be based on agreement on the assumptions for projection, insurance companies’ future financial results and margins for adverse deviation. This approach essentially revise the original agreement and delineate the current policyholders’ and companies’ shares of the contractual obligations. Projected loss ratio becomes a metric rather than the determinant of the rate increase. It should be recognized that the companies’ future financial result factor may vary between open and closed book of business.

**California**
Few, if any, rate filings have indicated past LTC claims were higher than expected. Nearly all rate increase requests were based on lapse and mortality being much lower than in the initial pricing.

**Colorado**
Yes, ideally they should be identified and differentiated in the analysis. See item #11 in the Colorado LTC Rate Filing Template attached.

There are 2 groups of policyholders no longer paying premium. There are policyholders on limited premium paying policies which will never pay any more premiums on their policy. There are also active claims on Waiver of Premium, where premiums do not have to be paid while on claim which means no premium in the near future and potentially no premium anymore on active claim policies.

Policies with limited premium paying policies where the premium payment period should not be part of the rate increase analysis. These policies and their active and potentially active future claims should be ignored in the analysis. On the other hand, policies which have remaining premium scheduled to be paid should be included in the analysis whether the policies are on active claim or not.

**Connecticut**
No

**Indiana**
We do not make explicit distinctions between the two, since our review is based on lifetime experience. However, administratively, we do give greater consideration to rate increases when adverse experience has been manifested in higher than expected historical loss ratios, and generally will not consider requests when experience is not sufficiently developed to produce a historical loss ratio of at least 20%.

**Louisiana**
The experience of the entire block should be part of a rate increase study since the entire block was part of the original pricing experience expectation.

**Minnesota**
the present value of future loss under current assumptions with the same measure under all original assumptions for the policies in force at the projection date.

3. Is it preferable for a rate increase to be approved in its entirety (e.g., 60% this year or pre-approved 20% per year for 3 years) or to be approved in stages (e.g., approve 30% now and review again next year for the other 30%)? If in stages, how should this approach be communicated with policyholders?

ACLI/AHIP
The NAIC Long-Term Care Insurance Model Regulation and Model Bulletin provide for “provisional approval” of a series of increases that are actuarially equivalent with the timing and amount of each increase being established at the time of approval. This allows for improved disclosure of the full series of increases so that policyholder can make more informed decisions. We believe only approved future increases should be required to be disclosed; disclosing more than approved increases would be at the option of the company. We recommend assessing whether this approach works over the next several years.

Bob Yee
It is a deceptive practice to grant a smaller rate increase without letting policyholders know the total ultimate increase. Policyholders purchased insurance to protect an unknown event in exchange for known premiums. They have a right to know the degree of premium deficiency so that they can react to it. We need to do a better job in determining the appropriate amount of rate increase, load it with a margin and have the companies guaranteed the premiums for a time period. Otherwise, the policies have little value to the policyholders since they do not know their costs. LTC experience is much better known than before. There is currently sufficient expertise and knowledge to set proper assumptions. Companies should be able to demonstrate the level of needed rate increase and the regulators should be able to agree within a reasonable range.

California
California approves rate increases in stages. The Department must approve the letter to policyholders to ensure a complete understanding by policyholders of estimated future company rate increases, that the increase is based on evolving experience, and has been approved by the Department. The Department prefers experience be re-filed for each increase as credibility develops.

Colorado
Colorado attempts to identify the full amount of rate increases that we believe would be allowed by the state, which may be less than the carrier had proposed. Our internal guidelines are that the rate increases subsequently implemented in any one year should not exceed 15%, so larger pre-approved increases need to be phased in over multiple years.

Carriers must provide policyholder letters in which they demonstrate that they are correctly and transparently indicating to policyholders all current and future needed increases. Typically now Colorado will request the inclusion of a statement that the carrier will not be allowed to come back for any additional rate increases unless future LT LR experience or projections show a significant further deterioration (such as 15% worse or more).

Connecticut
Prefer steady approach to approving rate increases with annual filings submitted to support future rate increases that were not allowed in previous rate filings. The policyholder should be notified of the approved rate increase and any future rate increase that the carrier anticipates submitting for review the following year.

**Louisiana**

Our commissioner currently restricts any approved rate increase to a one-time only basis with an option to file an independent rate increase with actuarial justification in subsequent years.

**Texas**

From a solvency standpoint, we believe it is better to implement the full needed increase as quickly as possible. However, absent solvency concerns, frequent small adjustments to address emerging experience is probably preferable to policyholders.

We have approved phased-in rate increases. Under a phased-in approach, we require the company to fully disclose all increases of the phase-in to the policyholder, and to use the full approved rate increase to determine eligibility for contingent nonforfeiture upon lapse.

**Virginia**

Given the two options it is usually preferable to spread out rate increases over multiple years; unless there is a material change in experience/projections, staged rate increases can be helpful for insureds to budget. Such rate increases should be clearly and understandably communicated to policyholders, and such communication should be reviewed by the Insurance Dept. (preferably for approval). Regarding the up-front approval of multiple increases versus requirement of multiple filings, the Bureau has traditionally approved multiple staged increases at once when the entire increase appears to be justified.

4. **Should deficiencies associated with higher past claims (for those no longer paying premiums) be differentiated from deficiencies associated with past premiums (for those still paying premiums) being insufficient due to updated expectations on lapses, mortality, morbidity, and interest?**

**ACLI/AHIP**

We understand this question to differentiate between block-of-business losses that have already occurred (“past losses”) and those that are expected to occur based on revised assumptions. We believe that there would be significant complexity in attempting to determine if any portion (of claims incurred in the many years prior the date of a rate filing) is to be excluded from the block’s experience and lifetime loss ratio. One measure of losses to be excluded from the lifetime loss ratio calculation applies to new policies subject to Section 20.1 C (2) and (3) – i.e. incurred claims that exceed the projected claims under filed pricing or re-pricing assumptions (including margins in the claims assumptions). This approach is likely impossible to administer to older, closed blocks. We believe that the vast majority of rate increase requests are moderated such that recovery of past losses is not considered.

**Bob Yee**

At the time of issue, the loss ratio requirement is the underlying contractual agreement between the companies and the policyholders (with regulators acting as their representatives). Regulators approved the initial rate filings. This is no different than in other lines of accidental and health insurance business.
I believe how we address the shrinking block issue, as described in our response to item 2, addresses this issue. If a bulk of the reason for a rate increase is claims that have already occurred, a shrinking number of policyholders will not be responsible for making up those losses.

Note that we have struggled with the concept of past losses and how that applies to a long-term block of business. For instance, if future aggregate claims are expected to be higher due to lapses and mortality being lower than expected, then the gains from the policies where the people did lapse or die are helping the situation for the remaining policyholders. It’s really a situation where claims that have already occurred are substantial where the concept of past losses may come into play.

**Nebraska**
We ask the company to provide LTLR demonstrations without including projections of future claims from policyholders who are paid up or close to paid up at the time of the projection of future premiums. So we try to address future claims of those who are paid up by the design of their limited pay premium schedule, paid up because their spouse went on claim but they haven't, or paid up due to contingent or other nonforfeiture election. However, we do not have a consistent approach yet to removing past high claims in order to prevent "making up for past losses." We have therefore addressed an issue with premium payers paying more of a justified increase simply because there are lives included in the demonstrations that will never pay another premium, but we have not tried to remove claimants that are on waiver because they themselves are on claim (different companies include the waived premium as a premium and the waived premium as a claim for their projection while some companies would remove both from the projections, so we try to understand how these are being treated but only really address the non-premium payers who could potentially have a future claim rather than the non-premium payers who already have an incurred past claim).

We have also asked companies, for purposes of the increase justification, to remove margin from incurred claim durations that make up the past portion of the projection (represented as "actuals") so that the margin isn't inadvertently used as a way to collect premium that is higher than justified by best estimate assumptions.

**North Carolina**
Our procedures consider the total past experience and projected future experience of the policy form. If the portion of the block that is “limited pay” is significant, we do look separately at the experience of the lifetime-pay policies alone.

**Texas**
Texas sees both of these as past losses. Past losses are insurance risks, and thus sunk costs that the company should not recoup. Companies must find some other way, such as through capital and surplus, to fund the deficiency.

**Utah**
We don't.

**Virginia**
Generally speaking, yes, though the Bureau has not previously required this differentiation. Anything that can assist in explaining the sources of required increases is preferred.

5. **With LTC, many rate increase proposals are based on assumption changes that significantly increase projected loss ratios, even though yearly actual-to-expected ratios up to the current year based on historical experience may be favorable. How can states get comfortable with 40- or 50-year projections to justify a rate increase?**

**ACLI/AHIP**
The new Guidance Manual is intended to provide guidance to regulators regarding what constitutes a reasonable range of assumptions across the industry. With respect to long-term projections, regulators should be able to compare assumptions in rate increase filings to those used for reserve adequacy. Per the Model Regulation, loss ratios below anticipated may allow a state to require reduced rates or increased benefits.

**Bob Yee**
All projections involve an element of doubt and a level of comfort. LTC experience is much better known than before. There are more data on later durational and older age experience. The LTC insurance knowledge base is growing. What remain unknown are future trends. However, many of the intangibles tend to be favorable even though they cannot be quantified. To be comfortable with the projections, regulators should require more detailed demonstration of experience analysis and assumption setting process from the companies. Independent peer reviews should also accompany every rate filing. Finally, an acceptable method of refunding experience gain should be proposed. Since LTC has a very long time horizon, refunds should go to every policyholder who is affected by the rate increase that generates any future gains.

**California**
Projections over very long periods of time should; include adequate margin for uncertainty and adverse development in claims experience and legal decisions, be sensitivity tested, use appropriate discount rates, assume conservative investment and reinvestment rates, and assume continuing mortality improvement in the future.

**Colorado**
Colorado requires detailed LT LR spreadsheet calculations be provided, with additional support of claim projections, and a number of adjustments and split outs in order to become “comfortable” with a proposed rate increase. The LTC rate Filing Template attached includes additional support that we require at a minimum for an actuarial review, beyond our basic rate filing regulation requirements. This includes becoming comfortable that the assumptions used the projection are correct for this block of business, checking that the Actual to Projected experience for the main assumptions (morbidity, voluntary lapse, mortality) are similar. In our LT LR spreadsheet analysis we verify that the transition from recent year premiums and claims amounts to the first few projected years premiums and claims amounts looks smooth, verify that the incurred claims have not been loaded with unreasonable IBNR amounts in the last couple of years of experience to attempt to justify a higher rate increase.

**Connecticut**
Not sure it’s possible since the carriers themselves are having significant difficulty with accurate projections, especially towards the tail of those projections.

**Indiana**
We do some independent testing. We limit the increases to much lower than expected or requested. Our review of A:E analysis looks hard at both morbidity and persistency. In addition, we request projections from issue using the original pricing assumptions, which allows us to see more clearly how actual experience compares to original pricing experience on a cumulative historical basis. Comparisons against the original pricing basis projections also help us to see if the development of either morbidity or persistency patterns is significantly different in projected years than in past years. For instance we might see that actual annualized persistency has been running 1% higher than expected in past years, but is projected 2% higher in future years, which suggests projected persistency is too high. We do put the Company’s projections into our own spreadsheets for analysis and for computing present values; in this process we’ll occasionally make an adjustment to the projection where we see a disconnect between past and projected experience, but this is the exception.

**Louisiana**
It is my opinion that a LTC reviewing actuary should give less credence to long projection period. What may work is to model the filing and test various cut off points in the projection period.

Also, the company should show how well the actual experience from a new proposed increase matches that projected from the last approved increase.

**Minnesota**
We perform independent testing of sample cells (over 40 and 50 year horizons) to ensure that the direction and magnitude of rate increase accurately reflect the change in assumptions and expectations.

**Nebraska**
The unknown is the unknown. If the company can convince us that they have reason to believe that the future will be different and explain why, we will accept their assumptions for the projection. An example would be that they have not had an 80 year old with a claim yet, but that industry date available to them from outside has shown that 80 year olds with insurance are acting differently than their pricing table had suggested. They have an obligation to take care of the rate correction sooner rather than later. We would work with the company to understand this and we would like them to be forward with us about the information so that we can help them address a situation before it becomes a shrunken block (as many blocks with mostly 80 year olds are shrunken).

**North Carolina**
We perform an independent projection of future experience based on the relationship of actual past experience to the original pricing assumptions, including both morbidity and termination assumptions. When past claims have been favorable relative to the original pricing assumptions we consider the effect of alternative future loss ratio patterns on the level of rate increase that may be justified, if any.

**Texas**
Need frequent monitoring of actual to expected. If historical AE is less than 1.0, an interesting question would be what the company is doing with the surplus. Is the company creating a future deficiency by releasing the surplus to profit?

Utah
Generally we do not question the projections. We don't have an independent source of data, so we rely on the companies' projections. To the extent that we grant lower rate increase that is requested and/or could be justified on the basis of the loss ratio alone, this appears to be an adequate approach. Should the company file for a subsequent rate increase we evaluate emerging experience versus prior projections.

Virginia
Acknowledging that this is one of the many challenging aspects of rate review, states should review any and all data/assumptions used to justify a rate increase. One suggestion is to “stress test” the point-estimate assumptions by modelling the projections using a range of reasonable assumptions to determine if the rate increase is justifiable. Ultimately, this is the catch-22 of this product line – if we wait until the past experience bears out the deficiency in premium rates before approving a rate increase, it is too late for the rate increase to be effective and the company will experience large losses. If, however, the future estimate turns out to be too conservative, the company will eventually experience large windfalls.

6. Should lower-than-expected investment returns factor into the justification for a rate increase?

ACLI/AHIP
Per the NAIC Long-Term Care Insurance Model Regulation and Model Bulletin, actual investment returns would have no bearing on rate increases. We recommend all states uniformly apply the rule regarding the maximum statutory valuation interest rate.

Bob Yee
It is difficult to justify investment return experience as a reason for rate increases. Policyholders have no involvement or little influence on a company's investment practices as well as the general investment environment. Excess investment returns are not shared by the policyholders.

For all policies issued after rate stability regulation and many prior to the regulation, the discount rate is the statutory valuation interest rate. Thus investment return has no impact on the loss ratio formula. For the other policies, the higher interest assumption enabled the companies to offer the policies at a relatively lower premiums. Unlike adverse claim experience where the policyholders as a group benefited, policyholders should not have to pay for the result of aggressive investment assumption where they are not the beneficiaries.

For these reasons, the companies should not be allowed to use a lower discount rate for the loss ratio calculation.

California
No. Consumers assume insurers have investment expertise. This is one of the major reasons long term insurances and annuities are purchased. Passing investment risk back to the policyholders should have been
disclosed prior to sale and would likely have resulted in more self-insurance of the long term care risk by consumers.

**Colorado**
Colorado requires that a LT LR calculation be provided based on actual historical investment interest rates being applied. Colorado regulations allow us to investigate scenarios of investment interest rates. This is necessary given the typically large amount of premium and small amount of claims in the historic period. Directing issuers to apply actual historic rates more correctly accumulates premium and claims at appropriate rates usually demonstrating that the LT LR are much smaller than what carriers are attempting to base proposed rate increases on. Colorado requests scenarios with future period rates that are more realistic than the current valuation interest rate, though the Division is open to carriers proposing a realistic set of rates to evaluate.

**Connecticut**
Yes

**Indiana**
We do not allow for lower than expected returns. This is a policy decision. We ask for the discount rate to be consistent with initial pricing. In some cases, we’ll adjust initial pricing to the current discount rate, because the original rate is so high that it gives crazy results.

**Louisiana**
In my view, a lower than expected investment return could factor into a rate increase justification. However, for recently developed products one would have to question why the initial assumption was not adequate to begin with given that investment returns have been low for some time.

**Minnesota**
Yes. For loss ratio test compliance (which in Minnesota is just a constraint on the minimum loss ratio), the answer is “no”, but for our more rigorous test (considering all cash flows) which tends to result in lower increases than pure reliance on loss ratios, changes in investment return experience and expectations are considered. One unacceptable approach of demonstrating investment return adversity is comparing initial pricing assumptions to the required loss ratio discount rate. Any comparison of investment returns to demonstrate adversity should be apples to apples and based on reality.

**Nebraska**
NO, we do not allow a lower than expected investment return factor. The decision is mostly an actuarial decision that "actual" results are not actuarial and "actual past experience" needs to reflect actual results. We allow for discount rates to be a weighted average or for them to be graded from pricing to current and then for them to be graded into the future based on reasonable assumptions. We require all interest income/discount assumptions to be backed with experience and justification. This is our major current focus to not use lower than actual investment return factors for the past. Our loss ratio law requires us to consider investment income in our analysis of lifetime loss ratio but is not specific as to how to use investment income. We feel that investment income is just as important of a factor for representing the actual past as the past premiums and past claims are. In the current environment, we have seen companies try to use average investment yields as low as 4.5% for historical even though they issued business for
several years assuming they would get 7.5% or higher. We ask them to reflect on why they would have continued to issue new business at the original rates if they were only experiencing a 4.5% yield and original rates required 7.5%. Going back to item 1, we feel that the decision to continue to sell as you realize your actual investment income is an indication that you are/were most likely receiving an investment income rate close to the pricing rate for the years you continued to issue without adjusting new business rates. So if original pricing investment income assumption was 7.5% and original premiums were offered under the form from 1994-2004, we require that 7.5% is the "actual" investment rate through 2004 even if it wasn't a logical rate to achieve according to Moody's bond yield history. If they could not achieve the rate, we feel they were accepting, knowingly, a lower return on investment for each policy sold and using the 7.5% requirement in this example helps us adjust our analysis in consideration of the known risk/reward the company was deciding to operate under.

North Carolina
For rate stabilization policy forms we use the average maximum valuation rate as the discount rate, consistent with our rules. This may allow some effect of lower-than-expected investment returns, but limits the projection of assumed future low investment returns. For pre-stabilization policies we generally use a 4.5% discount rate in our analysis, which gives some recognition of lower-than-expected investment returns, but also ignores higher- than- expected historical investment returns. These approaches avoid debates about allocation of assets to lines of business.

Texas
Under the prospective present value formula, lower-than-expected investment returns are not factored into the calculation.

Utah
Generally no. We try to look at the pricing lifetime loss ratio at the valuation interest rate and we generally measure against it.

Virginia
Due to the long tail nature of LTCI, an argument could be made that actual and expected investment returns should play a part in justifying a rate increase. However, since most calculations are based on the valuation interest rate which is fixed at issue, this factor is largely ignored.

7. What are appropriate approaches for handling waiver-of-premium provisions? For instance, for policyholders currently on waiver of premium, is it appropriate to include those premiums as earned premiums with equal offsetting incurred claims?

ACLI/AHIP
Currently, company practices vary regarding waiver-of-premium. The approach mentioned in the question would be one acceptable approach, but other approaches could also be acceptable for rate increase filings, and thus HATF should not mandate only one approach for rate increase filings.

Bob Yee
For rate filing purposes, projections of premiums and benefits should only focus on active lives. Presumably, the disabled life reserve is adequate to fund future claim liabilities on current claimants. In most instances,
current claimants have a very negligible effect on future benefits and premiums since few recover and claim again. Current claimants’ financial impact should be ignored.

In a ‘total lives’ projection model, it is appropriate to included waived premiums as earned premiums with an offset to incurred claims. In a ‘first principle’ projection model, only cash flows are considered. Thus, there are no premiums from claimants.

**California**
Waiver of premium is not a material consideration in LTC pricing adequacy so should WP not be included in premium or claims when determining if a LTC rate increase is needed.

**Colorado**
WOP should be removed from premiums, would NOT include those premiums as earned premiums with equal offsetting incurred claims.

**Connecticut**
No

**Louisiana**
In my opinion, WOP should be part of both incurred claims and earned premium.

**Texas**
The prospective present value approach only includes active, premium paying policyholders, so the formula excludes policyholders on waiver of premium.

**Virginia**
We generally prefer that WOP be deducted from premium rather than added to claims experience and/or projections since the loss ratios would be greater than 100% for those folks which may serve to generate a higher rate increase than excluding them entirely. However, as noted before, companies rarely request the maximum increase that can be justified, so this change would rarely impact the approvability of a request on its own.

8. **Is it appropriate to address a deficiency in the disabled-life reserve (associated with current claims) via a rate increase, or do you think the company should fund the additional disabled-life reserve in other ways, such as through company surplus?**

**ACLI/AHIP**
The most recent disabled life reserve should be used to determine historic incurred claims, just like any paid claim would impact historic incurred claims.

**Bob Yee**
Reserve adequacy, whether it is contract reserve or disabled life reserve, should not be a part of policyholders’ obligations in the revised view of the insurance contracts as described above. Policyholders have no influence on the adequacy of the reserves. Thus, reserves should not be part of the rate increase determination.
California
Correction of any claim reserve deficiency is part of updating claims incurred. It should be part of any rate increase justification as an adverse development from initial pricing assumptions.

Colorado
Carriers should indicate changes in assumptions from the prior rate filing to the new rate filing in their DLR development, any impact of the changes in the DLR on the LT LR calculation should be documented. Colorado often obtains incurred claims for each historic period split out into:
(1) Actual paid on incurred claims;
(2) estimated Disabled Life reserve claims;
(3) estimated IBNR claims.
Carriers should be able to verify the method used for estimating the DLR and IBNR claims, changes in assumptions. We have not adopted a policy to disallow impacts from changes in DLRs.

Connecticut
Combination of rate increases and surplus, as necessary

Indiana
This should not be funded via a rate increase. However, we do consider historical claim experience on a best-estimate basis, and when a company recognizes a claim reserve deficiency, that also means their best-estimates for past incurred claims go up, which flows into the rate increase analysis.

Louisiana
A disabled life reserve that is part of the expected claim payments should use best estimate techniques. This then makes it part of incurred claims. It should be released when no longer needed thereby reducing incurred claims. It is our belief that the company should use surplus for any associated reserve deficiency.

Guaranteed renewability does not mean guaranteed profitability.

Minnesota
Since disabled life reserves are associated with people already on claim and not paying premiums, I don’t think increases in that reserve should be funded with rate increases on those still paying premiums. However, the assumption that claims are longer than expected can be part of the rate increase review analysis of the dynamics impacting the cost of people still paying premiums.

Nebraska
We do not feel it is appropriate to address such a deficiency in the rate increase. The deficiency can be used to justify higher future claims being projected than were projected for past rate decisions, but the deficiency referenced here is a past loss and should not be used to justify a rate increase for policyholders who have not claimed unless the deficiency prudently demonstrates that it is likely for future claimants to claim more than previously expected.

North Carolina
For a closed block of business it may be inappropriate to pass the cost of funding a deficiency in the disabled life reserve to the remaining policyholders via a rate increase. In those cases the company should fund the additional reserves from surplus.

**Texas**  
We believe the company should fund through company surplus. See response to question #4.

**Utah**  
Not sure.

**Virginia**  
Any deficiency in the DLR is inherently included in the justification for a rate increase through the inclusion of claim reserves, presumably based on current assumptions, in the past incurred claims. As such, it would be difficult to exclude this effect.

### Additional Questions

9. **(Virginia)** Is it appropriate to allow a rate increase based on a different mix of business distribution of issued policies than originally priced for? As a simple example, if half of the pricing cells had an expected loss ratio of 40% and half 80% for an average of 60%, should a rate increase be approved if all policies actually sold had an expected 80% loss ratio?

**California**  
A change in mix from initial assumptions should amend the original base pricing target (ie raise the 58 in the 58/85) rather than represent a justification for a rate increase.

**Colorado**  
Yes, depending on what pricing cells are being referred to. In Colorado carriers cannot use gender rating, so estimating the mix of males and females is important, both cells may not be originally priced to the 60% target since their rates may be equal. If actual experience deviates from the original assumed mix then the carrier would definitely be allowed to reflect the actual mix at time of re-rating.

**Texas**  
We would not consider a mix of business that is different from the mix assumed at pricing to be valid reason for a rate increase.

10. **(New Hampshire)** To what extent should remaining policyholders be expected to bear the burden of mispricing? How should the burden of mispricing be parsed between remaining policyholders and the company?

**Colorado**  
Colorado now requests all carriers to provide the “If-Known” premium analysis, and determines how much higher the original premiums would needed to have been if known assumptions as of today had been implemented at policy origin. This is essentially adjusted against the total rate increase currently requested. Colorado regulations, and Division guidelines, also request carriers to provide a simpler “On-Rate-level”
premium analysis which similarly requires carriers to input all historic rate increases back to original sales date so that the current premium is reflected in the LT LR calculation.

The primary question with such analysis is how much of prior losses and mispricing should the carrier assume liability for, and how much should be allowed to be implemented on policyholders. As one measure, Colorado utilizes a tool from another state which assigns 60% responsibility to the carrier, 40% to policyholders. However Colorado does not yet have a hard rule, would be inclined to assign 50% to 100% responsibility for original mispricing to the carrier depending on the circumstances.

11. (New Hampshire) What considerations, if any, should be given to pricing requests from reinsurance companies or TPAs... entities that have assumed some ‘risk/reward’ in seeking out premium increases?

**Colorado**
We seek to understand the reinsurance arrangements at work in a rate filing. If the carrier submitting the rate filing reinsures the block to a reinsurer, and the reinsurer is at solvency risk, we consider the impact it may have on the carrier if the reinsurer went insolvent.

12. (New Hampshire) Should review standards and/or considerations change among companies that are actively selling, SEBO, under supervision or in liquidation?

**Colorado**
We now typically approach the domiciled state and request to be provided with the IPS of each company writing LTC business in Colorado. We attempt to understand the company’s financial condition, estimate the impact to our Guaranty Fund if the carrier becomes insolvent. We do consider this as part of the analysis for allowing rate increases, the commissioner in Colorado has broad authority to consider such factors.

If the company is actively selling, we need to ensure that the company is not selling new policies with premiums below rate increase requests for the same level of benefits.

13. (New Hampshire) Is there a point when its actually more beneficial for remaining policyholders to have the company go into liquidation versus allowing further rate increases to be passed through to policyholders? If so, how should this point be evaluated by regulators?

**Colorado**
Probably yes, we don’t have a fixed rule or measure when this should occur.

**Comments from Center for Economic Justice**

What is the role of the profit provision in the proposed rates? What risks are borne by investors? What risks are borne by policyholders? Which of these groups should be responsible for the insurers’ errors in various pricing assumptions regarding lapses/persistency, investment income or mortality?

What is the appropriate goal of the rate increase -- to restore the profitability of the book of business to the original profit target? To some portion of the profit target? To zero profit? To less-than-zero profit, but solvency? To some other standard?
What is the history of the book of business for which the rate increase is sought? Has the insurer created its own death spiral by offering and moving some original policyholders in the book of business other products? If so, should the original and alternative product blocks of business be combined for ratemaking purposes?

What tools exist for regulators to evaluate the policyholders' response to the large rate increase in order to evaluate the results of the rate increase? How should regulators consider policyholder responses to large rate increases in terms of an actuarial evaluation of the results/impacts of the rate increase? For example, will the rate increase be so great that assumptions about lapses/persistency or the number of policyholder's opting for reduced benefits should be changed?

How does a regulator navigate a situation in which the size of the rate increase will be so great to force most policyholders to surrender their policies, but without the rate increase the insurer's solvency may be threatened? What lessons have regulators taken from the Penn Treaty saga? At what point does is a rate increase unreasonable regardless of the actuarial indication either because of the impact on consumers (i.e., force surrenders due to unaffordability of premiums or force consumers to choose reduced benefits) or because of historical errors by the insurer? What is the role of the guaranty fund system in this type of situation? When does the rate increase request become a public policy issue for the Commissioner instead of simply a technical review of a rate filing?

If a large rate increase is approved and such rate increase is phased in over several years, what principles should guide this phase-in? Are consumers served by phasing in, say, a 50% rate increase over 3 years instead of a single 50% rate increase? What type of disclosure to policyholders should be required with a phase-in rate increase?
The Long-Term Care Valuation (B) Subgroup of the of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Jan. 6, 2017. The following Subgroup members participated: Perry Kupferman, Chair (CA); Tricia Dave (CT); Lisa Parker (FL); Nicole Boyd (KS); Fred Andersen (MN); Rhonda Ahrens (NE); Terry Seaton (NM); Jan Graeber (TX); and Tomasz Serbinowski (UT).

1. Discussed a Proposal for Stand-Alone LTCI Asset Adequacy Requirements

The Subgroup continued discussion of a proposed draft actuarial guideline (Attachment One) with requirements for performing stand-alone asset adequacy analysis of long-term care insurance (LTCI) blocks. Ms. Ahrens said the Subgroup will either modify the draft actuarial guideline to incorporate issues discussed during the Subgroup’s report to the Long-Term Care Actuarial (B) Working Group at its Dec. 9, 2016, meeting, or incorporate the substance of the proposed actuarial guideline into the Health Reserves Guidance Manual. She said she will present issues that need to be addressed in the modifications and will explain why state insurance regulators are interested in providing guidance so insurers can demonstrate that their LTCI reserves are appropriate and sufficient for the risks that are present.

Ms. Ahrens said she thinks stand-alone asset adequacy testing for LTCI blocks implies the regulator will be able to understand the given block of business and understand how each of the separate blocks of business support each other. She said when adequacy is considered in the aggregate, general account assets that are not needed for some blocks can offset deficiencies in other blocks. She said the Subgroup should consider what effect the stand-alone asset adequacy requirement will have on the establishment of additional reserves.

Ms. Ahrens said the Subgroup needs to determine what method is appropriate for conducting the adequacy analysis. She said cash-flow testing (CFT) may be an appropriate method. She said a gross premium valuation (GPV) also may be appropriate, but there may need to be additional requirements, such as support for the discount rate used and addressing risk factors that are used in CFT but not in GPV.

Ms. Ahrens said the terms “asset adequacy” and “reserve adequacy” should be considered to be equivalent for purposes of discussion of stand-alone LTCI asset adequacy. She said modifications to the draft actuarial guideline possibly will include improvements to the description of aggregation of blocks, guidance on the best method to demonstrate asset adequacy, discounting and investment income assumptions, and the treatment of rate increases in the analysis.

Mr. Andersen asked if companies should be required to establish additional reserves if asset adequacy testing indicates deficient formula reserves, or if excess reserves from the aggregation of blocks can be used to offset the deficiencies. Mr. Seaton said the frequent changes in ownership of LTCI blocks may mean aggregation may not be appropriate. Ms. Ahrens said she also is concerned about such situations. She said stand-alone LTCI asset adequacy analysis will help state insurance regulators understand the effects on company financial positions in such situations. Mr. Serbinowski said he favors requiring stand-alone analysis for LTCI blocks with the ability to offset LTCI deficiencies through aggregation of other blocks. He said that, however, to the extent a company does not segregate its asset purchases by block, the stand-alone analysis is artificial. Ms. Dave said she agrees with allowing the offset of deficiencies through aggregation.

Mr. Andersen said the key concepts that should be present in the stand-alone asset adequacy testing requirement are the ability of state insurance regulators to see and understand the stand-alone analysis, consistency of testing among companies nationwide, and specific guidance for companies on documenting investment income and rate increase assumptions.

Mr. Serbinowski said since a GPV does not take into account the assets supporting reserves, it is not a test of asset adequacy, but a GPV may be appropriate if the discount rate used in the GPV can be demonstrated to be an appropriate representation of the supporting assets. Mr. Andersen asked if the default test for the stand-alone analysis should be CFT, or if GPV with documentation of assumptions also should be considered appropriate. Mr. Andersen asked if explicit modeling and projection of assets should be a requirement for the analysis. Ms. Parker said she is not in favor of requiring explicit asset modeling.
Mr. Andersen said a request for comment will be made asking if explicit asset modeling and projection should be the default treatment of assets for the analysis, or if an approach where current and future asset returns are estimated and blended into a discount rate or series of discount rates is acceptable.

Having no further business, the Long-Term Care Valuation (B) Subgroup adjourned.
Actuarial Guideline LTC

THE APPLICATION OF THE HEALTH INSURANCE RESERVES MODEL REGULATION FOR TESTING THE ADEQUACY OF LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance Reserves Model Regulation (#010) contains requirements for calculation of long-term care insurance (LTC) reserves. Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. For instance, the Model Regulation states, “a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts”; however, other wording in the Model Regulation creates confusion for some people on whether the test of adequacy is required at the major block of contract level. In the absence of uniform guidance, some insurers may not be determining adequacy of LTC reserves to the same degree as others, resulting in a non-level playing field and concerns that reserve adequacy is not being appropriately tested by each insurer.

This guideline provides uniform guidance for insurers with a major LTC block of contracts. In particular, this guideline:

1. Requires asset adequacy analysis of an insurer’s major LTC block of contracts.
2. Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area.
3. Requires a uniformity approach to assuming future rate increases.
4. Provides requirements on documentation of assumptions.

Text

1. Effective Date

This Guideline shall be effective for reserves reported in the December 31, 2017 and subsequent annual statutory financial statements.

2. Scope

This Guideline shall apply to all long-term care insurance contracts, whether directly written or assumed through reinsurance.

3. Definition

A. Major Long-Term Care Block of Contracts. A block of long-term care insurance contracts with over 1,000 inforce policyholders as of the valuation date will be considered major for purposes of applying this Guideline.

4. Asset Adequacy Analysis of a Major Long-Term Care Block of Contracts

A. Reserves for a major long-term care block of contracts must be supported by an asset adequacy analysis specific to this block of contracts for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding testing moderately adverse deviations in actuarial assumptions.

B. Reserves for the major long-term care block of contracts shall be increased by any additional reserves required by the asset adequacy analysis, subject to a phase-in option described in Section 4.E.
C. Where there are material asset risks, where liabilities have cash flows far out into the future, where there is a material risk of asset liability mismatch risk, or for other reasons, cash-flow testing may be the appropriate method unless the risks can be demonstrated to be appropriately captured in an alternative method such as a gross premium valuation. The method of analysis must be deemed appropriate based on Actuarial Standards of Practice.

D. The analysis shall anticipate no premium rate increases unless a rate increase plan is documented to be supported and approved by management, is highly likely to be executed, and contains documented, realistic estimated approved amounts and times by jurisdiction.

E. If additional reserves are required, a phase-in period of up to three years may be approved by the company’s domiciliary Commissioner. Such phase-in period shall only be permitted if the company is able to demonstrate to the satisfaction of the Commissioner that it would not be operating in a hazardous financial condition and that there is not adverse risk to its insureds.

F. The asset adequacy analysis shall be in the form of an Actuarial Memorandum which contains documentation of the assumptions and results of the analysis and shall be submitted to the state of domicile of the company by the April 30 following the valuation date. The state of domicile shall provide a copy of the Actuarial Memorandum to any other state in which the company is licensed.

5. Documentation of Assumptions Underlying Long-Term Care Insurance Asset Adequacy Analysis to be Provided in the Stand-Alone Actuarial Memorandum

A. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly site adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates for sample issue ages shall be provided. A summary of experience or other justification of expectations shall be documented.

B. Assumptions on lapse shall be documented in table format by duration band and by other factors impacting the lapse assumption, where applicable. A summary of experience or other justification of expectations shall be documented.

C. Assumptions on morbidity shall be documented and justification of the assumption shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

D. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross premium valuation, then justification shall be provided.

E. Assumptions on future rate increases shall be documented, by rate increase percentage assumed and jurisdiction; and the documentation and justification stated in Section 4.D. shall be provided.

F. Documentation of other material assumptions shall be provided.

G. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.
Long-Term Care Valuation (B) Subgroup
Conference Call
January 27, 2017

The Long-Term Care Valuation (B) Subgroup of the (of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Jan. 27, 2017. The following Subgroup members participated: Perry Kupferman, Chair (CA); Tricia Dave (CT); Lisa Parker (FL); Nicole Boyd (KS); Fred Andersen (MN); Rhonda Ahrens (NE); Terry Seaton (NM); William Carmello and Amanda Fenwick (NY); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Discussed Comments on a Proposal for Stand-Alone LTCI Asset Adequacy Requirements

Mr. Kupferman presented six comments (Attachment One, Attachment Two, Attachment Three, Attachment Four, Attachment Five and Attachment Six) on the Subgroup’s draft actuarial guideline that requires performing stand-alone asset adequacy analysis of long-term care insurance (LTCI) blocks.

David Hippen (Risk & Regulatory Consulting LLC—RRC) gave a summary of the RRC’s comments (Attachment One).

Ms. Fenwick gave a summary of comments from the New York State Department of Financial Services (NYSDFS) (Attachment Two).

Paul Graham (American Council of Life Insurers—ACLI) gave a summary of comments (Attachment Three) submitted by the ACLI and America’s Health Insurance Plans (AHIP). Mr. Andersen asked if the documentation of assumptions requirements in the Subgroup’s draft actuarial guideline would be incorporated into the ACLI/AHIP option 1 proposal. Mr. Graham said they will and said the requirements could be placed in the LTCI section of VM-30, Actuarial Opinion and Memorandum Requirements, of the Valuation Manual. Mr. Seaton said he is concerned about the exemption for non-material blocks of LTCI in option 1 and said that all LTCI blocks should possibly be subject to stand-alone analysis. Mr. Graham said Actuarial Standard of Practice (ASOP) No. 22, Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers, contains a suggestion that immaterial blocks or blocks that do not rely heavily on future asset cash flows can be valued using simplified methods. He said for such blocks, no guidance other than that currently available is necessary.

Mr. Serbinowski gave a summary of his comments (Attachment Four). Mr. Kupferman said he agrees with Mr. Serbinowski’s comments.

Laurel Kastrup (KPMB LLP) gave a summary of the comments (Attachment Five) submitted by the American Academy of Actuaries (Academy). Mr. Serbinowski said asset and liability cash flows must be taken into account to correctly test asset adequacy, so a gross premium valuation (GPV) is not an appropriate test of adequacy. Ms. Kastrup said many companies use a vector of interest rates instead of a single composite rate in their GPV analyses, and this takes asset cash flows into account when conducting the GPV. Mr. Kupferman asked if any participant can estimate what portion of the total reserve for a combination product is associated with the LTCI component of the policy. Ms. Kastrup said she estimates it to be a small percentage, but the percentage will increase when policyholders trigger the LTCI benefits under the policy. Mr. Kupferman asked if the LTCI component of combination products should be treated as stand-alone LTCI policies will be under the asset adequacy requirements. Mr. Andersen proposed that combination products not be included in the asset adequacy tests, as they have separate patterns of mortality, lapse and rate increase. He said he thinks combination products are currently being cash-flow tested and do not exhibit the same concerning issues as stand-alone products.

Mr. Andersen asked whether in all material cases, should the stand-alone LTCI asset adequacy tests be cash-flow testing (CFT) with explicit asset modeling, or if GPV without explicit asset modeling should be allowed in some cases. Ms. Parker proposed that a GPV be used to determine reserve adequacy and that CFT also be conducted for informational purposes only. She said the results of the CFT will be monitored over time, and the results of the CFT will be compared to the GPV results and examined for consistent results from the two tests. She said she is concerned that the segregation of assets in an insurer’s investment portfolio for the stand-alone test is inconsistent with the general asset account approach that the insurer actually uses to support the LTCI blocks. She said if regulators observe that insurers are using inappropriately high discount rates in their GPV calculations, a prescribed discount rate can be considered.
Mr. Kupferman said proper documentation of the assumptions used in the adequacy tests should be required. Ms. Ahrens agreed. She said for both GPV and CFT, regulators need to understand the sensitivity to changing interest rate scenarios of assets supporting the LTCI blocks.

Mr. Andersen suggested if an insurer’s company-wide asset adequacy analysis is done using CFT with assets projected under seven different interest rate scenarios, similar to the method described in the NYSDFS comments, then the stand-alone LTCI block tests also must be done using CFT in the same manner. He asked if any Subgroup members disagreed with this approach, and none did.

Mr. Andersen said the Subgroup prefers stand-alone LTCI asset adequacy tests be done with CFT with explicit modeling of underlying assets, but if an insurer wishes to offset LTCI reserve inadequacies with reserve excesses from other blocks, then the manner in which the stand-alone LTCI adequacy testing is conducted must be consistent with company-wide adequacy testing. He said if an insurer is willing to forgo being allowed to offset LTCI insufficiencies with company-wide excesses, then a GPV consistent with ASOP may be appropriate for the stand-alone LTCI test. In the event the GPV indicates LTCI reserve deficiencies, the insurer will be required to hold additional reserves on a stand-alone basis. He said the Subgroup will draft language to this effect to be included in the draft actuarial guideline. Ms. Dave suggested the inclusion of alternate prescribed declining interest rate scenarios in the requirements for a GPV.

Having no further business, the Long-Term Care Valuation (B) Subgroup adjourned.
Memo

To: Eric King, Health Actuary
From: David Hippen, Andy Rarus, and Tricia Matson, Risk & Regulatory Consulting, LLC (“RRC”)
Date: January 25, 2017
Subject: RRC Response to the Exposure “Actuarial Guideline Long Term Care Proposal”

Background
The National Association of Insurance Commissioners (“NAIC”) Long Term Care Valuation Subgroup (“LTCVS”) has published a draft proposed actuarial guideline titled “THE APPLICATION OF THE HEALTH INSURANCE RESERVES MODEL REGULATION FOR TESTING THE ADEQUACY OF LONG-TERM CARE INSURANCE RESERVES.” RRC appreciates the opportunity to offer our comments on this draft. Should you have any questions, we would be glad to discuss our comments with you and the LTCVS members.

RRC Comments
Long-term care insurance (LTC) loss development is very different from other accident and health (A&H), and has obvious differences from life and annuity contracts. LTC tends to be longer term with later claims than A&H, requiring an early and extended buildup of assets to handle future claims. Use of a gross premium valuation approach to assess reserve adequacy tends to understate the need for high-quality long-term assets to match the liabilities.

Asset/liability modeling using multiple sensitivity scenarios seems vital to managing the distinctive risks that are characteristic of LTC blocks. Actuarial Standards of Practice (ASOPs) include helpful guidance to the actuary in developing and implementing such tests. The lack of generally applicable morbidity, mortality, and persistency standards for statutory LTC reserves makes cashflow testing more important to LTC reserving due to the interrelationship of these factors with asset performance. For example, if claims are higher than expected in early years, the insurer may have to sell assets at a loss to cover those claims, a risk that would be captured in cash flow testing but not necessarily in a gross premium valuation. The reverse could occur if policyholders persist longer than expected, and therefore reinvestment is required at rates lower than assumed.

Due to high persistency and low mortality, combined with somewhat low early claims and persistent later claims, LTC business may require much longer term scenario tests to ascertain reserve adequacy. These characteristics emphasize the need for long-duration assets with high likelihood of long-term value. Scenario testing for LTC should be especially sensitive to a panorama of future investment, morbidity, and mortality possibilities, because the solvency of a block could be more significantly affected by distant future environments than is true of most life, annuity, and A&H insurance.
These factors make it very important to determine which assets should be held for the long haul. Asset characteristics needed to support LTC liabilities are too dissimilar in duration, frequency, and quality from those that might be acceptable for other lines of business. In addition, experience has taught us that insurers holding LTC blocks can commonly find that LTC no longer fits with the best long-term strategy of a company, and a cession or sale of a block of LTC should be accompanied by suitable assets.

One additional consideration that is particularly important for LTC is considerations beyond the investable universe. It is typically not possible for insurers to invest in assets with a duration that is aligned with the duration of the liabilities, since the asset pool is generally limited to 30 year assets. This exposes the insurer to interest rate risk that can be evaluated through cash flow testing.

For these reasons, we strongly support NAIC efforts to promote LTC reserve standards that include the identification and segregation of separate, suitable assets.

We appreciate the opportunity to provide comments to the LTCVS. If you have any questions, please contact us at the following:

- David.Hippen@riskreg.com
- Andy.Rarus@riskreg.com
- Tricia.Matson@riskreg.com
We have the following comments with respect to the methodology used in the asset adequacy analysis for long term care insurance.

New York supports the language found in section 4.C. of the 8/11/16 draft Actuarial Guideline LTC, i.e. Cash Flow Testing shall be the appropriate approach in the asset adequacy analysis of an insurer’s LTC business unless an alternative method such as Gross Premium Valuation is justifiable.

However, if an insurer applies a method other than Cash Flow Testing, e.g. Gross Premium Valuation, then the results of such testing should not be aggregated with cash flow testing results for other blocks of business.
January 26, 2017

Perry Kupferman
Chair
NAIC Long-Term Care Valuation Subgroup

RE: Question Exposed for Comment on 1/6/17 Conference Call – Asset Modeling

Dear Mr. Kupferman:

ACLI1 and AHIP2 appreciate the opportunity to comment on the following question exposed by the Long-Term Care Valuation Subgroup (“the Subgroup”) on January 6, 2017:

Should assets be explicitly projected for asset adequacy analysis of long-term care insurance for the purpose of stand-alone long-term care asset adequacy analysis or is it acceptable to use an alternative approach using a gross premium valuation where current and future asset returns are estimated and blended into a discount rate or series of discount rates?

Response to Question:

We believe the answer to this question is dependent upon the final form in which a stand-alone asset adequacy analysis is performed on material blocks of long-term care insurance (LTCI).

Option 1

During the 1/6/17 teleconference of the Subgroup, the Subgroup began considering a construct in which stand-alone asset adequacy testing of material blocks of LTCI would be a subset of the overall asset adequacy analysis performed by the company, with disclosure of the stand-alone results but no additional reserves required unless the overall asset adequacy analysis required such additional reserves. We are supportive of that construct, which we believe should be implemented through revisions to VM-30 (Actuarial Opinion and Memorandum Requirements) of the NAIC Valuation Manual. In this construct, we believe that the appointed actuary should choose a method for stand-alone analysis that is consistent with the asset adequacy analysis performed for the entire company. In most cases, that would include an explicit modeling of the assets along with the other cash flows of the product, although modeling of a wide variations in possible interest rate paths appropriate to some other lines of business should not be necessary for the LTCI block. However, there may be cases in which the LTCI block is small in which case simplified methods may be appropriate, such as a gross premium valuation performed in conjunction with a

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1 The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers’ products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 94 percent of industry assets, 93 percent of life insurance premiums, and 97 percent of annuity considerations in the United States. Learn more at www.acli.com.

2 America’s Health Insurance Plans (AHIP) is the national trade association representing the health insurance community. AHIP’s members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Learn more at www.ahip.org.
discount rate chosen using asset projection techniques. We believe this is consistent with current requirements of ASOP No. 22 (Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers), Section 3.2.2.

Non-material LTCI blocks should be subject to current rules with respect to reserve determination and conservatism.

**Option 2**

If the construct chosen is more like the requirements put forth in the previously exposed draft of Actuarial Guideline LTC (which included a requirement to increase reserves if the stand-alone analysis showed inadequate reserves), we believe that a gross premium valuation methodology where current and future asset returns are estimated and blended into a discount rate or series of discount rates can be an appropriate option, depending upon the facts and circumstances of the particular block of LTCI. In the event that the Subgroup determines that it would like to pursue that path, we believe that the wording provided in our previously submitted draft of the Health Reserves Guidance Manual, Section VII, can be slightly modified for this purpose by taking out the reference to the “safe harbor” as follows:

The discount rate used by the actuary must consider the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divestiture of existing assets. In certain cases, the actuary may use a discount rate that does not significantly deviate from the blended averages of the maximum statutory interest rates used in the calculation of the contract reserves. However, the actuary may determine that the use of more sophisticated asset projection techniques, including cash flow testing, is appropriate.

It would probably be more difficult to revise VM-30 under this construct. As stated in our November 5, 2016 letter, we continue to oppose the approach involving a new Actuarial Guideline to modify the minimum reserves requirements for existing business. (Letter attached in Appendix A)

**Summary**

ACLI and AHIP strongly believe that Option 1 is the preferred path. Incorporating separate LTCI disclosures within the existing requirements for the Actuarial Opinion and Memorandum does not retroactively change the reserve requirements for the product, appropriately handles any solvency concerns that may arise through the existing Actuarial Opinion and Memorandum requirements, leverages existing guidance provided by ASOPs 7, 22, and 28, and provides regulators insight into the adequacy of the LTCI block of business on a stand-alone basis.

We look forward to continuing discussions of this issue on the next teleconference of the Subgroup.

Sincerely,

Paul S. Graham, III, FSA, MAAA
Senior Vice President, Insurance Regulation & Chief Actuary
ACLI

William C Weller
Consultant to AHIP

cc: Members, NAIC Long-term Care Actuarial Working Group
Eric King, NAIC Staff
November 5, 2016

Perry Kupferman
Chair
NAIC Long-term Care Actuarial Working Group

RE: 8/25/2016 Exposure Draft of Actuarial Guideline LTC

Dear Mr. Kupferman:


Executive Summary

ACLI and AHIP are opposed to the Exposure Draft for the following reasons:

1. The Exposure Draft proposes to change the minimum reserve standard for LTC insurance policies after the date of issuance of the policies.
2. The proposed application of standalone asset adequacy testing—which in most cases involves a multi-scenario cash flow testing approach—is unnecessary for long-term care.
3. Any new guidance should build from existing guidance for LTC insurance reserve adequacy.

Retroactive Changes to Minimum Reserve Requirements

Changes to Minimum Reserve Requirements that increase reserves should not be made after a contract is issued. Reserve requirements should be known when a policy is issued to ensure that original pricing takes into account the required reserves. This is especially true for LTC insurance, where the ability to raise rates to actuarially-justifiable levels has been anything but certain. There is nothing unique about LTC insurance that suggests that company-wide asset adequacy analysis is not sufficient to ensure company solvency. As with other lines of business with tabular reserves, there are no reasons to make retroactive changes to the minimum reserve requirements established at the time the contracts were issued.

Stand-Alone LTC Asset Adequacy Analysis is Unnecessary

Asset adequacy analysis is used to determine whether the assets currently held plus the future premiums collected will mature the liabilities. The methodology is especially valuable when the assets and liabilities are related in some

³ The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 280 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 95 percent of industry assets, 92 percent of life insurance premiums, and 97 percent of annuity considerations in the United States. Learn more at www.acli.com.

⁴ America’s Health Insurance Plans (AHIP) is the national trade association representing the health insurance community. AHIP’s members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Learn more at www.ahip.org.
fashion and when the products being analyzed have embedded guarantees, i.e., when benefit payments vary with market movements, or book value cash out options exist. In the case of LTC insurance, the multi-scenario analysis used to identify the cost of embedded policyholder options does not add any additional information in the determination of whether reserves are adequate.

Because LTC insurance benefit cash flows are not interest sensitive, there isn’t a need to segregate and model the existing assets together with liabilities in a single projection, and it is a relatively straightforward exercise to establish guidance for the determination and documentation of an appropriate discount rate to use in the testing of reserve and gross premium adequacy.

ACLI and AHIP see no actuarial justification for stand-alone asset adequacy analysis for LTC insurance.

**Existing Guidance is Adequate, Although Clarification is Appropriate**

We have spent a considerable amount of time reviewing the existing Model Regulation and resulting guidance regarding LTC insurance reserves, and have found that it is relatively complete. There is already a requirement to test reserve adequacy, and we believe that requirement should be the basis for ensuring that LTC insurance reserves are sufficient to mature the liabilities. There are a few items that could use some clarification or additional guidance, especially in regards to how to handle premium rate increases, materiality, and choice of discount rate. We believe that a new section could be added to the Health Reserves Guidance Manual that would pull all the existing guidance on reserve adequacy into a stand-alone LTC insurance section, and add any needed clarifications. We have provided a draft of such a section, attached as Appendix I of this letter.

ACLI and AHIP thank the Working Group for considering our comments on this Exposure Draft. We look forward to discussing these comments with you at an upcoming meeting.

Sincerely,

Paul S. Graham, III, FSA, MAAA
Senior Vice President, Insurance Regulation & Chief Actuary
ACLI

William C Weller
Consultant to AHIP

cc: Members, NAIC Long-term Care Actuarial Working Group
    Eric King, NAIC Staff
Section VII. Long-term Care Insurance Reserves

A. Background and Purpose

The Health Insurance Reserves Model Regulation (#010) contains requirements for calculation of long-term care insurance (LTCI) reserves. There is a significant amount of guidance on LTCI reserve requirements based on the Model Regulation contained in the NAIC Accounting Practices and Procedures Manual (SSAP No. 54, IP No. 54, Appendix A-10), the NAIC Health Reserves Guidance Manual, and Actuarial Standard of Practice Nos. 18 (Long-Term Care Insurance) and 42 (Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims). The purpose of this Section is to aggregate guidance into a single location, as well as add clarifications to certain provisions of the guidance.

B. Applicability

All guidance in Section I through Section VI of this Guidance Manual applies to LTCI.

Note that there are two distinct tests of reserve adequacy within the Health Insurance Reserves Model Regulation. This Section will specifically discuss reserve adequacy testing as required by Section 4D of the Health Insurance Reserves Model Regulation that is specific to Contract Reserves. There is a broader reserve adequacy testing required by Sections 1A and 1B of the Health Insurance Reserves Model Regulation that requires testing of the aggregate of the claim reserves, premium reserves, and contract reserves, and guidance for such is not being covered by this Section of the Guidance Manual.

C. LTCI Contract Reserves

Section 4 of the Health Insurance Reserves Model Regulation establishes the minimum requirements for contract reserves for health insurance contracts.

Section 4D of the Model Regulation reads:

Annually, an appropriate review shall be made of the insurer’s prospective contract liabilities on contracts valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of Section 4B.

In the event a company has a contract or group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

Based upon the above citation, stand-alone reserve adequacy testing is required for material LTCI tabular contract reserves. This testing is separate and distinct from the requirement for the reserve adequacy testing required by Sections 1A and 1B of the Health Insurance Reserves Model Regulation, as well as the requirement for premium deficiency reserves set forth in SSAP No. 54, Paragraph 18.

D. Considerations for Setting Assumptions in Determining LTCI Contract Reserve Adequacy

There is considerable guidance available for the reserve adequacy required under Section 1A of the Health


**Insurance Reserves Model Regulation.** There is less guidance with respect to Section 4D. This section of the Guidance Manual will provide considerations for the actuary when determining LTCI tabular contract reserve adequacy. Where appropriate, the existing guidance for the Section 1 reserve adequacy requirement is the basis for providing guidance on stand-alone LTCI contract reserve adequacy testing. Section 1 of the Model Regulation says:

> With respect to any block or contract, or with respect to an insurer’s health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

Clearly, a gross premium valuation may be used to determine reserve adequacy, including contract reserves. For material blocks of LTCI, gross premium valuation is the preferred method of determining tabular contract reserve adequacy. Since, in this instance, only contract reserves are being tested for adequacy, only contracts that have contract reserves should be included in the testing. The primary decisions that an actuary must make in testing LTCI contract reserve adequacy are the determination of the gross premiums to be used in testing, the determination of expected benefit and expense cash flows, and the determination of the appropriate discount rate. While determination of expected benefit and expense cash flows is straightforward, additional guidance is appropriate for determining the appropriate gross premiums and the appropriate discount rate.

Actuarial Standard of Practice No. 42 has the following guidance regarding these two items:

> **Premium Rate Changes:** The actuary should consider whether an assumption may be appropriate to reflect premium rate changes in the reserve calculation. The actuary should use a premium rate change assumption that is reasonable in relation to the projected claims costs and the manner in which the rate change will be implemented (for example, on a given date for an entire block of business or on the next policy anniversary). This assumption should take into account factors such as market conditions, regulatory restrictions, and rate guarantees.

> **Interest Rates:** The actuary should use interest rates in the present value calculation that are reasonable and consistent with the purpose for which the reserve is being calculated.

For the purposes of LTCI contract reserve adequacy:

1. The actuary shall anticipate no premium rate increases unless a rate increase plan is documented to be supported and approved by management, is highly likely to be executed, and contains documented, realistic estimated approved amounts and times by jurisdiction.

2. The discount rate used by the actuary must consider the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments of existing assets. As a safe harbor, the actuary may use a discount rate that does not significantly deviate from the blended averages of the maximum statutory interest rates used in the calculation of the contract reserves. An actuary may use asset projection techniques to justify the use of higher discount rates.

**E. Simplified Methods**

Simplified methods may be used on immaterial blocks of LTCI policies. The threshold for materiality of the LTCI block shall be 5% of total company reserves.

**F. Remediation of Inadequate Tabular Contract Reserves**
As stated in Section 4D of the Model Regulation, the insurer shall make appropriate increments to the contract reserves if reserve adequacy testing indicates that the basis of the contract reserves is no longer adequate. While standalone testing is required for material LTCI tabular contract reserves, the Model Regulation further elaborates that such increments to cover shortfalls should be made “in the aggregate”. Consistent with the broader reserve adequacy requirements of Section 1, the grouping of contracts that are marketed, serviced, and measured in the same way is permitted when determining the aggregate level of additional reserves required.

G. Documentation of Assumptions Underlying LTCI Contract Reserve Adequacy Analysis

The actuary shall document the following assumptions that are used in the LTCI contract reserve adequacy analysis. Such documentation shall be available upon request by the domestic regulator.

1. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly site adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates for sample issue ages shall be provided. A summary of experience or other justification of expectations shall be documented.

2. Assumptions on lapse shall be documented in table format by duration band and by other factors impacting the lapse assumption, where applicable. A summary of experience or other justification of expectations shall be documented.

3. Assumptions on morbidity shall be documented and justification of the assumption shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

4. Assumptions on investment returns and interest rates shall be documented.

5. Assumptions on future rate increases shall be documented and justified, by rate increase percentage assumed and jurisdiction(s).

6. Any other material assumptions shall be documented.

7. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.

8. Any increments to the contract reserves made as a result of Section F shall be documented.
Eric, here is my comment.

To the extent that the product is deemed not interest sensitive and therefore it is determined that there is no need to consider a variety of economic scenarios, gross premium valuation may be acceptable if the discount rate is carefully selected (not necessarily flat) based on the assets and reinvestment strategy.

An asset adequacy analysis requires assets to be looked at. Gross premium valuation approach, where current and future asset returns are estimated and blended into a discount rate or series of discount rates, may be sufficient if the actuary believes that the result reasonably approximates what would result from a projection reflecting assets' cash flows.

Tomasz Serbinowski, Actuary
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On Wed, Jan 11, 2017 at 6:35 AM, King, Eric <EKing@naic.org> wrote:

The Long-Term Care Valuation (B) Subgroup is accepting comments through Friday, January 27, 2017 on whether assets should be explicitly projected for asset adequacy analysis of long-term care insurance for the purpose of stand-alone long-term care asset adequacy analysis. The alternative would be a gross premium valuation approach where current and future asset returns are estimated and blended into a discount rate or series of discount rates.

Please send comments to Eric King ekimg@naic.org.
confidential, privileged or exempted status of the information transmitted. Unauthorized forwarding, printing, copying, distribution or use of such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error by e-mail or by calling the NAIC Help Desk at (816)783-8500.
January 26, 2017

Perry Kupferman, Chair
Long-Term Care Valuation (B) Subgroup
National Association of Insurance Commissioners

Re: Asset Treatment for Stand-Alone LTC Asset Adequacy Analysis

Dear Mr. Kupferman:

On behalf of the Health Financial Reporting and Solvency Committee of the American Academy of Actuaries, we appreciate the opportunity to offer comments to the Long-Term Care Valuation (B) Subgroup on whether assets should be explicitly projected for asset adequacy analysis of stand-alone long-term care (LTC) insurance plans.

We believe there is sufficient existing actuarial guidance on asset adequacy testing (AAT), which includes both cash flow testing (CFT) and gross premium valuation (GPV). In particular:

1. Section 3.3.2 of ASOP No. 22 (Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers) includes discussion of the various methods for asset adequacy analysis and the situations in which use of a given method is appropriate. Methods other than CFT test the moderately adverse deviations in actuarial assumptions such as morbidity, lapse, and mortality. The choice of an appropriate testing method is based on the professional judgment of the actuary.

2. Section 3.6 in ASOP No. 18 (Long-Term Care Insurance) states “the actuary should consider cash flow testing as a potentially important part of any LTC insurance plans’ financial analysis”. Section 4.1 in ASOP No. 18 states that “the actuary should document the assumptions, the processes used, and the general sources of the data in sufficient detail such that another actuary could use the documentation where appropriate.” Therefore, CFT already is to be considered for LTC insurance and the actuary’s reasoning for not conducting CFT is to be documented.

3. Section 3.2.6 of ASOP No. 18 states: “The expected investment return used should be consistent with the initial and reinvestment returns on assets supporting the LTC insurance benefit promise.” Therefore, the actuary should be able to document how the discount rate used in a GPV calculation complies with this guidance.

We would note that there is divergence in practice among companies with LTC insurance blocks of business, so it is not possible to compare companies’ AAT reserves. Requiring AAT testing does not remove this incomparability. For example:

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1 The American Academy of Actuaries is a 19,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
Only companies subject to the Actuarial Opinion and Memorandum Regulation, which are life insurance companies, are required to perform AAT. If a company with an LTC block of business is not a life insurance company, they may only perform premium deficiency analysis using a GPV on their LTC block of business. These companies would only hold premium deficiency reserves (PDR) if needed in addition to their contract reserves.

Some companies perform premium deficiency analysis using a GPV first and then perform AAT. These companies are likely holding a PDR in addition to their contract reserves and may have an AAT reserve of 0.

Some companies only perform AAT on their LTC block of business, instead of first calculating a PDR. These companies are likely holding an AAT reserve if needed in addition to their contract reserves and do not have a PDR.

Finally, some companies have petitioned their regulator and have received permission to increase their contract reserves, which may remove the need for PDR and possibly reserves from AAT.

We also note that for many companies, LTC insurance may not have a separately defined asset portfolio and, therefore, assigning specific assets to the LTC liabilities may not be feasible. In addition, the LTC product does not generally have embedded options and may not be sensitive to asset cash flows.

We have some additional comments on the scope of the proposed asset adequacy analysis:

1. Section 3.3.4.c of ASOP No. 22 states “For a reserve or other liability to be reported as ‘not analyzed,’ the actuary should determine that the reserve or other liability amount is immaterial.” (Section 6A(2) of the AOMR indicates that the statement of actuarial opinion should describe the scope of the actuary’s work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, and identify the reserves and related actuarial items covered by the opinion that have not been analyzed.) Guidance on materiality is provided in the Preamble to Codification, Section VII (i.e., “Is this item large enough for users of the information to be influenced by it?”). Therefore, we would recommend that you use a percentage, such as where LTC is more than 5 percent of the total reserves, in addition to the set number of 1,000 policies.

2. Does this “Stand-Alone LTC Asset Adequacy Analysis” include combo-products? Combo products are usually grouped with the base policy (UL) instead of being part of the LTC block of business. The committee believes that combo products should not be included with stand-alone LTC but with the base policy product to follow the SSAP 54 guidance of grouping policies by how they are marketed, serviced, and measured.

We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact David Linn, the Academy’s health policy analyst, at 202-785-6931 or linn@actuary.org.

Sincerely,

Laurel Kastrup, MAAA, FSA
Chairperson, Health Financial Reporting and Solvency Committee
American Academy of Actuaries
Thank you for the opportunity to comment on the proposal regarding LTC reserve adequacy. We support and agree with the comment letter from the ACLI and AHIP.

Other than for the state of New York that has specific requirement and specific expectations as outlined in their annual “Special Considerations” letter, current guidance does not require standalone asset adequacy for LTC business. There is guidance regarding premium deficiency considerations for lines of business that expect future periods of losses. However, the guidance for this does not appear to require any specific provision for adverse developments. This implies that premium deficiency calculations can be performed using best estimate assumptions including those for expected investment results.

Consideration of moderately adverse conditions should be considered for a company in the aggregate and the reserve margins required for such scenarios may come from a variety of product lines (but not necessarily all of them). In fact, one of the reasons for aggregation is to allow for and possibly even quantify the impact of natural hedging. Some product lines, like LTC and other traditional products may perform better in increasing interest rate scenarios while other product lines like deferred annuities may not perform as well. Consideration of moderate adverse conditions should allow for this natural hedging; higher gains on some product lines should be allowed cover losses in other product lines. If two product lines perfectly offset each other in various interest rate scenarios, a company should not be required to hold additional reserves for potential changes in this assumption.

Therefore, specifically regarding the question below, we support gross premium valuation of LTC blocks to determine their reserve adequacy using projected yield rates. Such yield rates should be justified based on current portfolio and projected new investment expectations. Specific results for a single product line under a variety of interest rate scenarios should not be required.

MEB

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The Long-Term Care Valuation (B) Subgroup of the of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Feb. 17, 2017. The following Subgroup members participated: Perry Kupferman, Chair (CA); Tricia Dave (CT); Lisa Parker (FL); Fred Andersen (MN); Derek Wallman (NE); Terry Seaton (NM); William Carmello (NY); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Discussed a Revised Proposal for Stand-Alone LTCI Asset Adequacy Requirements

Mr. Andersen presented a revised version (Attachment One) of the Subgroup’s draft actuarial guideline that requires performing stand-alone asset adequacy analysis of long-term care insurance (LTCI) blocks that reflects comments received on its initial exposure.

Mr. Serbinowski asked if the definition of “major long-term care block of contracts” in Section 3.A. of the draft actuarial guideline as being 10,000 lives refers to a single LTCI block or all of the company’s LTCI blocks in aggregate. Mr. Andersen said this depends on whether a state requires reserves to be held at a distinct block level or at an aggregated level. He said, at a minimum, a company should model its LTCI blocks in aggregate. Mr. Boerner asked if a company that has at least one LTCI block with 10,000 or more lives will be required to conduct separate stand-alone asset adequacy tests for each of its LTCI blocks. Mr. Andersen said his intention is that there will be one stand-alone test for the company’s LTCI blocks in aggregate at a minimum, but a company may need to do separate analyses of each LTCI block if state-specific rules require this. He said this issue can be commented on when the next version of the draft is exposed.

Ms. Parker said the language in Section 4.C. may be ambiguous. Mr. Andersen said the intent is that a company may only use excess reserves from cash-flow testing (CFT) its entire portfolio to offset reserve deficiencies in its LTCI blocks if the LTCI blocks are subjected to stand-alone CFT. If the company conducts its stand-alone LTCI test using a gross premium valuation (GPV), and a reserve inadequacy is indicated, it cannot use excess reserves from the company’s entire portfolio, and will be required to increase its LTCI reserves. Ms. Parker said the language should be revised to make the intent of this section more clear.

Mr. Kupferman said a version of the actuarial guideline that reflects changes discussed during the conference call will be exposed for a public comment period of 30 days once it is available.

Having no further business, the Long-Term Care Valuation (B) Subgroup adjourned.
Actuarial Guideline LTC

THE APPLICATION OF THE HEALTH INSURANCE RESERVES MODEL REGULATION FOR TESTING THE ADEQUACY OF LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance Reserves Model Regulation (HEO10) contains requirements for calculation of long-term care insurance (LTC) reserves. Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. For instance, the Model Regulation states, “a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts”; however, other wording in the Model Regulation creates confusion for some people on whether the test of adequacy is required at the major block of contract level. In the absence of uniform guidance, some insurers may not be determining adequacy of LTC reserves to the same degree as others, resulting in a non-level playing field and concerns that reserve adequacy is not being appropriately tested by each insurer.

This guideline provides uniform guidance for insurers with a major LTC block of contracts. In particular, this guideline:

1. Requires asset adequacy analysis of an insurer’s major LTC block of contracts.
2. Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area.
3. Provides a process for increasing reserves, where applicable.
4. Requires a uniformity approach to assuming future rate increases.
5. Provides requirements on documentation of assumptions.

Text

1. Effective Date

This Guideline shall be effective for reserves reported in the December 31, 2017 and subsequent annual statutory financial statements.

2. Scope

This Guideline shall apply to all long-term care insurance contracts, whether directly written or assumed through reinsurance. Accelerated death benefit products or other combination products where the substantial risk is associated with life insurance or an annuity are not subject to this Guideline.

3. Definition

A. Major Long-Term Care Block of Contracts. A block of long-term care insurance contracts with over 10,000 inforce policyholders as of the valuation date will be considered major for purposes of applying this Guideline.

4. Asset Adequacy Analysis of a Major Long-Term Care Block of Contracts (LTC block)

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-flow testing and gross premium valuation, are available to actuaries.
The method of analysis shall conform, in recognition of the typical significant asset- and liability-related risks, with ASOP No. 22.

B. Reserves for a major Long-Term Care LTC block of Contracts must be supported by an asset adequacy analysis specific to this block of contracts for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks (assumptions) associated with the block of business and determination of asset adequacy over moderately adverse conditions across key actuarial assumptions. Testing moderately adverse deviations in actuarial assumptions.

BC. When determining whether additional reserves are necessary:

1. In the case where cash-flow testing is used both for an LTC block and for the companywide analysis, aggregation of projected LTC losses may be offset by projected and justified overall company gains. The LTC-related assumptions in the companywide cash-flow testing shall be the same as with the standalone LTC cash-flow testing.

2. In cases where cash-flow testing is not used for the LTC block, reserves for the LTC block shall be increased by any additional reserves required by the standalone LTC block asset adequacy analysis.

3. Phase-in of additional reserves according to considerations stated in Section 4.F. may be available. Reserves for the major long-term care block of contracts shall be increased by any additional reserves required by the asset adequacy analysis, subject to a phase-in option described in Section 4.E.

C. Where there are material asset risks, where liabilities have cash flows far out into the future, where there is a material risk of asset liability mismatch risk, or for other reasons, cash-flow testing may be the appropriate method unless the risks can be demonstrated to be appropriately captured in an alternative method such as a gross premium valuation. The method of analysis must be deemed appropriate based on Actuarial Standards of Practice.

D. The analysis shall represent investment income associated with the LTC block consistently with the way assets within the General Account are managed. If a segment of the General Account is used to manage the investment risk for the LTC block, the assets from that segment should be appropriately represented within the asset adequacy analysis whether asset cash flows are explicitly generated or whether a simpler method to reflect investment income is used in the analysis.

If a gross premium valuation method is used, the discount rate used by the actuary must consider the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divesture of existing assets.

DE. The analysis shall anticipate no premium rate increases unless a rate increase plan is documented, is supported by and has been to be supported and approved by management, is highly likely to be executed, and contains documented, realistic estimated approved amounts and times by jurisdiction.

EE. If the stand-alone asset adequacy analysis for the LTC block demonstrates a potential need for additional reserves, with or without aggregation with other block of business as contemplated in Section 4.B., a phase-in period of up to three years may be approved by the company’s domiciliary Commissioner. Such phase-in period shall only be permitted if the company is able to demonstrate to the satisfaction of the Commissioner that it would not be operating in a hazardous financial condition and that there is not adverse risk to its insureds.

FG. The asset adequacy analysis shall be in the form of an Actuarial Memorandum which contains documentation of the assumptions and results of the analysis and shall be submitted to the state of domicile of the company by the April 30 following the valuation date. The state of domicile shall provide a copy of the Actuarial Memorandum to any other state in which the company is licensed, upon request.
5. Documentation of Assumptions Underlying Long-Term Care Insurance Asset Adequacy Analysis to be provided in the Stand-Alone Actuarial Memorandum

A. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly site adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates for sample issue ages shall be provided. A summary of experience or other justification of expectations shall be documented, including an explanation of any material differences between the assumption and a standard table.

B. Assumptions on lapse shall be documented in table format by duration band and by other factors such as gender, marital status, with versus without inflation rider, and lifetime versus non-lifetime benefit impacting the lapse assumption, where applicable. A summary of experience or other justification of expectations shall be documented.

C. Assumptions on morbidity shall be documented and justification of the assumption shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

D. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross premium valuation as contemplated in Section 4.D., then justification shall be provided.

E. Assumptions on future rate increases shall be documented, by rate increase percentage assumed and jurisdiction; and the documentation and justification stated in Section 4.DE. shall be provided.

F. Documentation of other material assumptions shall be provided.

G. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.
March 22, 2017

Perry Kupferman
Chair
NAIC Long-term Care Valuation Subgroup

RE: Actuarial Guideline LTC

Dear Mr. Kupferman:

ACLI1 and AHIP2 appreciate the opportunity to comment on the most recent Exposure Draft of Actuarial Guideline LTC (AG LTC).

By and large, we are agreeable to the concepts contained in the Exposure Draft. Having said that, we believe that there is a serious legal issue in the draft because it ties the Actuarial Guideline to the NAIC Health Reserves Model Regulation (Model #10) and the subsequent guidance contained in VM-25 of the Valuation Manual. The legal flaw will likely invalidate the intent of the Actuarial Guideline because it will be in conflict with states’ regulations. Our analysis is below.

Legal Analysis of Conflict between AG LTC and State Adopted Equivalents to Model #10

Wording of Model #10 (and state-adopted equivalents)

Section 1 of Model #10 contains the following wording:

With respect to any block or contract, or with respect to an insurer’s health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected

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1 The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 94 percent of industry assets, 93 percent of life insurance premiums, and 97 percent of annuity considerations in the United States. Learn more at www.acli.com.

2 America's Health Insurance Plans (AHIP) is the national trade association representing the health insurance community. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Learn more at www.ahip.org
expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

There is no ambiguity in regards to either the “ultimate test of reserve adequacy” (a prospective gross premium valuation), or the basis under which the gross premium valuation is to be performed (expected benefits, expected expenses, and expected premiums).

Wording of Exposure Draft of AG LTC
The wording in the Background Section of AG LTC says:

This guideline provides uniform guidance for insurers with a major LTC block of contracts. In particular, this guideline:
(1) Requires asset adequacy analysis of an insurer’s major LTC block of contracts.
(2) Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area.

And, Section 3B of AG LTC states:

Reserves for an LTC block must be supported by an asset adequacy analysis specific to this block of contracts for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks (assumptions) associated with the block of business and determination of asset adequacy over moderately adverse conditions across key actuarial assumptions.

AG LTC clearly is requiring that testing be performed at moderately adverse conditions, and specifies the use of a more robust form of reserve testing than gross premium valuation in order to get the benefits of aggregation.

The Conflicts

AG LTC calls for a more robust version of testing than gross premium valuation, while Model #10 does not allow for a more robust version of testing than gross premium valuation, since it states that gross premium valuation is the ultimate test of reserve adequacy. Additionally, reserve testing under Model #10 is to be performed using assumptions set at the expected level, while reserve testing under AG LTC is to be performed using assumptions set at moderately adverse levels.

The Problem

An actuarial guideline receives its authority through its inclusion in the NAIC Accounting Practices and Procedures Manual, which is incorporated into each state’s law. The preface to the NAIC Accounting Practices and Procedures Manual states that the guidance contained in the Manual is to be used unless it is in conflict with a state law, regulation, or bulletin. As shown above, AG LTC is in conflict with each state’s adopted version of Model #10, and, therefore, the actuarial guideline is overridden by the state’s regulation.

The Solution

ACLI and AHIP believe that the only solution to this issue is to completely divorce AG LTC from Model #10. Needing a state law or regulation to tie AG LTC, we suggest the most appropriate existing
requirement is the Actuarial Opinion and Memorandum Regulation, which is now contained in the
NAIC Valuation Manual as VM-30. And while tying AG LTC to VM-30 solves the legal issue, it also
comes with some significant benefits. Those benefits are:

1. VM-30 contains all of the requirements for asset adequacy analysis. There is no need to
   make sure that guidance in the Actuarial Guideline has mistakenly been omitted;
2. VM-30 requires assumptions at a moderately adverse level;
3. VM-30 contains appropriate confidentiality requirements;
4. VM-30 contains robust memorandum disclosure requirements and can be expanded upon
   for LTC; and,
5. VM-30 already contains the consequences of inadequate reserves, i.e., a qualified actuarial
   opinion.

We have attached a clean version as well as a marked-up version of AG LTC which divorces it from
Model #10 and, instead, ties it to VM-30. The changes made to the actuarial guideline are generally
made only to conform it for use with VM-30. We have noted in the mark-up any suggested changes,
and their rationale, that are not a result of tying the actuarial guideline to VM-30.

Summary

ACLI and AHIP strongly believe that the legal challenges faced by the current Exposure Draft of AG
LTC can only be overcome by using VM-30 as legal basis for the actuarial guideline. In addition,
there are regulatory benefits of doing so, without any perceptible downsides.

We believe that, should you agree with us, the revised AG LTC can be exposed for a short period and
still adopted in time for use at year-end 2017. We would also point out that we believe that it makes
sense to incorporate these requirements directly into VM-30 at the earliest possible time, and the
actuarial guideline can sunset upon the effective date of those changes.

We look forward to continuing discussions on this issue at the next meeting of the Subgroup.

Sincerely,

Paul A. Graham, III, FSA, MAAA
Senior Vice President, Insurance Regulation & Chief Actuary
ACLI

William C. Weller
Consultant to AHIP

cc: Members, NAIC Long-term Care Actuarial Working Group
    Eric King, NAIC Staff
THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance Reserves Model Regulation (#010) and the NAIC Valuation Manual (VM-25) contain requirements for the calculation of long-term care insurance (LTC) reserves. Section 1 of Model #10 states:

With respect to any block or contract, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. Additionally, gross premium valuations are based on assumptions of expected outcomes, rather than moderately adverse assumptions. As a result, the reserve adequacy testing required by Model #10 and VM-25 does not give regulators comfort as to the actual reserve adequacy of companies with material blocks of LTC business. As such, regulators must rely upon asset adequacy analysis required by the NAIC Valuation Manual (VM-30) to ensure the solvency of companies with sizable blocks of LTC business. This Guideline provides uniform guidance and clarifies requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to an insurer's LTC block of contracts. In particular, this Guideline:

1. Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area;
2. Clarifies what type of adequacy testing methods must be used for aggregation with other blocks of business for asset adequacy analysis purposes;
3. Requires a uniform approach to supporting acceptable assumptions regarding future LTC premium rate increases;
4. Provides requirements for documentation of assumptions associated with all key LTC risks; and
5. Provides requirements for documentation of standalone LTC asset adequacy testing results.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) for valuation years beginning 1/1/18, and that this Guideline will, thus, cease to apply to subsequent annual statutory financial statements.

Text

1. Effective Date

This Guideline shall be effective for reserves reported with the December 31, 2017 and subsequent annual statutory financial statements.

2. Authority

Pursuant to Section 1, paragraph 3, of VM-30 of the NAIC Valuation Manual, the commissioner shall have the
authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

3. Scope

This Guideline shall apply to an insurer with long-term care insurance contracts with over 10,000 in force lives as of the valuation date. All long-term care insurance contracts, whether directly written or assumed through reinsurance are included. Accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity are not subject to this Guideline.

4. Asset Adequacy Analysis of LTC Business

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-flow testing and gross premium valuation, are available to actuaries for this analysis.

   The method of analysis used for LTC shall conform with ASOP No. 22 in recognition of the typical significant asset- and liability-related risks associated with LTC.

B. Asset adequacy analysis specific to LTC business, and without consideration of results for other block of business within the company, must be performed for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding consideration of key risks and sensitivity testing of moderately adverse deviations in assumptions.

C. When determining whether additional reserves are necessary:

   1. The LTC block may be aggregated with other Company blocks of business for the purposes of developing an actuarial opinion, if cash-flow testing is used both for the analysis of the LTC business and for all substantial blocks of non-LTC business within a company.

   2. A prospective gross premium valuation utilized for purposes of asset adequacy analysis of a LTC block under this Guideline may not be aggregated with other Company blocks of business.

   3. If the LTC is not aggregated with the other Company blocks of business, then additional LTC reserves must be based upon the asset adequacy of the LTC block on a stand-alone basis and the asset adequacy of the other Company blocks may not be supported by the LTC block asset adequacy analysis. An appointed actuary shall not issue an unqualified actuarial opinion if the appointed actuary determines that there is a deficiency in the LTC block of business, which has not been remediated by establishing additional reserves.

D. When determining the effect of investment returns or the time value of money:

   1. In the case where cash-flow testing is used, the company must allocate investment income to the LTC block of business consistently with the way investment income generated by the General Account is managed. If, however, a segment of the General Account is used to manage the investment risk for LTC business, the investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis.

   2. In the case where a gross premium valuation method is used or asset cash flows are not explicitly modeled, the discount rate used by the actuary must reflect consideration of the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divestiture of existing assets.

E. The analysis shall anticipate no premium rate increases unless a rate increase plan is documented, is
supported by and has been approved by management, is highly likely to be undertaken, and contains documented, realistic estimated approved amounts and implementation timelines by jurisdiction.

5. Documentation Required

The documentation requirements below are to be incorporated into the appointed actuary’s Actuarial Memorandum required by the NAIC Valuation Manual (VM-30) if such a Memorandum is required. If a companywide memorandum is not required, a special Actuarial Memorandum containing LTC-specific information is required. The confidentiality provisions regarding the Actuarial Memorandum contained in VM-30 are applicable to this special Memorandum, which shall be submitted to the commissioner of the insurer’s state of domicile. The special Actuarial Memorandum shall be available to other state insurance commissioners in which the company is licensed upon request to the company.

A. Results of the asset adequacy analysis of the LTC business shall be separately reported and documented.

B. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly cite adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates and comparison of the applied rates to rates from an unmodified standard mortality table for sample issue ages shall be provided. A summary of experience or other actuarial support of assumptions used shall be documented.

C. Assumptions on voluntary lapse shall be documented in table format by duration band and by other factors such as gender, marital status, with versus without inflation rider, and length of benefit period impacting the lapse assumption, where applicable. A summary of experience or other support of assumptions shall be documented.

D. Assumptions on morbidity shall be documented and actuarial support of the assumptions shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

E. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross premium valuation as contemplated in Section 4.D.2., then justification shall be provided.

F. Assumptions on future rate increases shall be documented, by rate increase percentage assumed and by block of policy forms if rate increase expectations vary.

G. Documentation of any other material assumptions shall be provided.

H. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.
THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance reserves Model Regulation (#10) and the NAIC Valuation Manual (VM-25) contain requirements for the calculation of long-term care insurance (LTC) reserves. Section 1 of Model #10 states:

With respect to any block or contract, or with respect to an insurer’s health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims states, or in a continuation of benefits states on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. Additionally, gross premium valuations are based on assumptions of expected outcomes, rather than moderately adverse assumptions. For instance, the Model Regulation states: “A gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts.” However, other wording in the Model Regulation creates confusion for some on whether the test of adequacy is required at the major block of contract level. In the absence of uniform guidance, insurers may not be determining adequacy of LTC reserves in a uniform manner. As a result, the reserve adequacy testing required by Model #10 and VM-25 does not give regulators comfort as to the actual reserve adequacy of companies with material blocks of LTC business. As such, regulators must rely upon asset adequacy analyses required by the NAIC Valuation Manual (VM-30) to ensure the solvency of companies with sizable blocks of LTC business. This Guideline provides uniform guidance and clarifies requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to an insurer’s major LTC block of contracts. In particular, this Guideline:

1. Requires asset adequacy analysis of an insurer’s LTC business that falls within the scope of the Guideline (LTC business):
   1. Requires that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area;
   2. Requires that the type of adequacy testing methods must be used for aggregation with other blocks of business for asset adequacy analysis purposes;
   3. Provides a process and maximum timeframe for increasing reserves determined to be inadequate, where applicable;
   4. Requires a uniform approach to supporting acceptable assumptions regarding future LTC premium rate increases;
   5. Provides requirements for documentation of assumptions associated with all key LTC risks; and

2. Provides requirements for documentation of standalone LTC asset adequacy testing results.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30 for valuation years beginning 1/1/18, and that this Guideline will, thus, cease to apply to subsequent annual statutory financial statements.

Text

1. Effective Date

This Guideline shall be effective for reserves reported with the December 31, 2017 and subsequent annual statutory financial statements.
2. Authority

Pursuant to Section 1, paragraph 3, of VM-30 of the NAIC Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

3. Scope

This Guideline shall apply to an insurer with long-term care insurance contracts with over 10,000 in force lives as of the valuation date. All long-term care insurance contracts, whether directly written or assumed through reinsurance, are included. Accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity are not subject to this Guideline.

3.4 Asset Adequacy Analysis of LTC Business

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-flow testing and gross premium valuation, are available to actuaries for this analysis.

The method of analysis used for LTC shall conform with ASOP No. 22 in recognition of the typical significant asset and liability-related risks associated with LTC.

B. Asset adequacy analysis specific to LTC business, and without consideration of results for other blocks of business within the company, must be performed for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks and sensitivity testing of moderately adverse deviations in assumptions. Material assumptions associated with the LTC business shall be determined testing moderately adverse deviations in actuarial assumptions.

C. When determining whether additional reserves are necessary:

1. In the case where cash-flow testing is used both for LTC business and for the companywide analysis, the LTC block may be aggregated with other Company blocks of business for the purposes of developing an actuarial opinion, if cash-flow testing is used both for the analysis of the LTC business and for all substantial blocks of non-LTC business within a company.

   a. A deficiency in the LTC segment may be offset by a projected and justified overall cash-flow testing sufficiency in non-LTC segments. The LTC-related assumptions in the companywide cash-flow testing shall be the same as with the standalone LTC cash-flow testing.

   b. To the extent projected LTC reserve insufficiency is not offset through aggregation, reserves for LTC business shall be increased by any additional reserves required to eliminate the projected reserve insufficiency.

   c. Requirements for standalone analysis for a health insurance major block of contracts, per Model Regulation 1910, still apply even if aggregation of cash-flow testing results occurs.

2. In cases where cash-flow testing is not used for LTC business, reserves for LTC business shall be increased by any additional reserves required by the standalone LTC business asset adequacy analysis to eliminate a reserve insufficiency. A prospective gross premium valuation utilized for purposes of asset adequacy analysis of a LTC block under this Guideline may not be aggregated with other Company blocks of business.

3. If the LTC is not aggregated with the other Company blocks of business, then additional LTC reserves must be based upon the asset adequacy of the LTC block on a stand-alone basis and the asset adequacy of the other Company blocks may not be supported by the LTC block asset adequacy analysis. An appointed actuary shall not issue an unqualified actuarial opinion if the appointed actuary determines that there is a deficiency in the LTC block of business, which has not been remediated by establishing additional reserves.

   a. Phase-in of additional reserves according to considerations stated in Section 3.1, may be available.
D. When determining the effect of investment returns or the time value of money:

1. In the case where cash-flow testing is used, the company must allocate investment income to the LTC block of business; the analysis shall represent investment income associated with LTC business consistently with the way investment income generated by assets associated with the General Account is managed. However, a segment of the General Account is used to manage the investment risk for LTC business, the investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis, whether asset cash flows are explicitly generated or whether a simpler method to reflect investment income is used in the analysis.

2. In the case where a gross premium valuation method is used or asset cash flows are not explicitly modeled, the discount rate used by the actuary must reflect consideration of the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divestures of existing assets.

E. The analysis shall anticipate no premium rate increases unless a rate increase plan is documented, is supported by and has been approved by management, is highly likely to be executed and undertaken, and contains documented, realistic estimated approved amounts and implementation timelines by jurisdiction.

F. If the standalone asset adequacy analysis for LTC business demonstrates a potential need for additional reserves, with or without offsets from non-LTC business as contemplated in section 3.C., a phase-in period of up to three years may be approved by the company's domiciliary Commissioner. Such phase-in period shall only be permitted if the company is able to demonstrate to the satisfaction of the Commissioner that it would not be operating in a hazardous financial condition and that there is not adverse risk to its insureds. G. The asset adequacy analysis shall be in the form of an Actuarial Memorandum which contains documentation of the assumptions and results of the analysis and shall be submitted to the state domiciliary of the company by the April 30 following the valuation date. The company shall provide a copy of the Actuarial Memorandum to any state in which the company is licensed, upon request.

45. Documentation Required of Assumptions Underlying Long-Term Care Insurance Asset Adequacy Analysis to be provided in the Standalone Actuarial Memorandum

The documentation requirements below are to be incorporated into the appointed actuary's Actuarial Memorandum required by the NAIC Valuation Manual (PM-30) if such a Memorandum is required. If a companywide memorandum is not required, a special Actuarial Memorandum containing LTC-specific information is required. The confidentiality provisions regarding the Actuarial Memorandum contained in PM-30 are applicable to this special Memorandum, which shall be submitted to the commissioner of the insurer's state of domicile. The special Actuarial Memorandum shall be available to other state insurance commissioners in which the company is licensed upon request to the company.

A. Results of the asset adequacy analysis of the LTC business shall be separately reported and documented.

A.B. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly state adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates and comparison of the applied rates to rates from an unmodified standard mortality table for sample issue ages shall be provided. A summary of experience or other actuarial support of assumptions used shall be documented.

B.C. Assumptions on voluntary lapse shall be documented in table format by duration band and by other factors such as gender, marital status, with versus without inflation rider, and length of benefit period impacting the lapse assumption, where applicable. A summary of experience or other justifications support of assumption assumptions shall be documented.

D.G. Assumptions on morbidity shall be documented and justifications actuarial support of the assumptions shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

D.E. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross premium valuation as contemplated in Section 3.D.2., then justification shall be provided.
B.7 Assumptions on future rate increases shall be documented, by rate increase percentage assumed and jurisdiction, and the documentation and justification stated in Section 3.E. shall be provided and by block of policy forms if rate increase expectations vary.

F.4 Documentation of any other material assumptions shall be provided.

G.4 Documentation shall be provided for assumptions that have significantly changed from the prior year's analysis.

Commented [A4]: We do not believe that the jurisdictions need to be named in the disclosure requirements due to political sensitivities of cross-subsidization.
Acuarial Guideline LTC

THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance Reserves Model Regulation (#010) and the NAIC Valuation Manual (VM-25) contain requirements for the calculation of long-term care insurance (LTC) reserves. Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. For instance, the Model Regulation states, “a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts”; however, other wording in the Model Regulation creates confusion for some on whether the test of adequacy is required at the major block of contract level. In the absence of uniform guidance, insurers may not be determining adequacy of LTC reserves in a uniform manner. As a result, the reserve adequacy testing required by Model #10 and VM-25 does not provide regulators comfort as to the actual reserve adequacy of companies with material blocks of LTC business. As such, regulators must rely upon asset adequacy analysis required by the NAIC Valuation Manual (VM-30) to ensure the solvency position of companies with sizable blocks of LTC business.

This Guideline provides uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to an insurer’s major LTC block of contracts. In particular, this Guideline:

1. Requires asset adequacy analysis of an insurer’s LTC business that falls within the scope of the Guideline (LTC business).
2. Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area.
3. Clarifies what the type of adequacy testing methods that must be used for aggregation with other blocks of business to be allowed for asset adequacy analysis purposes.
4. Provides a process and maximum timeframe for increasing reserves determined to be inadequate, where applicable.
5. Requires a uniform approach to supporting acceptable assumptions regarding future LTC premium rate increases;
6. Provides requirements for documentation of assumptions associated with all key LTC risks; and
7. Provides requirements for documentation of standalone LTC asset adequacy testing results.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) at a future date, effective for a future valuation year, for valuation years beginning 1/1/18, and that this Guideline will thus cease to apply to subsequent annual statutory financial statements at the time the corresponding VM-30 requirements become effective.

Text

1. Effective Date

This Guideline shall be effective for reserves reported with the December 31, 2017 and subsequent annual statutory financial statements.

2. Authority

Pursuant to Section 1, paragraph 3, of VM-30 of the NAIC Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.
2.3 Scope

This Guideline shall apply to an insurer with long-term care insurance contracts with over 10,000 inforce lives as of the valuation date. All long-term care insurance contracts, whether directly written or assumed through reinsurance, are included. Accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity are not subject to this Guideline.

3. Asset Adequacy Analysis of LTC Business

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-flow testing and gross premium valuation, are available to actuaries for this analysis. The method of analysis used for LTC shall conform with ASOP No. 22 in recognition of the typical significant asset- and liability-related risks associated with LTC.

B. Asset adequacy analysis specific to all inforce LTC business, and without consideration of results for other block of business within the company, must be performed for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTC business shall be determined through testing moderately adverse deviations in actuarial assumptions.

C. When determining whether additional reserves are necessary:

1. In the case where cash-flow testing is used both for LTC business and for the companywide analysis, a reserve deficiency in the LTC block may be aggregated with sufficiencies in the company’s other Company blocks of business for the purposes of developing an actuarial opinion, if cash-flow testing is used for both the LTC business and for all substantial significant blocks of non-LTC business within a company.

   a. A deficiency in the LTC segment may be offset by a projected and justified overall cash-flow testing sufficiency in non-LTC segments. The LTC related assumptions in the companywide cash flow testing shall be the same as with the standalone LTC cash flow testing.

   b. To the extent projected LTC reserve insufficiency is not offset through aggregation, reserves for LTC business shall be increased by any additional reserves required to eliminate the projected reserve insufficiency.

   c. Requirements for standalone analysis for a health insurance major block of contracts, per Model Regulation #010, still apply even if aggregation of cash-flow testing results occurs.

2. In cases where cash-flow testing is not used for LTC business, reserves for LTC business shall be increased by any additional reserves required by the standalone LTC business asset adequacy analysis to eliminate a reserve insufficiency. A reserve deficiency revealed from a prospective gross premium valuation utilized for purposes of LTC reserve asset adequacy analysis of the LTC block under Model #10 is not considered asset adequacy analysis and thus this Guideline may not be aggregated with sufficiencies in the company’s other Company blocks of business.

3. If reserve deficiencies in the LTC block are not aggregated offset with sufficiencies in the company’s other Company blocks of business, then additional LTC reserves must be based upon the asset adequacy of the reserves in the LTC block on a stand-alone basis and the asset adequacy of the other Company blocks may not be supported by the LTC block asset adequacy analysis. An appointed actuary shall not issue an unqualified actuarial opinion if the appointed actuary determines that there is a deficiency in the LTC block of business, which has not been remediated by establishing additional reserves.

D. When determining the effect of investment returns or the time value of money:
1. In the case where cash-flow testing is used, the company must allocate investment income to the LTC block of business. The analysis shall represent investment income associated with LTC business consistently with the way investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis. If, however, a segment of the General Account is used to manage the investment risk for LTC business, the investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis, whether asset cash flows are explicitly generated or whether a simpler method to reflect investment income is used in the analysis.

2. In the case where a gross premium valuation method is used or asset cash flows are not explicitly modeled, the discount rate used by the actuary must reflect consideration of the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divesture of existing assets.

E. The analysis shall anticipate no premium rate increases unless a rate increase plan is documented, is supported by and has been approved by management, is highly likely to be executed, and contains documented, realistic estimated approved amounts and implementation timelines by jurisdiction.

F. If the standalone asset adequacy analysis for LTC business demonstrates a potential need for additional reserves, with or without offsets from non-LTC business as contemplated in section 3.C., a phase in period of up to three years may be approved by the company’s domicile Commissioner. Such phase in period shall only be permitted if the company is able to demonstrate to the satisfaction of the Commissioner that it would not be operating in a hazardous financial condition and that there is not adverse risk to its insureds. G. The asset adequacy analysis shall be in the form of an Actuarial Memorandum which contains documentation of the assumptions and results of the analysis and shall be submitted to the state of domicile of the company by the April 30 following the valuation date. The company shall provide a copy of the Actuarial Memorandum to any state in which the company is licensed, upon request.

45. **Documentation Required of Assumptions Underlying Long-Term Care Insurance Asset Adequacy Analysis to be provided in the Standalone Actuarial Memorandum**

The documentation requirements below are to be incorporated as a separate section of into the appointed actuary’s Actuarial Memorandum required by the NAIC Valuation Manual (VM-30) if such a Memorandum is required. If a companywide memorandum is not required, or in a special Actuarial Memorandum containing LTC-specific information is required and . The confidentiality provisions regarding the Actuarial Memorandum contained in VM-30 are applicable to this special Memorandum, which shall be submitted to the commissioner of the insurer’s state of domicile. The separate section of the companywide Actuarial Memorandum or the special Actuarial Memorandum shall be available to other state insurance commissioners in which the company is licensed upon request. The confidentiality provisions regarding the Actuarial Memorandum contained in VM-30 are applicable to the separate section of the Actuarial Memorandum and to the special Memorandum.

A. Results of the asset adequacy analysis of the LTC business shall be separately reported and documented in the separate section of the Actuarial Memorandum or the special Memorandum, as appropriate.

A-B. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly site adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates and comparison of the applied rates to rates from an unmodified standard mortality table for sample issue ages shall be provided. A summary of experience or other actuarial support of assumptions used shall be documented.

B-C. Assumptions on voluntary lapse shall be documented in table format by duration band and by other factors such as gender, marital status, with versus without inflation rider, and length of benefit period impacting the lapse assumption, where applicable. A summary of experience or other justification of expectations assumptions shall be documented.

C-D. Assumptions on morbidity shall be documented and justification-actuarial support of the assumption shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

D-E. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross
premium valuation as contemplated in Section 3.E.2., then justification shall be provided.

E-F. Assumptions on future rate increases shall be documented, by rate increase percentage assumed, and by jurisdiction; and the documentation and justification stated in Section 3.E. shall be provided, and by blocksubset of policy forms if rate increase expectations vary. The Memorandum shall contain a signed and dated written representation from management that the analysis appropriately reflects management’s intent to carry out the actions specified in Section 4.E.

F-G. Documentation of any other material assumptions shall be provided.

G-H. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.
Actuarial Guideline LTC

THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance Reserves Model Regulation (#010) and the NAIC Valuation Manual (VM-25) contain requirements for the calculation of long-term care insurance (LTC) reserves. Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. The reserve adequacy testing required by Model #10 and VM-25 does not provide regulators comfort as to the reserve adequacy of companies with material blocks of LTC business. As such, regulators must rely upon asset adequacy analysis required by the NAIC Valuation Manual (VM-30) to evaluate the solvency position of companies with sizable blocks of LTC business. This Guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to an insurer’s LTC block of contracts. In particular, this Guideline:

1. Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area;
2. Clarifies the type of adequacy testing methods that must be used for aggregation with other blocks of business to be allowed for asset adequacy analysis purposes;
3. Requires a uniform approach to supporting acceptable assumptions regarding future LTC premium rate increases;
4. Provides requirements for documentation of assumptions associated with all key LTC risks; and
5. Provides requirements for documentation of standalone LTC asset adequacy testing results.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) at a future date, effective for a future valuation year. This Guideline will cease to apply to annual statutory financial statements at the time the corresponding VM-30 requirements become effective.

Text

1. Effective Date

This Guideline shall be effective for reserves reported with the December 31, 2017 and subsequent annual statutory financial statements.

2. Authority

Pursuant to Section 1, paragraph 3, of VM-30 of the NAIC Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

3. Scope

This Guideline shall apply to an insurer with long-term care insurance contracts with over 10,000 inforce lives as of the valuation date. All long-term care insurance contracts, whether directly written or assumed through reinsurance are included. Accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity are not subject to this Guideline.

4. Asset Adequacy Analysis of LTC Business

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-
flow testing and gross premium valuation, are available to actuaries for this analysis.

The method of analysis used for LTC shall conform with ASOP No. 22 in recognition of the typical significant asset- and liability-related risks associated with LTC.

B. Asset adequacy analysis specific to all inforce LTC business, and without consideration of results for other block of business within the company, must be performed for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTC business shall be determined testing moderately adverse deviations in actuarial assumptions.

C. When determining whether additional reserves are necessary:

1. A reserve deficiency in the LTC block may be aggregated with sufficiencies in the company’s other blocks of business for the purposes of developing an actuarial opinion, if cash-flow testing is used for both the LTC business and for all significant blocks of non-LTC business within a company.

2. A reserve deficiency revealed from a gross premium valuation utilized for purposes of asset adequacy analysis of the LTC block under this Guideline shall not be offset with sufficiencies in the company’s other blocks of business.

3. If reserve deficiencies in the LTC block are not offset with sufficiencies in the company’s other blocks of business, then additional LTC reserves must be based upon the adequacy of the reserves in the LTC block. An appointed actuary shall not issue an unqualified actuarial opinion if the appointed actuary determines that there is a deficiency in the LTC block of business which has not been remediated by establishing additional reserves.

D. When determining the effect of investment returns or the time value of money:

1. In the case where cash-flow testing is used, the company must allocate investment income to the LTC block of business consistently with the way investment income generated by the General Account is managed. If, however, a segment of the General Account is used to manage the investment risk for LTC business, the investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis.

2. In the case where a gross premium valuation method is used or asset cash flows are not explicitly modeled, the discount rate used by the actuary must reflect consideration of the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divesture of existing assets.

E. The analysis shall anticipate no premium rate increases unless a rate increase plan is documented, is supported by and has been approved by management, is highly likely to be undertaken, and contains documented, realistic estimated approved amounts and implementation timelines by jurisdiction.

5. Documentation Required

The documentation requirements below are to be incorporated as a separate section of the appointed actuary’s Actuarial Memorandum required by the NAIC Valuation Manual (VM-30) or in a special Actuarial Memorandum containing LTC-specific information and shall be submitted to the commissioner of the insurer’s state of domicile. The separate section of the companywide Actuarial Memorandum or the special Actuarial Memorandum shall be available to other state insurance commissioners in which the company is licensed upon request to the company. The confidentiality provisions regarding the Actuarial Memorandum contained in VM-30 are applicable to the separate section of the Actuarial Memorandum and to the special Memorandum.

A. Results of the asset adequacy analysis of the LTC business shall be reported and documented in the separate section of the Actuarial Memorandum or the special Memorandum, as appropriate.

B. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly site adjustments, select factors, and mortality improvement factors, where applicable. If a reference
standard valuation table is not used in setting the mortality assumption, then a table of rates and comparison of
the applied rates to rates from an unmodified standard mortality table for sample issue ages shall be provided. A
summary of experience or other actuarial support of assumptions used shall be documented.

C. Assumptions on voluntary lapse shall be documented in table format by duration band and by other factors such
  as gender, marital status, with versus without inflation rider, and length of benefit period impacting the lapse
  assumption, where applicable. A summary of experience or other support of assumptions shall be documented.

D. Assumptions on morbidity shall be documented and actuarial support of the assumption shall be provided. If an
  outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that
  source and any adjustments to the factors from that source shall be documented.

E. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied,
  such as implicit reflection of projected investment returns through the use of discount rates in a gross premium
  valuation as contemplated in Section 4.D.2., then justification shall be provided.

F. Assumptions on future rate increases shall be documented, by rate increase percentage assumed, by jurisdiction,
  and by subset of policy forms if rate increase expectations vary. The Memorandum shall contain a signed and
  dated written representation from management that the analysis appropriately reflects management’s intent to
  carry out the actions specified in Section 4.E.

G. Documentation of any other material assumptions shall be provided.

H. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.
Long-Term Care Pricing Subgroup

Addressing Issues Impacting Rate Increase on Existing Blocks of Business

Background
Over the last several months, the Long Term Care Pricing Subgroup has worked on addressing issues relating to rate increases on existing blocks of long-term care business. The goal of this project is to highlight issues that regulators often contemplate when reviewing existing blocks of long-term care business, and provide reasonable approaches for review. By outlining issues and approaches for handling them, education, transparency, and uniformity will improve, making the rate filing and review process more predictable, accurate, and efficient.

As a first step, regulator-only calls were held to discuss company-specific rate filings that were pending in various states. Through this process, 8 questions were developed and distributed to subgroup members and interested parties for comment. The survey questions along with a summary of the responses are provided below.

Survey Questions

Question 1
What should a company be required to provide to justify a rate increase based on a consultant’s new industry morbidity study?

Issue question addresses
Many companies will reference a consultant’s new morbidity study to justify a rate increase. Consultants update their studies as data becomes available, many times every three to five years. A change in assumptions reflecting an updated study can result in a request for a significant rate increase.

General consensus
• The company should provide an explanation of why the consultant’s morbidity study properly reflects the company’s current and prospective experience.
• The company should present evidence that the characteristics of their block of business are similar to the block underlying the new industry study (coverage type, demographics, underwriting, etc.).
• The company should include a comparison of actual recent incurred claims with expected (where expected applies the new morbidity table to inforce), where appropriate.

Other considerations for regulators
• Allow less than 100 percent credibility of data from an outside consultant unless there is substantial evidence of the relevance and stability of the outside data.
• Consider that outside data may not be a perfect match but may be the most credible information the company has access to on relevant trends in LTC morbidity. Apply
partial credibility to balance between providing no credit (possibly leading to the need for substantial increases in the future) and providing full credit (possibly leading to unjustifiably high rate increases).

Next step for increase in education
• Receive communication from a major LTC consultant on how their morbidity studies are intended to be applied by companies.

Question 2
What approaches are appropriate for handling the "shrinking block" issue, i.e., to avoid astronomical rate increases to get back to original lifetime loss ratios when the block has significantly shrunk due to mortality, lapses, or claims? Are rules that cap increases effective in addressing this issue? What approaches are used when a company combines a shrunken block with a more established block into one rate increase request? What criteria should be used to defend similarities among forms that would allow or disallow combinations? Is it appropriate to allow the maximum rate increase that the 58/85 lifetime loss ratio test will support?

Issue question addresses
How should rate increases be determined for small remaining blocks?

General consensus
• In practice, the 58/85 lifetime loss ratio is not appropriate to be the sole standard of reasonableness in certain situations. An extreme example is that it could take over a 1,000 percent rate increase for a small number of remaining policyholders to make up the company losses caused by claims that were incurred by the bulk of original policyholders in the past to return the lifetime loss ratio to 58/85. In many states, the law explicitly states that the lifetime loss ratio measure is only a minimum standard and not the standard of reasonableness.
• In almost every state, an extreme rate increase would not be considered (nor requested by a company) to return the block’s lifetime loss ratio to 58/85. There is a range in alternative review methods to attempt to attain reasonable results.
• Artificial caps on rate increases have not been effective in moving towards the goal of creating more uniformity in state rate increase review processes and balancing consumer fairness with preventing financial harm of insurers.
• The concept of the “if knew” premium is useful as part of the calculation in computing an appropriate rate increase.
• Combining blocks is acceptable, as long as the blocks are similar or adjustments are made for differences between the blocks.

Other considerations for regulators
• Since more frequent monitoring of experience would result in smaller and timelier rate increases, should carriers be required to periodically report experience to
regulators? If so, can and would regulators require earlier increases if needed or justification is indicated?

- Some states do not allow a rate increase if the number of remaining lives or the proportion of remaining premium volume is below a certain threshold.
- The appropriateness of the lifetime loss ratio depends on the credibility of the experience and the size of the remaining block.
- When a block is purchased or reinsured, rate increases should only be based on changes in actuarial assumptions going forward, rather than attempting to make up for past deficiencies that should have been realized at the time the block was purchased or reinsured.

**Question 3**
Is it preferable for a rate increase to be approved in its entirety (e.g., 60 percent this year or pre-approved 20 percent each year for 3 years) or to be approved in stages (e.g., approve 30 percent now and review again next year for the other 30 percent)? If in stages, how should this approach be communicated with policyholders?

**Issue question addresses**
Should a phase in of rate increases be allowed? If so, is advanced notice of likely future rate increases important?

**General consensus**

- Approaches vary. Some states feel that it’s preferable to phase in pre-approved rate increases. Some only allow one-time increases for the “full amount”. Others allow one-time increases for a small amount with the expectation that the company will request another small amount the following year.
- Proper consumer disclosure is essential when rate increases are phased in or when there is an expectation of an upcoming, approvable filing. Some states require that the disclosure letter be filed for approval.

**Other considerations for regulators**

- Should the consumer disclosure letter mention all anticipated future rate increases or only approved stages of the rate increase?
- What happens if experience deteriorates further before the phase in has been implemented?

**Question 4**
Should deficiencies associated with higher past claims (for those no longer paying premiums) be differentiated from deficiencies associated with past premiums (for those still paying premiums) being insufficient due to updated expectations on lapses, mortality, morbidity, and interest?
**Issue question addresses**

The lifetime loss ratio from inception approach that is currently used to justify rate increases directly permits recoupment of past losses. Without differentiation, past and future paid claims for disabled lives as well as projected incurred claims for active lives are commingled, which contributes to this issue.

**General consensus:**

- There is no general consensus. The responses tend to fall into three major categories:
  1. Differentiation is essential to prevent recoupment of past losses.
  2. Differentiation is difficult to provide and is not necessary. Past losses are a minor contributor to most rate increase requests.
  3. Differentiation is not generally required; however, it may be required when a substantial number of claims have already occurred, such as in small closed blocks.

- It is complicated to define past losses in association with a lifetime product (as opposed to a year-to-year health insurance product).
  - There is consensus that less-than-fully-recoverable past losses occur when a majority of a block’s claims have occurred in the past (leaving a shrinking block of participants available to make up any of those losses with future rate increases).
  - There is no consensus on whether past premium deficiencies are considered past losses. An extreme example is a block where there have been no decrements to date (100 percent of original policyholders are still active) but assumptions changes such that substantial losses are expected on the block even though no claims have occurred to date. Some states would consider some or most of the past premium deficiencies to be non-recoverable, whereas other states take the opposite view.

**Other considerations for regulators**

- The issue seems to be not whether reserve deficiencies should be omitted, most agree. The problem is how this is accomplished given the way most companies model and monitor their business.

**Question 5**

With LTC, many rate increase proposals are based on assumption changes that significantly increase projected loss ratios, even though yearly actual-to-expected ratios up to the current year based on historical experience may be favorable. How can states get comfortable with 40- or 50-year projections to justify a rate increase?
Issue question addresses
How to evaluate rate increase requests when the current historical experience is favorable, particularly when projections are for very long time periods.

General consensus
- Although LTC experience is better known and more data is available, there are still many unknowns that make long-term projections difficult if not impossible.
- Margins, modeling, and conservative assumptions may mitigate the effects of uncertainty.
- Projections that differ from actual experience must be adequately supported.
- Frequent monitoring is necessary, but may make it difficult to distinguish emerging trends from random variations.

Other considerations for regulators
- Rate increases that are too low may be difficult to correct in later years, but rate increases that are too high may produce windfalls for the issuers. Due to the inherent uncertainty, a method for refunding experience gains may be needed.
- There is varying depth in rigor of analysis of companies’ projections. Not all states have the expertise and resources to conduct an effective review for reasonableness. Coordination among states may be desirable, especially for the more complex filings that are similar among states.

Question 6
Should lower-than-expected investment returns factor into the justification for a rate increase?

Issue question addresses
Many companies have requested a rate increase based on the current low-yield investment environment. Should policyholders bear some or all risk for poorer than expected investment returns?

General consensus:
The responses are divided, with the majority of respondents opposed to considering investment returns when evaluating rate increases. A significant minority permits the practice.

Key comments:
- Policyholders do not benefit from higher than expected returns, so they should not bear the cost of adverse performance.
- Investment risk was not disclosed at the time of purchase and may have factored into the purchasing decision if it was.
- Lower return assumptions may be acceptable on a prospective basis, but not for past experience.
• The respondents use several different methods to ensure investment returns are not a factor.
• Most respondents favoring the practice did not elaborate in their responses.
• One response from a state was that a company must pass two tests to have a rate increase approved. For the prescribed lifetime loss ratio test, actual investment returns are not considered. If a rate increase passes the lifetime loss ratio test, the second test is less prescriptive, more principle-based, and contains consideration of all key factors, including investment returns.

Other considerations for regulators:
Is it reasonable to permit a rate increase if it can be demonstrated that the statutory valuation interest rate cannot be matched with current investments?

Question 7
What are appropriate approaches for handling waiver-of-premium provisions? For instance, for policyholders currently on waiver of premium, is it appropriate to include those premiums as earned premiums with equal offsetting incurred claims?

Issue question addresses
Many companies include “waived premium” as both a premium and claim component in their future projections. What are the consequences? Should there be a consistent approach?

General consensus:
All but two of the respondents agreed that waived premiums should not be considered earned premiums with offsetting incurred claims. Of the remainder, one endorsed the practice, and one took the position that there are many acceptable approaches and HATF should not mandate a particular one.

Key Comments:
• For rate filing purposes, some believe projections of premiums and benefits should only focus on active lives.
• Waiver of premium is not a material consideration in LTC pricing adequacy and should not result in a higher approved rate increase than in the absence of a waiver of premium benefit.
• Including waived premium, with offsetting claims, will drive loss ratios closer to 100 percent, which may justify higher rate increases than other methods.

Other considerations for regulators:
Although most of the respondents are opposed to the offsetting claims approach, a recent Milliman survey indicates 82 percent of companies use this method of reserving.
Question 8
Is it appropriate to address a deficiency in the disabled-life reserve (associated with current claims) via a rate increase, or do you think the company should fund the additional disabled-life reserve in other ways, such as through company surplus?

Issue question addresses
Should DLR deficiencies be excluded from consideration for rate increases since it requires premium paying active lives to pay for prior incurred claims on policyholders who no longer pay premium?

General consensus:
As in question 4, the responses are mixed but fall into several categories:
1. The majority agree that a reserve deficiency, whether it is contract reserve or disabled life reserve, should not be a part of a rate increase.
2. Others take the position that correction of any claim reserve deficiency is part of updating claims incurred and should be part of any rate increase justification as an adverse development from initial pricing assumptions.
3. Many responded that DLR deficiencies should not be considered, but may indicate a need to revise assumptions going forward.

Other considerations for regulators:
• Including DLR deficiencies requires premium-paying policyholders to pay for prior incurred claims thus permitting companies to recoup past losses.
• As the number of active lives decreases, this approach becomes unsustainable.