HEALTH ACTUARIAL (B) TASK FORCE

Health Actuarial (B) Task Force Dec. 5, 2022, Minutes
- Health Actuarial (B) Task Force Sept. 28, 2022, Minutes (Attachment One)
  - Group Life Waiver of Premium Valuation Table (GLWPVT) Proposal (Attachment One-A)
  - 2023 Charges (Attachment One-B)
- Health Actuarial (B) Task Force Sept. 6, 2022, Minutes (Attachment Two)
- Long-Term Care Actuarial (B) Working Group Oct. 17, 2022, Minutes (Attachment Three)
  - Comments on the Long-Term Care Insurance (LTCI) Mortality and Lapse Study (Attachment Three-A)
- Center for Consumer Information and Insurance Oversight (CCIIO) Update (Attachment Four)
- American Council of Life Insurers (ACLI) Update (Attachment Five)
- Society of Actuaries (SOA) Research Institute Activities Update (Attachment Six)
- American Academy of Actuaries (Academy) Health Practice Council Update (Attachment Seven)

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Health Actuarial (B) Task Force
Virtual Meeting (*in lieu of meeting at the 2022 Fall National Meeting*)
December 5, 2022

The Health Actuarial (B) Task Force met Dec. 5, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, and Julie Weinberg (NM); Mark Fowler represented by Jennifer Li (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Eric Unger and Sydney Sloan (CO); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Jeff Ji (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Julia Lyng (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Michael Gurgiolo (PA); Michael Wise represented by Andrew Dvorine (SC); Cassie Brown represented by Aaron Hodges (TX); Mike Kreidler represented by Lichiou Lee (WA); and Allan L. McVey represented by Ellen Potter (WV).

1. Adopted its Sept. 28, Sept. 6, and Summer National Meeting Minutes

Lombardo said the Task Force met Sept. 28, Sept. 6, and Aug. 1. During these meetings, the Task Force took the following action: 1) adopted the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposal for valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44); and 2) adopted its 2023 proposed charges.

Weinberg made a motion, seconded by Leung, to adopt the Task Force's Sept. 28 (Attachment One), Sept. 6 (Attachment Two), and Aug. 1 (*see NAIC Proceedings – Summer 2022, Health Actuarial (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Lombardo said the Working Group met Oct. 17 and took the following action: 1) discussed comments received on an exposure of the Academy and the SOA Research Institute's final *Long-Term Care Insurance Mortality and Lapse Study*.

Weinberg made a motion, seconded by Schallhorn, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Three). The motion passed unanimously.

3. Heard an Update from the CCIIO

Megan Mason (federal Center for Consumer Information and Insurance Oversight—CCIIO) presented an update on plan ear 2024 federal Affordable Care Act (ACA) rate filing submissions (Attachment Four).

Lombardo asked if the reminder that once a filing is closed that it must be deactivated is a limitation of the System for Electronic Rates & Forms Filings (SERFF) or if it is a CCIIO requirement. Mason said this is a SERFF limitation and that the CCIIO is working with SERFF to resolve this issue.

Sloan said that last year, there was an issue with SERFF filings not having the capability of making Unified Rate Review Template (URRT) filings publicly accessible. She asked if this issue has been resolved. Mason said she thinks the SERFF team has resolved this issue for this year.

4. Heard a Presentation from the ACLI on Combination LTCI Products

Jan Graeber (American Council of Life Insurers—ACLI) gave a presentation (Attachment Five) on combination LTCI products.

Andersen asked if there is a certain type of consumer who would tend to buy a combination LTCI product rather than a chronic illness combination product. Graeber said she thinks the choice would be made based on the individual's needs and that she can ask ACLI member companies if they have any additional information.

Lombardo said a general concern in Connecticut is the possibility that combination product consumers may not understand that they do not have two separate policies—for example, a life insurance policy and a long-term care insurance (LTCI) policy—but that they actually have one policy, which will have reduced death benefits in the event LTCI benefits are paid. He asked what ACLI member companies are doing to ensure that combination product consumers understand how the policy works.

Bonnie Burns (California Health Advocates) said explaining how combination products work to consumers is fraught with hazard and that the California Department of Insurance (DOI) has begun to develop a continuing education (CE) curriculum to address how to educate consumers on this topic. She said these products should be more closely scrutinized and that disclosures and disclosure standards for them should be developed.

Toal said that New Mexico generally takes a dim view of combination products because they seem to be deliberately designed to confuse consumers and do not provide information disclosures that are easily understood.

5. Heard an Update on SOA Research Institute Activities

Achilles Natsis (SOA) presented an update on SOA Research Institute activities (Attachment Six).

6. Heard an Update from the Academy on HPC Activities

Barbara Klever (Blue Cross Blue Shield Association—BCBSA) gave an update on Academy Health Practice Council (HPC) activities (Attachment Seven).

Having no further business, the Health Actuarial (B) Task Force adjourned.

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Draft: 10/14/22

Health Actuarial (B) Task Force
Virtual Meeting
September 28, 2022

The Health Actuarial (B) Task Force met Sept. 28, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM); Mark Fowler represented by Jennifer Li (AL); Michael Conway represented by Eric Unger (CO); Amy L. Beard represented by Heir Cooper (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Jeff Ji (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Michael Humphreys represented by Jim Laverty (PA); Cassie Brown represented by Aaron Hodges (TX); Scott A. White represented by David Shea (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. Adopted a GLWPVT AG 44 Proposal

Mr. Lombardo said no comments were received on the Sept. 8 exposure of revisions to the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposal for changes to *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44).

Ms. Weinberg made a motion, seconded by Mr. Dyke, to adopt the Academy and SOA Research Institute GLWPVT Work Group proposal for valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in AG 44, including the Sept. 8 revisions (Attachment One-A) to AG 44. The motion passed unanimously. Mr. Lombardo said the replacement valuation tables and the revised version of AG 44 will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration.

2. Adopted its 2023 Proposed Charges

Mr. Lombardo presented a draft of the Task Force's 2023 proposed charges.

Mr. Leung made a motion, seconded by Mr. Shea, to adopt the Task Force's 2023 proposed charges (Attachment One-B). The motion passed unanimously. Mr. Lombardo said the 2023 proposed charges will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.

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Actuarial Guideline XLIV

GROUP TERM LIFE WAIVER OF PREMIUM DISABLED LIFE RESERVES

DRAFT ONLY - VERSION ASSUMES GRANDFATHERING OF 2005 TABLES AND ASSOCIATED USE OF COMPANY EXPERIENCE PROVISIONS (SEE SECTION V). ALSO HAS RECOGNITION OF NEW TABLES AND NEW USE OF COMPANY EXPERIENCE PROVISIONS, EFFECTIVE WITH JANUARY 1, 2023 DISABILITIES (SEE SECTION VI). SECTION VI, USE OF COMPANY EXPERIENCE PROVISIONS ASSOCIATED WITH THE NEW TABLES, LARGELY MODELS THOSE OF GROUP LONG-TERM DISABILITY (GLTD) ACTUARIAL GUIDELINE XLVII.

I. Background

Section 4.G. of the Standard Valuation Law establishes tables approved by the commissioner as the minimum standard for computing reserves for group life insurance and special benefits. The purpose of this Actuarial Guideline (Guideline) is to determine the minimum standard of valuation for group term life waiver of premium disabled life benefits and to recognize the ~~2005~~ 2023 Group Term Life Waiver (GTLW) Mortality and Recovery Valuation Tables. The Guideline also maintains recognition of the 2005 Group Term Life Waiver Mortality and Recovery Tables for purposes outlined in Section V of the Guideline.

Claims subject to Section V of the Guideline (applicable to individuals who become disabled on or after January 1, 2009 and on or before December 31, 2022) may be valued under Section VI (applicable to individuals who become disabled on or after January 1, 2023) at the election of the insurer provided these claims, for all future valuation dates, are valued under that section or any newer succeeding section at the insurer's election.

Group term life policies do not maintain contract reserves beyond the duration of the policy issued to the group policyholder. However, some policies guarantee an extended death benefit to an individual insured who is disabled according to the terms of the policy. Thus, to the extent such guarantees are made, a disabled life reserve must be maintained for each individual that is so disabled. However, prior to the creation of this guideline, there has been no formal guidance regarding the calculation of these disabled life reserves.

II. Scope

This guideline applies to group term life certificates on individuals who become disabled on or after January 1, 2009. Based on the provisions of Section 4.G. of the Standard Valuation Law, companies may apply this to group term life certificates on individuals who became disabled prior to January 1, 2009, provided they obtain permission from the commissioner.

III. Definitions

"2005 GTLW Mortality Tables" means the mortality rate tables shown in Attachments A ~~A~~ and B~~B~~.

"2005 GTLW Recovery Tables" means the recovery rate tables shown in Attachments ~~C~~ C and ~~D~~D.

"2023 GTLW Mortality Valuation Table" means the mortality rate tables shown in Attachments E and F.

"2023 GTLW Recovery Valuation Table" means the recovery rate tables shown in Attachments G and H.

IV. The Group Waiver of Premium Reserve Calculation

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A. The minimum standard of valuation for group term life waiver of premium disabled life benefits shall be the present value of the death benefit payable discounted for interest and recovery. Since there is not a contract reserve based upon an aggregate table, the discounted value of waived premiums is inadequate to support this liability.

B. The maximum interest rate to be used in determining the minimum valuation standard for any group term life waiver of premium disabled life benefit incurred on or after the effective date of this guideline shall be the maximum rate permitted by law in the valuation of life insurance of the same guaranteed duration issued on the same date as the claim incurral date of disability. For most groups and companies this rate shall be the rate for life insurance with guaranteed duration greater than 20 years. The guaranteed duration used to determine the life insurance rate of interest is equal to the largest term in years between the point at which any individual in the group may become disabled and the point at which no death benefit is available. Thus, if a person could become disabled at age 20, and remain disabled, and receive a benefit upon death before age 65, the guaranteed duration would be 45 years.

C. The valuation tables were derived from employer-employee group life experience. Other forms of group term life insurance are also subject to the same requirements if they contain similar extended death benefit provisions.

~~IV~~V. Text - Group Term Life Certificates on Individuals Who Become Disabled on or After January 1, 2009 and on or Before December 31, 2022.

Claims subject to this section of the Guideline may be valued under Section VI (applicable to disabilities incurred January 1, 2023 and later) at the election of the insurer provided these claims, for all future valuation dates, are valued under that section or any newer succeeding section at the insurer's election.

A. Group Waiver of Premium Reserve Calculation

~~1. The minimum standard of valuation for group term life waiver of premium disabled life benefits shall be the present value of the death benefit payable discounted for interest and recovery. Since there is not a contract reserve based upon an aggregate table, the discounted value of waived premiums is inadequate to support this liability.~~

1~~2~~. Except as provided in Section V.B, the 2005 GTLW Mortality and Recovery Tables shall be used for determining the minimum standard of valuation for any group term life waiver of premium disabled life benefit incurred ~~on or after the effective date of~~during the effective period of this section of this ~~guideline~~ Guideline. ~~The valuation tables were derived from employer-employee group life experience. Other forms of group term life insurance are also subject to the same requirements if they contain similar extended death benefit provisions.~~ Section V.B offers ways to modify the underlying rates of mortality or recovery if they differ from those associated with the underlying experience in the valuation table.

~~3. The maximum interest rate shall be the maximum rate permitted by law in the valuation of life insurance of the same guaranteed duration issued on the same date as the claim incurral date of disability. This maximum interest rate shall be used for determining the minimum standard of valuation for any group term life waiver of premium disabled life benefit incurred on or after the effective date of this guideline. The guaranteed duration used to determine the life insurance rate of interest is equal to the largest term in years between the point at which any individual in the group may become disabled and the point at which no death benefit is available. Thus, if a person could become disabled at age 20, and remain disabled, and receive a benefit upon death before age 65, the guaranteed duration would be 45 years. For most groups and companies this would mean the~~

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~~maximum interest rate shall be the rate for life insurance with duration greater than 20 years.~~

B. Use of Company Experience

1. The Appointed Actuary shall review company experience at least once every five years. The review of company experience can range from a detailed experience study to a high level analysis. The extent of the review must be sufficient to enable the Appointed Actuary to defend any conclusion reached. Company experience shall:

   i. Be segmented into policies with similar benefits, on individuals of each gender;

   ii. Be experience-specific to the company;

   iii. Include all relevant experience in the past three most recent years;

   iv. Exclude experience that is not in the past six most recent years;

   v. Otherwise be relevant, in accordance with the professional judgment of the Appointed Actuary; and

   vi. Not be deemed irrelevant by the commissioner.

2. The commissioner may require a company to use its experience based upon the most recent review referenced in Section V.B.1 to establish its specific valuation tables if:

   i. Actual mortality experience is reasonably expected to be greater than 90% of the 2005 GTLW Mortality Tables; or

   ii. Actual recovery experience is reasonably expected to be less than 125% of the 2005 GTLW Recovery Tables.

   Under these circumstances, the commissioner may require a company to use the process set out in Section V.B.4 and establish for the company a minimum value for Z.

3. A company may use its experience exclusively without reference to the standard tabular mortality expected experience or to the standard tabular recovery expected experience to create its specific valuation tables if:

   i. The Appointed Actuary can demonstrate and certify the following:

      a) The company-specific valuation tables are based on company experience with allowances for graduation and margins for adverse experience;

      b) The company-specific mortality valuation tables used for computing minimum reserves for group term life waiver of premium benefits are such that there is at least an 85% statistical confidence that the actual annual aggregate mortality will be

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less than the mortality in the company-specific-mortality valuation tables; and

c) The company-specific recovery valuation tables used for computing minimum reserves for group term life waiver of premium benefits are such that there is at least an 85% statistical confidence that the actual annual aggregate recoveries will be greater than the recoveries in the company-specific recovery valuation tables.

ii. The company has written permission from the domiciliary commissioner to use the company-specific valuation tables.

iii. Unless otherwise exempted or required, the specific valuation tables shall apply to the computation of minimum reserves for group term life waiver of premium disabled life benefits for claims incurred during or after the calendar year in which the study was performed.

iv. The company shall not use mortality and recovery tables with rates that produce reserves less than the reserves produced by using 75% of the 2005 GTLW Mortality Tables and 160% of the 2005 GTLW Recovery Tables for all durations of disability combined.

4. If not invoking Section V.B.3, a company may use a credibility-weighted combination of company mortality experience with the 2005 GTLW Mortality Tables and/or of company recovery experience with the 2005 GTLW Recovery Tables to create its specific valuation tables.

i. The blended tables for each gender and type of experience (mortality and recovery) shall be computed using the formula Blended Table = T x S, where:

a) Z shall be a credibility weighting factor, between 0 and 1, developed by the Appointed Actuary using credibility theory methods not unacceptable to the commissioner;

b) F shall be the ratio of the company's actual experience to the expected experience for the 2005 GTLW Mortality and Recovery Tables for each gender and type of experience (mortality and recovery);

c) M shall be 1.12 for mortality tables and 0.80 for recovery tables. The values provide a smooth transition between the 2005 tables and company experience when Z = 1;

d) S shall be the 2005 GTLW Mortality and Recovery Tables; and

e) T shall be computed using the following steps:

Step 1: Compute the raw value of T = [Z x (F x M) + (1 – Z)].

Step 2: Round T to the nearest 5%.

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Step 3: If the absolute difference between the T produced in step 2 and the value of T utilized immediately prior to the study is less than 10%, then set T equal to the value of T utilized immediately prior to the study.

Step 4: For all durations of disability, combined for each gender, set the value of T to the greater of 75% and the T resulting from step 3 for mortality and set the value of T to the lesser of 160% and the T resulting from step 3 for recovery.

ii. The company has written permission from the domiciliary commissioner to use the blended valuation tables.

iii. Unless otherwise exempted or required, the specific valuation tables shall apply to the computation of minimum reserves for group term life waiver of premium disabled life benefits for claims incurred during or after the calendar year in which the study was performed.

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VI. Text - Group Term Life Certificates on Individuals Who Become Disabled on or After January 1, 2023.

<<< BEGINNING OF GLW-ADAPTED GLTD AG 47 SECTION >>>

A. When the insurer follows the instructions provided in this guideline, the selected claim mortality rates and recovery rates are deemed to be tables approved by the commissioner as the minimum standard for computing reserves as established by Section 4.G of the Standard Valuation Law.

B. Valuation Table Modifications for Company Experience

If not invoking the small company exception specified in Section VI.D, a company must use a credibility-weighted combination of its own claim mortality experience and claim recovery experience with the 2023 GTLW Mortality and Recovery Valuation Tables to create its specific valuation table.

i. For claim durations within the elimination period, mortality rates and recovery rates may be developed as below consistent with other Duration Groups or in any other manner deemed appropriate by the actuary. With respect to credibility, any value between 0 and 1 that the actuary deems appropriate for the block may be used.

ii. For claim durations beyond the elimination period, the valuation mortality rates and recovery rates shall be computed using the mortality rates from the 2023 GTLW Mortality Valuation Table (S_M) and recovery rates from the 2023 GTLW Recovery Valuation Table (S_R) multiplied by mortality experience adjustment factors (T_M) and recovery experience adjustment factors (T_R) that are calculated separately for three different duration groups for mortality and separately for three different duration groups for recovery.

Valuation Mortality Rate = T_M x S_M

Valuation Recovery Rate = T_R x S_R

The duration groups are defined as follows:

Group 1: duration > the satisfaction of the elimination period and duration <= 24 months
Group 2 duration > 24 months and duration <= 60 months
Group 3: duration > 60 months

a) S_M and S_R shall be the mortality rates and recovery rates respectively from the 2023 GTLW Mortality and Recovery Valuation Tables.

b) T_M shall be computed as $T_M = [Z_M \times F_M + (1 - Z_M)] \times (1 + M_M)$ and T_R shall be computed as $T_R = [Z_R \times F_R + (1 - Z_R)] \times (1 - M_R)$

where

1) Z_M shall be a mortality credibility weighting factor, between 0 and 1, developed for each duration group according to the following specifications:

Group 1-3: $Z_M = Min\left(\sqrt{N_M/K_M}, 1\right)$ where N_M is the number of expected death counts determined by using claim mortality rates from the 2023 GTLW Mortality Valuation Table, and

2) K_M is a set of constants defined by duration group as follows for mortality:

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Group 1: K_M = 800 Group 3: K_M = 800
Group 2: K_M = 800

3) Z_R shall be a recovery credibility weighting factor, between 0 and 1, developed for each duration group according to the following specifications:

Group 1-3: $Z_R = Min\left(\sqrt{N_R/K_R}, 1\right)$ where N_R is the number of expected recovery counts determined by using claim recovery rates from the 2023 GTLW Recovery Valuation Table, and

4) K_R is a set of constants defined by duration group as follows for recoveries:

Group 1: K_R = 1,700 Group 3: K_R = 1,700
Group 2: K_R = 1,700

5) F_M shall be the ratio of the company's actual death counts to the expected death counts in the 2023 GTLW Mortality Valuation Table for each duration group specified above and F_R shall be the ratio of the company's actual recovery counts to the expected recovery counts in the 2023 GTLW Recovery Valuation Table for each duration group specified above.

If the actuary has reserve adequacy or other significant analysis that demonstrates in the development and use of company-specific experience (see Section VI.C below) that an alternative measurement is deemed appropriate, such as:

I. Use of some other weighting of claims (for example, death benefit amount) that is not only appropriate for measuring actual to expected (A to E), but also is expected to generally produce reserves not less than those produced by using a claim count measurement.
II. Use of an increased mortality credibility factor Z_M if F_M is greater than 1 and / or use of an increased recovery credibility factor Z_R if F_R is less than 1 to give unfavorable company experience more weight.

Then, a basis other than claim count may be used.

6) M_M and M_R are the company experience margins for mortality and recovery respectively, determined for each duration group, according to the following formulas:

$$M_M = Min\left(15\%, Max\left(5\%, 3\% + 1.65 * \sqrt{A_M/C_M}\right)\right)$$

$$M_R = Min\left(15\%, Max\left(5\%, 3\% + 1.65 * \sqrt{A_R/C_R}\right)\right)$$

where A_M is a set of constants defined by duration group as follows for mortality:

Group 1: A_M = 1.0 Group 3: A_M = 1.0

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Group 2: $A_M = 1.0$

and A_R is a set of constants defined by duration group as follows for recoveries:

Group 1: $A_R = 2.0$ Group 3: $A_R = 2.0$
Group 2: $A_R = 2.0$

and C_M shall be the company's actual number of death counts by duration group.

and C_R shall be the company's actual number of recovery counts by duration group.

These are the minimum values for the definition of M_M and M_R prior to any reserve adequacy analysis. Adequacy tests and analysis of experience (for example, sharpness of fluctuations, trends over the period of the mortality rate study or recovery rate study, changing claims practices) may indicate that larger values of M_M or M_R may be more appropriate. If so, such values are deemed appropriate.

iii. The company shall not use mortality rates that are less than those produced by computing T_M as $T_M = 0.75$.

C. Company-Specific Experience - Own Experience Measurement

In computing values F_M, F_R, T_M, and T_R to comply with section VI.B above, the Appointed Actuary may consider the following:

i. Segment the company claim mortality experience and claim recovery experience into any major subgroups that may produce significantly different results (for example, market niches, claims operations, and unique benefit designs).

ii. Combine affiliated statutory entities and assumed reinsurance, where claim management is under a common structure, when considering company experience. It is also appropriate to evaluate experience separately when specific blocks of company business have distinct claim management practices or significantly different risk characteristics.

iii. Include all relevant experience the company is capable of providing for as many of the last five years as possible (not including the lag period described below). However, there are two situations where using other than a five-year period may be more appropriate. The first is when a company's experience in a longer period not only increases credibility but is still relevant and appropriate for the company's products and claim management practices. In this case, the period to be used is not to exceed ten years. The second is for a company that has had significant changes in product and/or claim management practices within the past five years that has diminished the relevance of the company's experience early in the five year period. In this second situation, less than five years of experience may be used for any duration band for which there is compelling logic and when either the company's experience to be used is at least 90% credible, or the shorter experience period produces higher reserves than using five years.

iv. Recognize a suitable lag period to allow for a full resolution of claim status. For example, the lag period used in the 2019 Group Term Life Waiver Experience Study performed by the Society of Actuaries was 12 months. However, the Appointed Actuary may use a

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different lag period based on his or her company experience. For example, company experience indicates that all changes after the selected lag period are negligible.

v. Measure actual (A) to expected (E) deaths and A to E recoveries based on claim count (unless another weighting is deemed more appropriate, as mentioned in Section VI.B(ii)(b)(5)), where the E is based on expected deaths and recoveries, respectively, from the 2023 GTLW Mortality Valuation Table and the 2023 GTLW Recovery Valuation Table. Claim count is also used in the measurement of credibility.

vi. Recognize where appropriate any flexibility built into the 2023 GTLW Mortality and Recovery Valuation Tables, such as not utilizing diagnosis-specific mortality rates and recovery rates when the information is deemed unreliable.

vii. Do not count as deaths or recoveries those claims that are closed due to settlement, or that have reached the end of the maximum benefit duration, or that are closed due to any other contractual limit.

viii. Use experience that is otherwise relevant in accordance with the professional judgment of the Appointed Actuary.

In the above paragraphs, the term "company" refers to a single company or a group of legally related companies subject to the same claim management.

D. Own Experience Measurement Exemption

Determine the number of claims that, according to the provisions of this Guideline, are subject to valuation using the 2023 GTLW Mortality and Recovery Valuation Tables. If, at the time of valuation, a company has fewer than 50 such open claims disabled within two years of the effective date of the valuation, and fewer than 200 such open claims disabled more than two years prior to the effective date of the valuation, the company is exempt from the requirement that the 2023 GTLW Mortality and Recovery Valuation Tables be modified by the company's own experience. Said company will use, based on the maximum values of M_M and M_R for any duration group according to Section VI(B)(ii)(b)(6) above, 115% of the 2023 GTLW Mortality Valuation Table for all duration groups to calculate claim mortality rates and 85% of the 2023 GTLW Recovery Valuation Table for all duration groups to calculate claim recovery rates in order to comply with the minimum valuation standard.

<<< END OF GLW-ADAPTED GLTD AG 47 SECTION >>

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[ATTACHMENT A = 2005 GTLW Mortality Rates, Select Period]
[ATTACHMENT B = 2005 GTLW Mortality Rates, Ultimate Period]
[ATTACHMENT C = 2005 GTLW Recovery Rates, Select Period]
[ATTACHMENT D = 2005 GTLW Recovery Rates, Ultimate Period]
[ATTACHMENT EA = 2023 2005 GTLW Mortality Rates, Select Period]
[ATTACHMENT FB = 2023 2005 GTLW Mortality Rates, Ultimate Period]
[ATTACHMENT GC = 2023 2005 GTLW Recovery Rates, Select Period]
[ATTACHMENT HD = 2023 2005 GTLW Recovery Rates, Ultimate Period]

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This workbook contains the proposed 2022 group life waiver tables and adjustment factors.

This workbook was developed by the Group Life Waiver of Premium (Waiver) Valuation Table Work Group (Work Group) of the American Academy of Actuaries (Academy) and the Society of Actuaries Research Institute (SOARI).
It contains the proposed tables, as well as the current tables (2005 Tables).
It supplements the information provided regarding an update to Actuarial Guideline XLIV (AG 44).
Waiver tables are on a select and ultimate basis. There are separate sets of rates for mortality and recovery.

The select period is through claim duration 10 years. The select tables are based on age at disability and duration of
The ultimate tables, which are for all claims in duration year 11 and beyond, are on an attained age basis only.
Diagnosis adjustment factors have also been developed for select and ultimate tables.

2022 Table Select contains the select mortality / recovery rates for males and females. It also contains the diagnosis adjustment factors for mortality / recovery, as well as commentary on adjustments made by the Work

2022 Table Ultimate contains the same information for the ultimate period.

2005 Table Select and *2005 Table Ultimate* contain the 2005 tables.

July 2022

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2022 TABLE **MALES**

PROBABILITY OF DEATH (1,000Q[X]+T) - SELECT PERIOD

Central Age =>	17	22	27	32	37	42	47	52	57	62	67	72
1 (3rd qtr.)	11	13	13	15	18	20	23	26	30	32	29	27
1 (4th qtr.)	14	17	17	19	22	26	29	34	39	41	37	34
2 (1st qtr.)	13	16	16	18	21	24	27	31	36	38	35	32
2 (2nd qtr.)	12	13	14	16	18	21	24	27	31	33	30	26
2 (3rd qtr.)	11	12	12	14	16	18	21	24	27	29	28	24
2 (4th qtr.)	10	10	10	12	14	16	18	21	24	25	25	22
3	29	33	32	37	42	48	56	64	73	81	81	81
4	13	19	23	27	31	35	41	47	54	60	61	65
5	8	11	21	24	28	32	37	42	48	53	55	58
6	7	11	20	23	26	30	35	40	46	51	56	59
7	8	12	19	22	26	30	34	39	45	49	63	70
8	10	16	19	22	25	29	33	38	45	50	68	75
9	11	17	19	22	25	29	33	38	46	51	68	75
10	13	19	19	22	25	29	33	38	47	52	70	81

MALES

PROBABILITY OF RECOVERY (1,000Q[X]+T) - SELECT PERIOD

4

Central Age => Year of Dis.	17	22	27	32	37	42	47	52	57	62	67	72
1 (3rd qtr.)	167	167	137	112	92	75	62	51	42	36	27	22
1 (4th qtr.)	165	165	136	111	91	75	61	50	41	36	27	22
2 (1st qtr.)	141	141	117	96	78	64	53	43	35	31	27	19
2 (2nd qtr.)	126	126	102	84	69	56	46	38	31	27	23	19
2 (3rd qtr.)	113	113	92	76	62	51	42	34	28	24	20	16
2 (4th qtr.)	102	102	86	70	58	47	39	32	26	23	18	14
3	434	434	353	290	244	187	143	115	90	73	54	50
4	259	259	195	163	130	99	77	59	45	36	23	20
5	189	189	139	114	86	66	52	38	29	23	16	14
6	136	136	116	87	65	49	38	28	21	16	11	10
7	107	107	97	71	52	40	31	23	17	13	8	6
8	92	92	83	61	45	34	26	19	14	11	5	4
9	78	78	74	54	40	30	22	16	12	9	4	2
10	74	74	68	49	37	27	20	15	11	8	4	0

Rates for both recovery and mortality for ages 17 and 22 were extended using the same slope from ages 27/22/17 as the 2005 table, on a gender specific basis

Rates for both recovery and mortality for ages 67 and 72 were extended using the same slope from ages 62/67/72 as the 2005 table, on a gender specific basis

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FEMALES

PROBABILITY OF DEATH (1,000Q[X]+T) - SELECT PERIOD

Central Age => Year of Dis.	17	22	27	32	37	42	47	52	57	62	67	72
1 (3rd qtr.)	6	7	9	11	13	16	19	22	26	27	26	24
1 (4th qtr.)	7	9	12	14	17	20	24	28	33	35	33	31
2 (1st qtr.)	7	8	11	13	16	19	22	27	32	33	31	29
2 (2nd qtr.)	6	8	10	12	14	17	20	24	28	29	26	23
2 (3rd qtr.)	6	7	9	10	12	15	17	21	25	26	25	22
2 (4th qtr.)	5	6	8	9	11	13	16	18	22	23	23	20
3	18	21	28	29	34	41	48	57	67	76	76	76
4	12	19	24	25	26	31	37	44	51	58	66	69
5	12	16	19	20	21	25	30	35	41	47	53	56
6	7	13	17	18	19	22	26	31	36	41	45	47
7	9	15	16	17	17	21	25	29	36	39	48	50
8	10	14	15	16	17	20	24	28	35	40	51	53
9	10	14	15	16	17	20	24	28	36	41	55	57
10	9	12	14	15	17	20	24	28	36	43	60	63

FEMALES

PROBABILITY OF RECOVERY (1,000Q[X]+T) - SELECT PERIOD

Central Age => Year of Dis.	17	22	27	32	37	42	47	52	57	62	67	72
1 (3rd qtr.)	244	244	200	168	105	88	73	61	51	44	34	27
1 (4th qtr.)	184	184	151	126	105	87	73	61	51	44	34	27
2 (1st qtr.)	152	152	127	106	88	73	61	51	43	37	31	26
2 (2nd qtr.)	133	133	109	91	76	63	52	44	36	32	26	20
2 (3rd qtr.)	116	116	97	81	67	56	47	39	32	28	22	19
2 (4th qtr.)	107	107	89	74	62	51	43	36	30	26	22	17
3	430	430	350	295	276	214	174	135	106	86	67	59
4	286	286	215	187	152	117	94	70	54	42	26	21
5	201	201	147	126	100	76	60	45	33	25	19	16
6	144	144	122	93	73	55	42	32	23	17	12	9
7	114	114	102	75	57	43	32	24	17	13	9	7
8	96	96	87	64	47	36	26	19	14	11	6	4
9	82	82	77	55	41	30	22	16	12	9	4	1
10	76	76	69	50	36	27	20	14	10	8	5	0

Rates for both recovery and mortality for ages 17 and 22 were extended using the same slope from ages 27/22/17 as the 2005 Table, on a gender-specific basis

Rates for both recovery and mortality for ages 67 and 72 were extended using the same slope from ages 62/67/72 as the 2005 table, on a gender-specific basis

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Death Diagnosis Adjustment

Adjusted & Finalized

Duration	Unclassified	Low Non-Cancer	High Non-Cancer	Cancer
Q3	1.00	0.20	0.50	3.65
Q4	1.00	0.20	0.50	3.95
Q5	1.00	0.20	0.60	4.20
Q6	1.00	0.25	0.60	4.50
Q7	1.00	0.30	0.65	4.70
Q8	1.00	0.35	0.75	4.73
3	1.00	0.40	0.90	4.75
4	1.00	0.50	1.25	4.60
5	1.00	0.60	1.35	4.00
6	1.00	0.65	1.45	3.60
7	1.00	0.70	1.55	3.05
8	1.00	0.70	1.65	2.65
9	1.00	0.75	1.60	2.30
10	1.00	0.75	1.57	2.15

Diagnosis factors were adjusted from those originally regressed by Jerry Holman to smooth transition points between duration groups. This applied to both Mortality and Recovery Adjustments

Recovery Diagnosis Adjustment

Adjusted & Finalized

Duration	Unclassified	Low	Mid	High
Q3	1.00	0.55	1.15	1.40
Q4	1.00	0.55	1.15	1.40
Q5	1.00	0.60	1.15	1.40
Q6	1.00	0.65	1.15	1.35
Q7	1.00	0.65	1.15	1.35
Q8	1.00	0.65	1.15	1.38
3	1.00	0.65	1.15	1.40
4	1.00	0.68	1.13	1.48
5	1.00	0.70	1.10	1.55
6	1.00	0.70	1.15	1.45
7	1.00	0.70	1.20	1.35
8	1.00	0.70	1.20	1.35
9	1.00	0.70	1.20	1.35
10	1.00	0.70	1.20	1.25

Death Diagnosis Adjustment

Jerry Holman

Duration	Unclassified	Low Non-Cancer	High Non-Cancer	Cancer
Q3	1.00	0.20	0.50	3.65
Q4	1.00	0.20	0.50	3.95
Q5	1.00	0.20	0.60	4.20
Q6	1.00	0.25	0.60	4.50
Q7	1.00	0.30	0.70	4.70
Q8	1.00	0.30	0.80	4.90
3	1.00	0.40	0.95	4.75
4	1.00	0.50	1.25	4.60
5	1.00	0.60	1.35	4.00
6	1.00	0.65	1.45	3.60
7	1.00	0.70	1.55	3.05
8	1.00	0.70	1.65	2.65
9	1.00	0.75	1.60	2.30
10	1.00	0.75	1.65	2.15

Recovery Diagnosis Adjustment

Jerry Holman

Duration	Unclassified	Low	Mid	High
Q3	1.00	0.55	1.05	1.60
Q4	1.00	0.55	1.15	1.35
Q5	1.00	0.60	1.15	1.40
Q6	1.00	0.65	1.15	1.35
Q7	1.00	0.65	1.15	1.35
Q8	1.00	0.75	1.10	1.30
3	1.00	0.65	1.15	1.40
4	1.00	0.60	1.10	1.65
5	1.00	0.70	1.10	1.55
6	1.00	0.70	1.15	1.45
7	1.00	0.70	1.25	1.35
8	1.00	0.75	1.15	1.35
9	1.00	0.70	1.25	1.35
10	1.00	0.70	1.10	1.25

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Death Diagnosis Adjustment

Duration	Comparison			
	Unclassified	Low Non-Cancer	High Non-Cancer	Cancer
Q3	100%	100%	100%	100%
Q4	100%	100%	100%	100%
Q5	100%	100%	100%	100%
Q6	100%	100%	100%	100%
Q7	100%	100%	93%	100%
Q8	100%	117%	94%	96%
3	100%	100%	95%	100%
4	100%	100%	100%	100%
5	100%	100%	100%	100%
6	100%	100%	100%	100%
7	100%	100%	100%	100%
8	100%	100%	100%	100%
9	100%	100%	100%	100%
10	100%	100%	95%	100%

Recovery Diagnosis Adjustment

Duration	Comparison			
	Unclassified	Low	Mid	High
Q3	100%	100%	110%	88%
Q4	100%	100%	100%	104%
Q5	100%	100%	100%	100%
Q6	100%	100%	100%	100%
Q7	100%	100%	100%	100%
Q8	100%	87%	105%	106%
3	100%	100%	100%	100%
4	100%	113%	102%	89%
5	100%	100%	100%	100%
6	100%	100%	100%	100%
7	100%	100%	96%	100%
8	100%	93%	104%	100%
9	100%	100%	96%	100%
10	100%	100%	109%	100%

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2022 Table

Graduated Rates(1,000Q[X]), No Margin
Ultimate Period (Durations 11 years and beyond)

Attained	Male		Female	
Age	Recovery	Death	Recovery	Death
27	71	16	73	11
28	70	16	72	11
29	70	16	71	11
30	69	18	70	12
31	68	18	69	12
32	68	18	69	12
33	67	18	68	12
34	66	18	67	12
35	66	19	66	13
36	65	19	65	13
37	64	19	64	13
38	60	20	60	14
39	56	20	55	14
40	53	21	51	14
41	49	21	48	15
42	46	22	44	15
43	43	22	41	16
44	41	23	39	16
45	38	24	36	17
46	35	24	33	17
47	33	25	30	18
48	30	26	28	18
49	29	26	27	19
50	27	27	26	20
51	26	28	24	20
52	24	29	23	21
53	23	29	22	22
54	22	30	21	22
55	20	31	20	23
56	19	32	19	24
57	18	33	18	24
58	17	34	17	25

Mortality rates for attained ages prior to 45 were extended back to attained age 27 using judgment, holding to monitonically decreasing slope, and to create a reasonable transition from the select period rates

Recovery rates for attained ages prior to age 45 were extrended back to age 27 using a monitonically increasing slope, and to create a reasonable transition from the select period rates

Decrement rates for ages 45-70 were taken directly from Jerry Holman's Regressions/graduations

2015 VBT Unismoke Tables		
Attained Age	Male	Female
27	0.86	0.35
28	0.84	0.36
29	0.84	0.38
30	0.86	0.41
31	0.90	0.44
32	0.97	0.48
33	1.05	0.52
34	1.13	0.57
35	1.23	0.64
36	1.33	0.72
37	1.44	0.80
38	1.55	0.87
39	1.67	0.93
40	1.81	0.98
41	1.93	1.02
42	2.02	1.06
43	2.07	1.10
44	2.13	1.14
45	2.19	1.21
46	2.25	1.31
47	2.30	1.41
48	2.36	1.52
49	2.45	1.64
50	2.57	1.78
51	2.72	1.94
52	2.90	2.11
53	3.10	2.30
54	3.34	2.51
55	3.62	2.74
56	3.93	3.00
57	4.29	3.30
58	4.71	3.63

59	16	35	16	26
60	15	37	14	27
61	14	39	13	27
62	13	40	13	28
63	12	42	12	30
64	11	44	11	31
65	10	45	10	33
66	10	47	9	35
67	9	48	8	36
68	8	49	8	38
69	8	50	7	39
70	7	51	6	40
71	6	53	6	42
72	6	55	5	44
73	5	58	4	47
74	4	61	3	50
75	4	64	3	53
76	3	68	2	57
77	2	72	2	61
78	2	76	1	65
79	1	80	1	69
80	1	85	0	74
81	0	92	0	81
82	0	97	0	85
83	0	103	0	90
84	0	109	0	95
85	0	117	0	101
86	0	126	0	108
87	0	136	0	116
88	0	147	0	124
89	0	159	0	134
90	0	172	0	144
91	0	185	0	155
92	0	199	0	166
93	0	212	0	178
94	0	225	0	191
95	0	236	0	204
96	0	248	0	218
97	0	263	0	235
98	0	279	0	254

From Age 71 to 99, Mortality Rates were graduated to transition from the Jerry Holman rate at age 70 to 100% of the 2015 VBt table at age 100. This was done as the committee views that disabled mortality and the total mortality represented in the 2015 VBT table will converge by age 100.

Recovery rates were graduated down to 0 by age 80 from the Jerry Holman rates at age 70.

59	5.19	4.01
60	5.75	4.43
61	6.38	4.92
62	7.09	5.46
63	7.89	6.08
64	8.75	6.76
65	9.67	7.53
66	10.65	8.37
67	11.69	9.31
68	12.85	10.35
69	14.18	11.49
70	15.74	12.74
71	17.56	14.10
72	19.69	15.59
73	22.11	17.25
74	24.79	19.11
75	27.71	21.21
76	30.85	23.60
77	34.26	26.30
78	38.02	29.34
79	42.27	32.78
80	47.14	36.77
81	52.61	41.41
82	58.97	46.66
83	66.47	52.66
84	75.06	59.53
85	84.93	67.38
86	96.15	76.12
87	108.69	85.66
88	122.34	96.11
89	136.76	107.46
90	151.63	119.54
91	166.51	132.30
92	181.13	145.88
93	195.09	159.87
94	207.76	174.25
95	221.27	190.71
96	237.50	209.82
97	255.11	230.48
98	274.22	252.51

99	0	296	0	273		99	294.48	275.55
100	0	316	0	299	Mortality rates for attained ages 100-120 were set equal to the 2015 VBT unismoke tables. See columns H-J for reference of those rates	100	315.52	299.21
101	0	337	0	323		101	336.99	323.14
102	0	359	0	347		102	358.54	346.98
103	0	380	0	370		103	379.81	370.36
104	0	400	0	393		104	400.44	392.92
105	0	420	0	414		105	420.09	414.30
106	0	438	0	434		106	438.40	434.13
107	0	455	0	452		107	455.01	452.05
108	0	470	0	468		108	469.56	467.69
109	0	482	0	481		109	481.70	480.68
110	0	491	0	491		110	491.07	490.65
111	0	497	0	497		111	497.31	497.23
112	0	500	0	500		112	500	500
113	0	500	0	500		113	500	500
114	0	500	0	500		114	500	500
115	0	500	0	500		115	500	500
116	0	500	0	500		116	500	500
117	0	500	0	500		117	500	500
118	0	500	0	500		118	500	500
119	0	500	0	500		119	500	500
120	0	500	0	500		120	500	500
121	0	1,000	0	1,000	All lives assumed to terminate by age 121			

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Attained Age	Recovery Diagnosis Group Adjustments			
	Other	Low	Medium	High
0-44	100%	70%	125%	110%
45-49	100%	70%	125%	105%
50-54	100%	75%	130%	110%
55-59	100%	75%	125%	120%
60-64	100%	77%	120%	105%
65+	100%	80%	120%	120%

As recovery rates are relatively small (compared to mortality) for ages 65, and reach a terminus value of 0 at age 80, no graduating of adjustments for diagnosis groups was deemed material or necessary for ages 65+

Attained Age	Death Diagnosis Group Adjustments			
	Other	Low	Medium	High
0-44	100%	75%	170%	200%
45-59	100%	85%	160%	200%
60-64	100%	80%	155%	200%
65-69	100%	75%	155%	200%
70	100%	75%	155%	200%
71	100%	76%	153%	197%
72	100%	77%	151%	193%
73	100%	78%	150%	190%
74	100%	78%	148%	187%
75	100%	79%	146%	183%
76	100%	80%	144%	180%
77	100%	81%	142%	177%
78	100%	82%	140%	173%
79	100%	83%	139%	170%
80	100%	83%	137%	167%
81	100%	84%	135%	163%
82	100%	85%	133%	160%
83	100%	86%	131%	157%
84	100%	87%	129%	153%
85	100%	88%	128%	150%
86	100%	88%	126%	147%
87	100%	89%	124%	143%
88	100%	90%	122%	140%
89	100%	91%	120%	137%
90	100%	92%	118%	133%
91	100%	92%	117%	130%
92	100%	93%	115%	127%
93	100%	94%	113%	123%
94	100%	95%	111%	120%
95	100%	96%	109%	117%
96	100%	97%	107%	113%
97	100%	97%	106%	110%
98	100%	98%	104%	107%
99	100%	99%	102%	103%
100+	100%	100%	100%	100%

Diagnosis Adjustments more death rates were assumed to ultimately disapper by age 100, and are so graduated to 100% by attained age 100, indicating no mortality differences by diagnosis grouping for ages 100+

2005 TABLE **MALES**

PROBABILITY OF DEATH (1,000Q[X]+T) - SELECT PERIOD

Central Age =>	17	22	27	32	37	42	47	52	57	62	67	72
1 (4th qtr.)	17	20	20	23	28	28	28	30	31	37	34	31
2 (1st qtr.)	21	23	24	29	30	30	30	30	30	30	27	24
2 (2nd qtr.)	22	24	24	30	28	28	27	27	27	27	26	23
2 (3rd qtr.)	25	27	27	27	21	21	22	22	23	23	23	20
2 (4th qtr.)	27	31	30	26	18	18	18	18	17	17	17	17
3	30	45	55	56	57	58	59	60	65	67	69	73
4	18	26	48	48	49	50	50	50	55	57	59	62
5	12	18	33	39	40	41	42	42	45	47	52	55
6	12	18	30	33	34	35	36	37	42	43	55	61
7	12	18	22	25	26	27	28	30	39	42	57	63
8	12	18	20	23	25	26	27	29	44	46	62	68
9	12	18	18	19	23	25	27	32	45	48	65	75
10	12	18	15	17	19	22	27	34	45	50	70	81

MALES

PROBABILITY OF RECOVERY (1,000Q[X]+T) - SELECT PERIOD

Central Age => Year of Dis.	17	22	27	32	37	42	47	52	57	62	67	72
1 (4th qtr.)	61	61	50	41	39	30	23	15	12	8	6	5
2 (1st qtr.)	58	58	48	40	36	25	21	13	11	8	7	5
2 (2nd qtr.)	53	53	43	35	34	24	19	12	10	7	6	5
2 (3rd qtr.)	49	49	40	33	32	23	15	11	9	6	5	4
2 (4th qtr.)	43	43	36	30	29	22	13	10	7	5	4	3
3	171	171	139	113	83	71	58	36	23	16	12	11
4	154	154	116	87	67	55	40	27	17	14	9	8
5	125	125	92	67	56	45	27	21	13	11	8	7
6	76	76	65	55	48	37	21	14	10	10	7	6
7	60	60	54	48	43	32	17	12	8	8	5	4
8	53	53	48	43	36	25	16	10	8	6	3	2
9	43	43	41	38	31	21	13	8	7	5	2	1
10	38	38	35	32	23	17	10	7	6	4	2	0

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FEMALES

PROBABILITY OF DEATH (1,000Q[X]+T) - SELECT PERIOD

Central Age => Year of Dis.	17	22	27	32	37	42	47	52	57	62	67	72
1 (4th qtr.)	10	12	16	17	18	21	25	27	29	32	30	28
2 (1st qtr.)	9	11	14	16	16	19	24	26	27	29	26	23
2 (2nd qtr.)	9	11	14	16	16	17	23	25	25	26	25	22
2 (3rd qtr.)	8	10	13	15	15	17	20	21	22	22	22	19
2 (4th qtr.)	8	9	12	13	13	14	16	17	16	16	16	16
3	15	23	29	30	32	35	42	52	53	54	61	64
4	12	17	20	21	23	25	32	39	44	45	51	54
5	8	15	19	20	21	23	25	30	36	41	45	47
6	8	13	14	14	16	19	24	28	36	39	48	50
7	8	11	12	13	14	19	24	28	35	40	51	53
8	8	11	12	13	14	18	23	27	35	41	55	57
9	8	10	12	13	14	16	23	27	33	42	59	62
10	8	9	11	12	14	16	23	27	32	42	63	67

FEMALES

PROBABILITY OF RECOVERY (1,000Q[X]+T) - SELECT PERIOD

Central Age => Year of Dis.	17	22	27	32	37	42	47	52	57	62	67	72
1 (4th qtr.)	94	94	77	63	44	38	26	25	20	13	10	8
2 (1st qtr.)	71	71	59	49	41	34	25	23	18	13	11	9
2 (2nd qtr.)	59	59	48	39	38	30	22	21	15	11	9	7
2 (3rd qtr.)	53	53	44	36	35	26	18	17	12	9	7	6
2 (4th qtr.)	46	46	38	32	31	23	14	13	9	6	5	4
3	199	199	162	132	108	91	65	49	31	22	17	15
4	193	193	145	109	85	68	45	35	21	18	11	9
5	164	164	120	88	67	53	33	23	18	16	12	10
6	101	101	86	73	55	41	27	17	15	15	10	8
7	75	75	67	60	47	34	25	14	12	12	8	6
8	62	62	56	50	40	28	23	13	11	9	5	3
9	49	49	46	43	35	24	19	11	9	7	3	1
10	42	42	38	35	29	18	11	8	8	5	3	0

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2005 Table

Graduated Rates(1,000Q[X]), No Margin
Ultimate Period (Durations 11 years and beyond)

Attained	Male		Female	
Age	Recovery	Death	Recovery	Death
27	25	10	25	8
28	25	10	25	8
29	25	10	25	8
30	25	11	25	9
31	25	11	25	9
32	25	11	25	9
33	25	11	26	9
34	25	11	27	9
35	25	12	29	10
36	25	12	31	10
37	25	12	33	10
38	24	12	32	10
39	23	13	31	11
40	23	14	30	11
41	22	15	28	12
42	22	15	27	12
43	21	15	27	12
44	20	16	27	13
45	19	16	26	14
46	18	17	26	14
47	17	17	26	15
48	17	18	24	15
49	17	19	22	15
50	16	20	20	16
51	16	21	18	16
52	16	22	17	16
53	15	24	16	18
54	14	25	15	19
55	12	26	14	20
56	11	28	12	22
57	10	29	11	23
58	9	31	10	24
59	8	33	10	25

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60	7	34	9	25
61	6	35	9	26
62	5	37	8	27
63	5	39	8	28
64	5	40	8	30
65	5	42	7	31
66	5	44	7	32
67	5	45	7	32
68	4	47	6	34
69	3	48	4	36
70	3	51	3	38
71	2	52	2	40
72	1	53	1	42
73	1	58	1	46
74	1	62	1	50
75	1	66	1	54
76	1	70	1	59
77	1	74	1	63
78	1	76	1	64
79	1	79	1	65
80	0	80	0	66
81	0	83	0	67
82	0	86	0	67
83	0	91	0	71
84	0	97	0	75
85	0	103	0	79
86	0	109	0	84
87	0	115	0	89
88	0	122	0	94
89	0	129	0	99
90	0	137	0	105
91	0	146	0	112
92	0	156	0	120
93	0	168	0	129
94	0	182	0	140
95	0	199	0	153
96	0	224	0	172
97	0	268	0	206
98	0	359	0	276
99	0	999.9	0	999.9

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Draft: 10/3/22
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2022
Adopted by the Health Insurance and Managed Care (B) Committee, Dec. __, 2022
Adopted by the Health Actuarial (B) Task Force, Sept. 28, 2022

2023 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

The mission of the Health Actuarial (B) Task Force is to identify, investigate, and develop solutions to actuarial problems in the health insurance industry.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.

2. The **Long-Term Care Actuarial (B) Working Group**:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
      ii. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      iii. Develop LTCI experience reporting requirements in VM-50 and VM-51.

3. The **Long-Term Care Pricing (B) Subgroup**:
   A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charge:
      i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices and rate changes.

4. The **Long-Term Care Valuation (B) Subgroup**:
   A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charges:
      i. Continue to develop health insurance reserving requirements (VM-25) using a PBR framework.
      ii. Develop LTCI experience reporting requirements in VM-50 and VM-51 of the *Valuation Manual*.

NAIC Support Staff: Eric King

Member Meetings/B CMTE/HATF/2022_Fall/09-28-22/2023 Proposed HATF Charges.docx

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Draft: 9/21/22

Health Actuarial (B) Task Force
Virtual Meeting
September 6, 2022

The Health Actuarial (B) Task Force met Sept. 6, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM): Ricardo Lara represented by Rodney Haviland (CA); Michael Conway represented by Eric Unger (CO); Doug Ommen represented by Andria Seip (IA); Amy L. Beard represented by Heir Cooper (IN); Kathleen A. Birrane represented by Jeff Ji (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Chris Murrah (MO); Marlene Caride represented by Seong-min Eom (NJ); Michael Humphreys represented by Jim Laverty (PA); Michael Wise represented by Andrew Dvorine (SC); Cassie Brown represented by Aaron Hodges (TX); Mike Kreidler represented by Lichiou Lee (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Discussed Revisions to a GLWPVT AG 44 Proposal

Mr. Lombardo said no comments were received on the exposure of the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute Group Life Waiver of Premium Valuation Table (GLWPVT) Work Group proposal for valuation tables to replace the 2005 Group Term Life Waiver Mortality and Recovery Tables in *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44).

Mr. Serbinowski said he is not comfortable with the language in Section VI(A) of the proposed revised AG 44 that states, "the selected claim mortality rates and recovery rates are deemed to be tables approved by the commissioner as the minimum standard for computing reserves as established by Section 4.G of the Standard Valuation Law." Mr. Dyke agreed that reference to deeming by the commissioner should be removed. He said he will draft two suggested alternatives, and he asked that it be reviewed by industry. Steven Clayburn (American Council of life Insurers—ACLI) said he will forward Mr. Dyke's suggestions to ACLI members for their review and input.

Mr. Lombardo said the Task Force will expose the revised language once it is available for a two-week public comment period, and a meeting of the Task Force will then be scheduled to discuss any comments received.

Having no further business, the Health Actuarial (B) Task Force adjourned.

Member Meetings\B CMTE\HATF\2022_Fall\Health Actuarial (B) TF\09-06-02\Minutes_HATF_09-06-22.docx

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Draft: 11/8/22

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
October 17, 2022

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met Oct. 17, 2022. The following Working Group members participated: Tomasz Serbinowski, Chair (UT); Charles Hale (AL); Lisa Luo (CA); Paul Lombardo (CT); Hannah Howard (FL); Wes Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman (OH); Andrew Schallhorn (OK); Jim Laverty (PA); and Aaron Hodges (TX). Also participating was: David Hippen (WA).

1. Discussed an LTCI Mortality and Lapse Study Exposure

Serbinowski presented comment letters received on the Working Group's exposure of the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute's Final Long-Term Care Insurance (LTCI) Mortality and Lapse Study from Risk & Regulatory Consulting LLC (RRC), the American Council of Life Insurers (ACLI), and America's Health Insurance Plans (AHIP) (Attachment Three-A).

Serbinowski said since the proposed mortality tables will be used in the calculation of active life reserves, the table versions based on active lives, rather than total lives, should be used. He asked the Working Group for its thoughts on which version should be used. Andersen and Lombardo agreed that the active life versions should be used. Serbinowski said the version of the mortality tables will be specified in VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual*, and this issue will be discussed further during the drafting process for the changes to VM-25. Ray Nelson (America's Health Insurance Plans—AHIP) suggested that flexibility in a company's choice regarding the use of active or total lives tables should be allowed, as different companies use different bases in their reserving processes. Roger Loomis (Actuarial Resources Corporation—ARC) said he agrees that the use of active lives tables makes more sense theoretically. Hippen asked if the new reserving standards are intended to be applied to all in-force policies or only new issues after the effective adoption date. Serbinowski said he believes the new standards will only apply to new issues. He said this will be verified during the VM-25 changes drafting process. He said the Working Group will refrain from considering adoption of the proposed mortality and lapse tables until the necessary VM-25 language has been drafted and adopted.

Serbinowski said current reserve standards limit allowable lapses to 80% of lapse assumptions used in pricing for the first five years, then 100% of the pricing assumptions thereafter. He asked if the Working Group believes this convention should be applied to the proposed lapse tables, or if lapses used in reserving should be limited to the lesser of those indicated by the proposed tables or those used in pricing. Andersen said limiting lapses to the lesser of the proposed tables and pricing makes sense. Nelson said he agrees with this.

Serbinowski asked if the mortality tables to be used should be static or generational tables. Nelson said the ACLI/AHIP comment letter suggests using a static table, which already reflects 11 years of mortality improvement. He said any future mortality improvements can be evaluated during the asset adequacy testing (AAT) process, and they would not need to be reflected in the prescribed mortality tables. Andersen said if companies assume morbidity improvement in their valuations, they should also be required to assume mortality improvement. He said if it is decided that there will be no mortality improvements, there should be a requirement that morbidity improvements should not be assumed. Warren Jones (Academy-Retired) said the Academy/SOA Work Group did not make a recommendation regarding which version of the tables should be used. Serbinowski asked Working Group members about what their preference is for static versus generational mortality tables. Thirteen Working Group members said they prefer static, and one member said they prefer generational.

Serbinowski said both comment letters argued for flexibility regarding the use of adjustment factors for risk class and marital status, such as allowing factors to be used for some blocks but not others, or for allowing the use of the factors for lapses but not mortality. He said the Academy/SOA Work Group did not provide recommended factors for these adjustments. He asked the commenters what kind of guardrails will be in place and support documentation required if state insurance regulators allow for flexibility in factor application. Nelson said given the differences in definitions and experience for risk classifications and marital status discounts between companies, and from block to block within the same company, the ACLI/AHIP recommends flexibility in factor application be allowed. He said he agrees that companies should be able to support and document their assumptions, and this should be done at both the time of pricing and the time of setting reserving assumptions for each valuation. He said support and documentation will also need to be provided when AAT, as required by *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51). Serbinowski said risk class and marital status definitions vary between companies, and since these are not well-defined, perhaps it is better to use valuation tables that are not adjusted for risk class or marital status. Carmello, Lombardo, and Trexler said they agree with this. Serbinowski asked Working Group members what their preference is for allowing adjustment factors for risk class and marital status. Fourteen Working Group members said they prefer to not allow these adjustments.

Serbinowski said the next step is for the Working Group to draft changes to VM-25 to incorporate the use of the proposed valuation tables and discuss the draft when it is available.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2022_Fall/LTCAWG/10-17-22/Minutes_LTCAWG_10-17-22docx

Tomasz Serbinowski
Chairman, NAIC Long-Term Care Actuarial (B) Working Group
Utah Insurance Department

Eric King
NAIC Staff

September 6, 2022

Dear Mr. Serbinowski and Mr. King,

The American Council of Life Insurers (ACLI)[i] and the America's Health Insurance Plans (AHIP)[ii] appreciate the opportunity to comment on the updated LTCI Mortality and Lapse Study, along with the cover letter, exposed by the NAIC Long-Term Care Actuarial (B) Working Group on July 5, 2022.

ACLI/AHIP support the work of the NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG) in their efforts to update the valuation standards for lapse and mortality assumptions which would be applicable prospectively to new LTC business being issued after adoption of the update. Following are comments regarding the Study/Tables and the items raised in the LTCAWG Cover Letter:

LTCI LAPSE AND MORTALITY STUDY

We noticed one small technical issue with respect to the LTC Mortality Tables excel file that is included in the SOA/AAA LTC Insurance Mortality and Lapse Study. The tab titled 'Final Tables' appears to have the male and female 2012 IAM mortality rates transposed, which causes the comparison ratios of the new mortality rates to the 2012 IAM mortality rates to be skewed. We believe the report itself reflects the correct ratios in various graphs and that this issue only impacts comparisons within the spreadsheet.

COMMENTS REGARDING ISSUES POSED IN LTCAWG COVER LETTER

1. *The Academy recommendation includes optional use of adjustment factors for marital status and risk class. However, the Academy is not recommending specific factors. Should only the aggregate mortality and lapse tables be adopted, or should the use of marital status and risk class adjustments be allowed?*

   We would suggest that the use of marital status and risk class adjustments be allowed, though not mandated, at the discretion of the carrier. There are many company differences in the areas of rating practices, definitions, markets, data availability, etc. that would suggest that these adjustments should not be mandated for all carriers. The

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carrier should be able to provide justification for any such adjustment factors used for reserving (and pricing) purposes.

2. *If regulators allow for the use of the adjustments for marital status and risk class, what guardrails should be put in place, if any, for the use of these factors? What kind of testing, certification, and/or demonstration should be required to support the use of such factors?*

   We do not believe that it would appropriate to set guardrails for these adjustments. The carrier should be able to provide justification for all of their reserving assumptions, including these adjustments, during their annual Actuarial Opinion work and completion of Actuarial Guideline 51 materials.

3. *If regulators allow the use of the adjustments for marital status and risk class, should companies be required to use them for all blocks of LTCI, or should companies be given a choice to use aggregate tables for some blocks and tables with adjustments for marital status and/or risk class for other blocks?*

   We believe that companies should have flexibility in their use the adjustment factors by block of insurance. Some policy forms or market segments will have different definitions and adjustments for marital status and/or risk class. Future forms and their definitions may well differ from what is currently sold. There could be other differences as well, (for example, group versus individual), that could cause a company to use different adjustments or aggregate tables for one block/form than another block/form. The company should be able to support any differential treatment of adjustment factors for different blocks/forms.

4. *If regulators allow the use of the adjustments for marital status and risk class, should companies be required to use them consistently for mortality and lapse (either use the aggregate table for both mortality and lapse, or use adjusted table for both mortality and lapse)?*

   While we might expect that a company using a marital and/or risk class adjustment for one assumption (lapse or mortality) would use adjustments for both, it could be that past historic data of the company shows that adjustments are only appropriate for one assumption and not the other. So long as the company is able to provide adequate support for applying adjustments to only one assumption and is able to demonstrate that the combined impact of the adjustments is representative of their business, we believe that flexibility should be maintained.

5. *The valuation mortality table recommended by the Academy includes 11 years of mortality improvement from the middle of the experience period (2008-2011) through*

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year-end 2020. Should valuation use a static table, or would it be more appropriate to use generational mortality, including future mortality improvements, similar to the valuation tables used for annuities?

We would suggest that the table, with its 11 years of mortality improvement, be adopted as a static table. The study notes that they did not do an actual analysis on the improvement piece itself but are using it due to the general consensus that it's been seen in prior population studies. Scale G2 is appropriate enough for this purpose but would hesitate to say we suggest including it for all future projection years without some additional analysis. Future mortality improvement can be considered as part of the AAT process, as it is today. But "locking in" a pattern of mortality improvement for many years into the future, especially now that we have just gone through a global pandemic that increased mortality rates significantly in the short term, seems overly conservative.

CONCLUSION

Thank you for the opportunity to provide these comments. ACLI/AHIP welcomes the opportunity to discuss our comments with you in the near future.

Sincerely,

Jan M. Graeber	Ray Nelson
Senior Actuary, ACLI	AHIP Consulting Actuary

[i] The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

[ii] AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public- private partnerships that improve affordability, value, access, and well-being for consumers.

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August 29,2022

Mr. Eric J. King, FSA, MAAA
Senior Health Actuary, Research & Actuarial Services, NAIC
1100 Walnut Street, Suite 1500
Kansas City, MO, 64106-2197

RE: Comments Regarding Recommended Mortality and Lapse Tables for Valuation of Long-Term Care Insurance Liabilities

Dear Mr. King:

In November of 2021, in response to an earlier request by the NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG), the American Academy of Actuaries (Academy) and the Society of Actuaries Research Institute submitted a report recommending new mortality and lapse tables for use in valuation of long-term care insurance liabilities. On July 6, 2022, the LTCAWG sent out an email inviting task force members, interested regulators, and interested parties to comment on the recommended tables, with particular emphasis on certain identified areas (items 1-5 below).

As an interested party, RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be happy to discuss with you and the LTCAWG members at your convenience.

<u>RRC Comments</u>

- General comments:
  - We observed that the experience data was restricted to calendar years 2008-2011 to capture more recent trends. It is unclear whether consideration was given to the impact of the 2008 financial crisis on mortality and lapse experience. If not, we suggest considering the potential impacts which could cause the data period to be less appropriate for setting long term assumptions.
  - We observed that significant reliance was placed on certain individuals for calculating exposures, identifying statistical significance of predictive variables, and developing the mortality tables. Given the broad financial impact of this work, it would seem prudent to acknowledge whether a peer review was conducted and indicate whether the party that performed the review possessed the requisite experience and technical expertise.

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- Although the report acknowledges that there is currently no known industry study on LTC mortality trends with respect to improvement, it isn't clear whether consideration was given to constructing a mortality table directly from LTC raw experience as opposed to developing a table based on the 2012 IAM as its foundation. If such a discussion were included in the report, it would afford the reader an appreciation as to whether due consideration was given to other potentially viable alternatives.

- The report states that an observation count of 1,082 (271) corresponds to full (partial) credibility as it corresponds to a 90% probability that the observed rate is within 5% (10%) of the true underlying rate. However, the report does not mention that these credibility parameters are premised on the assumption that both mortality and lapse will exhibit a normal distribution. It would therefore seem prudent to identify this underlying assumed distribution and discuss why this is considered reasonable and appropriate for both mortality and lapse.

- Figures 11 and 12 (pages 29 and 30 of the report) display chart axes, but they do not appear to show the actual smoothed curve associated with each issue age group cohort.

- With respect to the "Assumptions" tab of the mortality table spreadsheet, we would recommend:

  - Use of a drop down to select "Active" or "Total" in cell F4 as opposed to manual entry by the user; and

  - Incorporating a toggle to include or exclude the effects of mortality improvement.

- Although statutory guidance as to how the subject mortality and lapse tables are to be applied in determining contract reserves is perhaps beyond the scope of feedback that is being sought at this time, we thought that the following comments might prove to be helpful to the LTCAWG prospectively:

  - With respect to lapse rates, it is not clear whether there is an expectation that they be capped at the lesser of the proposed table rate and the voluntary lapse rate used in the calculation of the gross premium. We believe that it would be appropriate and consistent with current valuation considerations to cap the lapse rate at 100% of the voluntary lapse rate used in the calculation of the gross premium; and

  - Since current valuation mortality tables used for LTC are not expressed on both an active and total life basis, it would seem appropriate to include guidance as to which basis should be used, and whether once determined, the selection is "locked-in" for the life of the contracts.

- Specific comments related to areas of emphasis identified by LTCAWG:

1. *The Academy recommendation includes optional use of adjustment factors for marital status and risk class. However, the Academy is not recommending specific factors. Should only the aggregate mortality and lapse tables be adopted, or should the use of marital status and risk class adjustments be allowed?*

   Consistent with the gradual migration toward principle-based reserve (PBR) approaches for other products, we believe that the use of such adjustments should be permitted. However, consistent with PBR philosophy generally, the rationale for and supporting analysis justifying such adjustments should be documented and certified by a qualified actuary (as further discussed in response to #2 below).

2. *If regulators allow for the use of the adjustments for marital status and risk class, what guardrails should be put in place, if any, for the use of these factors? What kind of testing, certification, and/or demonstration should be required to support the use of such factors?*

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We believe that documentation of the factor development, including supporting rationale and how the factors meet moderately adverse conditions, should be required, similar to what is in place today for PBR and cash flow testing.

3. *If regulators allow the use of the adjustments for marital status and risk class, should companies be required to use them for all blocks of LTCI, or should companies be given a choice to use aggregate tables for some blocks and tables with adjustments for marital status and/or risk class for other blocks?*

   We believe that companies should have discretion to use different approaches for different blocks of business based on documented objective criteria, e.g., materiality. Requiring specific documentation of the objective criteria would mitigate the potential for "cherry-picking" that could otherwise be used to treat two similar blocks of business differently with the intent of minimizing reserves.

4. *If regulators allow the use of the adjustments for marital status and risk class, should companies be required to use them consistently for mortality and lapse (either use the aggregate table for both mortality and lapse, or use adjusted table for both mortality and lapse)?*

   We believe that companies should have discretion to use different approaches for mortality vs. lapse based on documented objective criteria, e.g., application of the adjustment is material for mortality, but not for lapse. Choices that are made just to minimize reserves should not be allowed.

5. *The valuation mortality table recommended by the Academy includes 11 years of mortality improvement from the middle of the experience period (2008-2011) through year-end 2020. Should valuation use a static table, or would it be more appropriate to use generational mortality, including future mortality improvements, similar to the valuation tables used for annuities?*

   We support the use of generational mortality, including future mortality improvements. We also believe that morbidity improvement could be considered if mortality improvement is used (with appropriate margins to cover moderately adverse conditions).

Thank you for the opportunity to provide comments on this important initiative. Please don't hesitate to contact us if you or other LTCAWG members have any questions.

Sincerely,

Tricia Matson, Partner
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Plan Year (PY) 2024 Rate Filing Submissions

December 5, 2022

NAIC, Health Actuarial Task Force Meeting

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The information provided in this presentation is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was shared. Links to certain source documents may have been provided for your reference. We encourage persons attending the presentation to refer to the applicable statutes, regulations, and other guidance for complete and current information.

Purposes of Rate Review

- Improve issuer accountability and transparency
- Carry out Secretary's responsibility to monitor premium increases of health insurance coverage offered inside and outside the Exchange
- Ensure compliance with Federal rating requirements and reasonableness of proposed rate increases

Which issuers must submit the Unified Rate Review Template (URRT)?

- **Annual Filings**
  - Issuers (for both QHPs and non-QHPs) offering a single risk pool plan in the individual or small group market for the 2024 plan year
- **Quarterly Filings**
  - Issuers can submit quarterly rate changes for the small group market if allowed by the State regulatory authority
  - Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change (or earlier State deadline)

What should issuers submit for Single Risk Pool Plans?

- If any plan within a filing includes a rate increase subject to review:
  - Part I – URRT
  - Part II – Written Description Justifying the Rate Increase
  - Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)
- If all plans within a filing have rate increases less than the subject to review threshold:
  - Part I – URRT
  - Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)
- If all plans within a filing are new, have no rate change(s), or have a rate decrease:
  - Part I – URRT

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Filing vs. Product vs. Plan

- A **filing** is submitted by a specific company for a specific state in either the individual or small group market.
- A **product** is a discrete package of health insurance coverage benefits that are offered using a particular network type within a service area.
- A **plan** is the pairing of the health insurance coverage benefits under a product and a particular cost-sharing structure, provider network, and service area.
  - Plans within a product can vary based on cost sharing structure and service area. The combination of all service areas of the plans constitutes the total service area of the product.

Acme Company – Individual Market Filing, Texas		
Product A	Product B	Product C
Essential Health Benefits (EHBs) only	EHBs Plus acupuncture	EHBs only
PPO	PPO	HMO
Plan A1 = bronze Plan A2 = silver Plan A3 = gold	Plan B1 = silver Plan B2 = gold	Plan C1 = bronze Plan C2 = silver Plan C3 = gold

Renewing Plans

- Issuers are able to designate plans as one (1) of three (3) options in the URRT: New, Renewing, or Terminated. Only "Renewing" plans are subject to the rate review provisions.
- Unless an issuer is brand new to the market, at least one (1) plan in the filing must be marked as "Renewing"; otherwise an issuer may be considered as having exited the market and may be subject to a 5-year ban.
- Issuers that replace an entire portfolio of products in a market with new products may avoid a 5-year ban if each newly offered product is cross-walked to a terminated product in the actuarial memorandum. An issuer must expect significant transfer of enrollment from one product to the other for this to be considered reasonable. The issuer should mark the newly mapped plan(s) as "renewing" and enter the current enrollment and current premium PMPM from the terminating plan(s) under the renewing plan(s) rather than in the terminating plan(s) columns.

Rate Filing Tips for PY 2024

- CMS intends to post preliminary single risk pool rate changes for all states on ratereview.healthcare.gov. Please remember the following:
  - New issuers and issuers with no rate changes will not be posted on the website.
  - The data from the most recent URRT and the most recent Actuarial Memorandum (or Redacted Actuarial Memorandum) entered into the system will be displayed on the website.
- Rate filing documents need to be submitted by the applicable deadline for proposed rates; they also need to be revised and resubmitted (as applicable) with the final rate information.
- State Based Exchanges that DO NOT use the federal platform have until the federal non-QHP deadline to finalize QHP rates in the URR Module.

URRT changes for PY 2024

- Lengthen Decimal Places in URR Template up to 16 characters, including decimal place, to improve calculation accuracy. Display will still only show two decimal places
- Update existing URR Template Rate Increase Formulas to round to 2 percentage decimal places
- Excel will no longer change "Paste" to "Paste Special, Values"
- Formulas will no longer disappear from cells when regenerating the URRT
- Move State & Market Field in the URRT from column J to column E for ease of reading

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URR Module changes for PY 2024

- Remove AV De Minimis range validations on URRT and URR Module
  - It will be the responsibility of the regulators to make sure the AV values are within permissible ranges. CMS will run internal error reports to notify regulators of issues that we find
- Return an error to users when documents fail to store
- Issuers in states that should be submitting through the SERFF to URR Transfer process will be blocked from access to the URR Module. This will prevent them from making changes that are not recorded in SERFF

SERFF to URR Transfer Updates for PY 2024

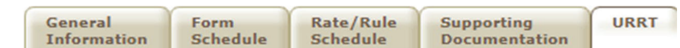
- The transfer system connection is not applicable to States without an Effective Rate Review program, or states that do not utilize the SERFF system. The issuers in these states should continue to submit filings in the HIOS URR module directly.
- SERFF URR Transfer validation errors have been added for:
  - Issuer ID is incorrect
  - Product is not registered in HIOS
  - Effective Date is prior to the current year
  - Active Submission is already found in HIOS
- Allow SERFF to transfer CJN updates without a new URRT at or above threshold, and allow CJN documents for every filing

Step 1 – URRT Tab in SERFF

- All rate filing information for the individual and small group markets will be entered directly into SERFF under the URRT Tab. This includes:
  - Part I –URRT
  - Part II – Written Description Justifying the Rate Increase
  - Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)
- Once validated by the system, the information will be automatically transferred to the URR module of HIOS.
- The URRT information was set up on 4 TOIs within SERFF: H16G and HOrg02G (Small Group only) and H16I and HOrg02I rates. If the filing is created outside of these combinations, the URRT tab will not show.

Step 2 – Is the URRT required?

Once the user navigates to the URRT view, they will be asked if URRT is applicable to this rate filing:



The Unified Rate Review Template is required to be submitted by Issuers (for both QHPs and non-QHPs) offering a single risk pool plan in the individual or small group market. Issuers can submit quarterly rate changes for the small group market if allowed by the State regulatory authority. Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change (or earlier State deadline)
Note: These filings do not include Student Health or Excepted Benefit products, such as Stand-alone Dental products.

Is the URRT required for this Filing? * ○Yes ◉No

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Step 3 – Adding the URRT

The second field is the template itself; additional items cannot be uploaded until the template has been added:

Unified Rate Review Template *

To download the latest version of the Unified Rate Review Template, please visit the CMS website at https://www.ghpcertification.cms.gov/s/Application%20Materials. Please upload the XML version of the template created by the 'Finalize' action and not the Excel file itself.

Select .xml File

Actuarial Memorandum * Can only be added after the Unified Rate Review Template is added.

Actuarial Memorandum - Redacted * Can only be added after the Unified Rate Review Template is added.

Consumer Justification Narrative Only needed if URRT is above the threshold. Can only be added after the Unified Rate Review Template is added.

Other Supporting Docs Can only be added after the Unified Rate Review Template is added.

13 WWW.REGTAP.INFO

Step 4 – Validation of the URRT

Once the template has been uploaded, it will be sent to CMS for validation and a message appears to the issuer:

Unified Rate Review Template *

To download the latest version of the Unified Rate Review Template, please visit the CMS website at https://www.ghpcertification.cms.gov/s/Application%20Materials. Please upload the XML version of the template created by the 'Finalize' action and not the Excel file itself.

In Progress: URRT validation with CMS is in progress. Check back later for validation success or failure.

1urrttemplatevalidationsuccess.xml Replace File

14 WWW.REGTAP.INFO

Step 5 – Regenerated URRT

Once the validation request has been processed, the message will update accordingly. If the validation is successful, SERFF also displays the regenerated Excel file:

Unified Rate Review Template *

To download the latest version of the Unified Rate Review Template, please visit the CMS website at https://www.ghpcertification.cms.gov/s/Application%20Materials. Please upload the XML version of the template created by the 'Finalize' action and not the Excel file itself.

Success: CMS URRT validation was successful.

1urrttemplatevalidationsuccess.xml Replace File

validated.xls

15 WWW.REGTAP.INFO

Step 6 – Actuarial Memorandum

Issuers will be required to upload the Actuarial Memorandum and Redacted Actuarial Memorandum:

Actuarial Memorandum *

The Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Unified Rate Review Template. The document should contain actuarial reasoning and assumptions, justifications and methodologies that support the entries in the URRT. This document must be a PDF.

Select .pdf File

Actuarial Memorandum - Redacted *

Upload a redacted version of the Actuarial Memorandum. This redacted document will be made available to the public on the CMS website. It should not contain any information that is a trade secret or confidential commercial or financial information. This document must be a PDF.

Select .pdf File

16 WWW.REGTAP.INFO

Step 7 – Consumer Justification Narrative

Issuers can upload the Consumer Justification Narrative (CJN) if not above threshold, but if the CJN is required, issuers will be required to upload the CJN and the user interface indicates this new requirement:

Consumer Justification Narrative
You must have at least one plan that meets or exceeds the threshold to require a Consumer Justification Narrative. This document must be a PDF.

Threshold criteria, One or more plans that meet all three criteria:

- Has 'Metal' level of Platinum, Gold, Silver, Bronze, or Catastrophic
- Has a 'Plan Category' of Renewing
- Has a 'Cumulative Rate Change %' (over 12 months prior) equal or greater than 15%

Select .pdf File

Consumer Justification Narrative is required for the URRT uploaded.

17 WWW.REGTAP.INFO

Step 8 – Supporting Documentation

There is an Additional Supporting Documentation section where up to 30 files can be uploaded.

Other Supporting Documents
Additional documentation relevant to the URRT submission. These documents must be PDFs.

Select .pdf Files

18 WWW.REGTAP.INFO

Step 9 – Other SERFF Functions

Upon Submission of the filing, the information from the URRT tab will be submitted to the state but also sent to CMS.

The template and supporting URR items can also have the following SERFF functions applied, but these functions will not be transferred to the URR module of HIOS:

- Request Confidentiality
- Objections/Objections Letters
- Change Schedule Items
- Response Letters
- Amendment Letters
- State Public Access

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Step 10 – State Determinations

Once the state review is complete, the state will mark the URRT as complete as their determination. If the filing contains only plans below the threshold:

Acknowledge Review * URRT Reviewed

HIOS ID
12345

URRT Documents

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Step 10 – State Determinations

If the filing contains at least one plan above the threshold:

General Information | Form Schedule | Rate/Rule Schedule | URRT | Supporting Documentation | State Specific | Companies and Contact | Filing Fees

Select URRT determination * -- Please Select --

Comments *

Send to CMS

Step 11 – Determination Display

Once a state regulator enters a final determination, the following information will be displayed. The URRT determination and the comments will be sent to the URR Module of HIOS and displayed on ratereview.healthcare.gov. Once a determination has been sent to CMS, there can be no further action on the URRT tab from the issuer or the state.

General Information | Form Schedule | Rate/Rule Schedule | URRT | Supporting Documentation | State Specific | Companies and Contact

State URRT Review

URRT Determination	Determination Date	Determined By
Not Unreasonable	05/25/2021	Hubert Franck

Comments

This is the reviewers comments about the URRT.

Important Reminder

Filings that are submitted through the SERFF transfer process can no longer be reopened after they are in a final status. If a change needs to be made to a filing, it will need to be deactivated by a member of the CCIIO staff in HIOS and then a new submission will need to come through SERFF.

Rate Review Inbox

- Send questions about the content of URR submissions to ratereview@cms.hhs.gov
- Include submission tracking number, State, Health Insurance Oversight System (HIOS) ID, and issuer legal name
- When there is an error or issue with the template:
  - Include screenshots or attach template
  - List steps taken that produced the error
- Please read the instructions before emailing ratereview@cms.hhs.gov

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Resources

- Instructions for the URRT, Actuarial Memorandum and Redacted Actuarial Memorandum https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#Review of Insurance Rates

- CMS Regulations and Guidance https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

Open Q&A Session

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ACLI
Financial Security for Life

Combination Products

Jan M. Graeber, ASA, MAAA
Senior Actuary
ACLI
jangraeber@acli.com
December 5, 2022

1

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Combination Products

- Market Landscape
- General Product Types
- Benefit Structures
- Indemnity and Reimbursement Models
- Combination Product Regulation
- LIMRA Data on Combination Products

2

2

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Financing Long-Term Care Needs

- Medicare
- Medicaid
- Self-Funding
- Private Insurance Solutions

3

3

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Private Insurance Solutions to Addressing Long-Term Care Needs

- Traditional Stand-Alone Long-Term Care Insurance
- Combination Products
  - Olih#Lqvxudqfh#Srolflhv#zlwk#Orqj0Whup#Fduh#Ehqhilw
  - Olih#Lqvxudqfh#Srolflhv#zlwk#Fkurqlf#Looqhvv#Ehqhilw

4

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General Combination Product Basics

- Typically. less expensive than stand-alone LTC
- Death benefit is accelerated if LTC benefits or chronic benefits are used
- Death benefit preserved if LTC benefits or chronic illness benefits are never used
- Some policies allow for:
  - Uhvwrudwlrq#ri#wkh#Ghdwk#Ehqhilw
  - H{whqvlrq#ri#wkh#OWF#ru#Fkurqlf#Loqhvv#ehqhilw
- Many contain no up-front or explicit premium for the accelerated benefit
- Tax benefits typically received through:
  - LUF#::35E#0Wd{0Txdolilhg#OWF/#ru
  - LUF#434+j,#0Fkurqlf#Loqhvv#DGE

5

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Combination Products Indemnity and Reimbursement Models

General Structure of Benefits:

- Indemnity benefits – benefit amount is paid once the policyholder qualifies for benefits
- Reimbursement benefits – benefits will only be reimbursed for the expenses incurred once the policyholder qualifies for benefits

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LTC Combination Product Terms

- LTC Acceleration of Benefit rider (ADB)
- LTC Extension of Benefits Rider (EBR)
- Some refer to products that bundle ADB plus EBR as “hybrids” or “linked benefit products”

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LTC Combination Products

Companies that wish to market or offer their combination products as Long-Term Care coverage must comply with the LTC Model Regulation or applicable state LTC law.

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LTC Combination Products and HIPAA

- Qualified LTCI will be subject to favorable tax treatment under the Federal Income Tax Code, similar to accident and health insurance products.
- Benefits paid by a tax-qualified policy will not be counted as taxable income to the policyholder under most circumstances, and premiums paid can be counted as a non-reimbursed medical expense for those itemizing their deductions for tax purposes.
- Almost all policies sold today are TQ policies, although non-TQ policies continue to be available.

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Chronic Illness Combination Products

- Provides an acceleration of the death benefit for chronic illness care needs
- At most, the benefit payout is 100 percent of the death benefit.
- Some products apply a charge at issue for the chronic illness rider
- Some do not apply a charge at issue and discount the benefit amount at time of claim
- Receive tax benefit under Section 101(g) of the Internal Revenue Code
- Cannot be marketed as LTC insurance.
- When benefits are paid, the life policy face amount is commonly reduced dollar-for-dollar up to 100% of the face amount of the life policy.
- Acceleration benefit options typically range between two years and four years, or range from 1% to 5% of the face amount per month.

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REGULATORY FRAMEWORK AND GUIDANCE

- NAIC Long-Term Care Model Regulation (640)
- NAIC Accelerated Benefits Model Regulation (620)
- Interstate Insurance Compact Uniform Standards

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LIMRA Data

Combination Products

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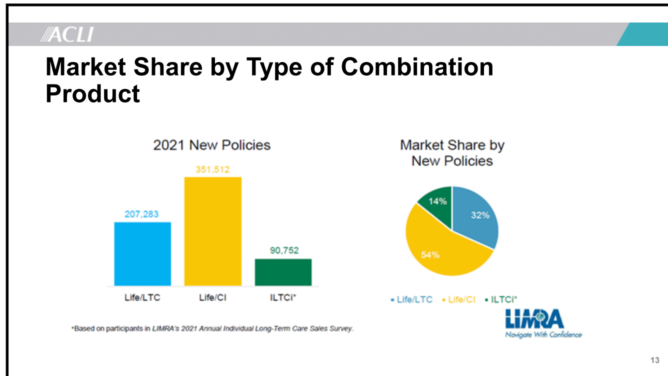

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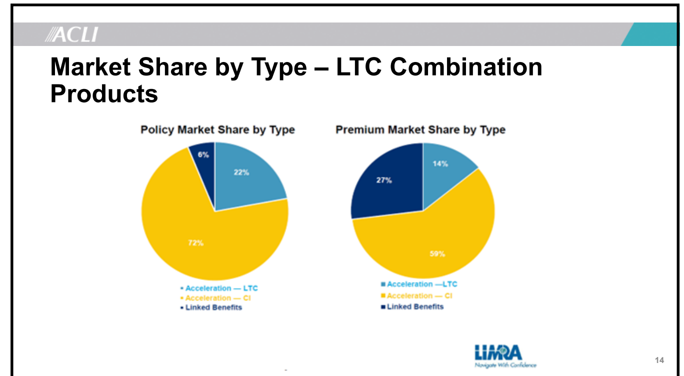

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LTC Combination Products

LTC Extension Benefit Duration

Benefit Duration	Share
2-Year	27%
3-Year	4
4-Year	22
5-Year	7
6-Year	20
7-Year	1
8-Year	*
Lifetime	*
Other	19

* Less than ½ of one percent

LTC Extension Inflation Protection Provisions

Benefit Duration	Share
3% simple	5%
3% compound	47
5% simple	7
5% compound	9
None	32

LTC Extension Couples Discount

Couples Discount	Share
Included	77%
Not included	23

LIMRA
Navigate With Confidence

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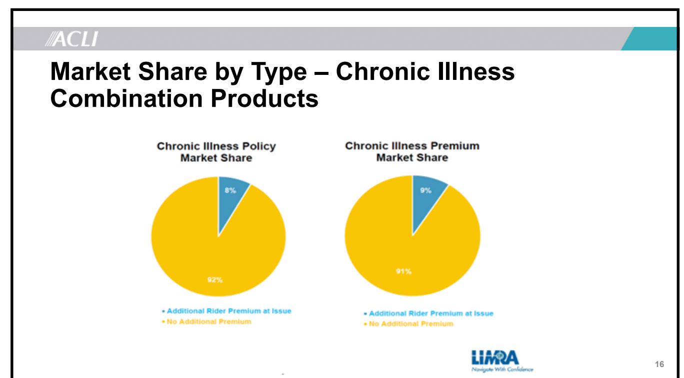

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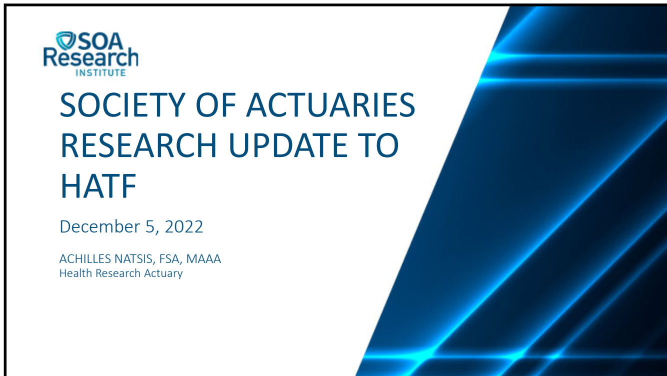

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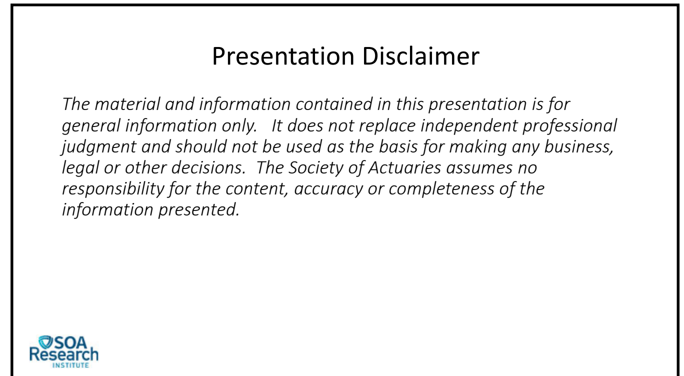

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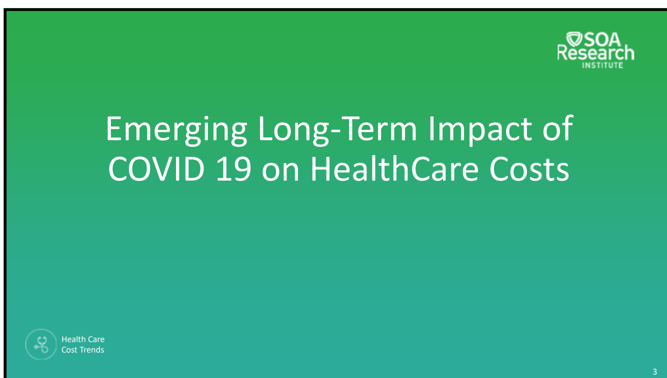

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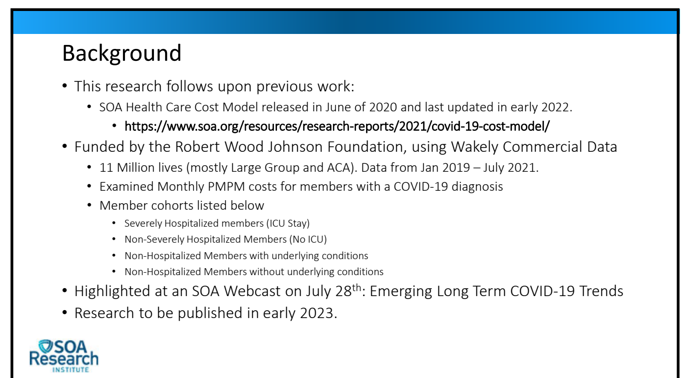

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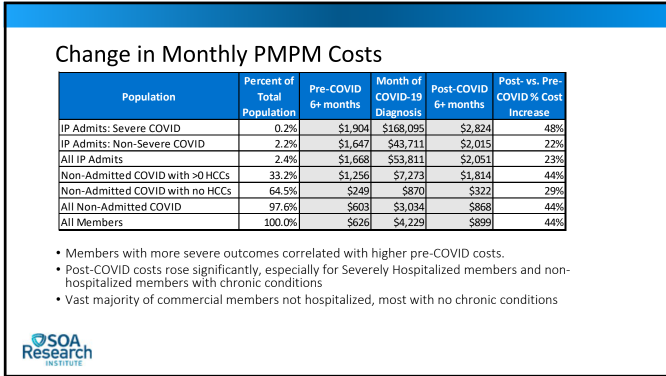

Population	Percent of Total Population	Pre-COVID 6+ months	Month of COVID-19 Diagnosis	Post-COVID 6+ months	Post- vs. Pre-COVID % Cost Increase
IP Admits: Severe COVID	0.2%	$1,904	$168,095	$2,824	48%
IP Admits: Non-Severe COVID	2.2%	$1,647	$43,711	$2,015	22%
All IP Admits	2.4%	$1,668	$53,811	$2,051	23%
Non-Admitted COVID with >0 HCCs	33.2%	$1,256	$7,273	$1,814	44%
Non-Admitted COVID with no HCCs	64.5%	$249	$870	$322	29%
All Non-Admitted COVID	97.6%	$603	$3,034	$868	44%
All Members	100.0%	$626	$4,229	$899	44%

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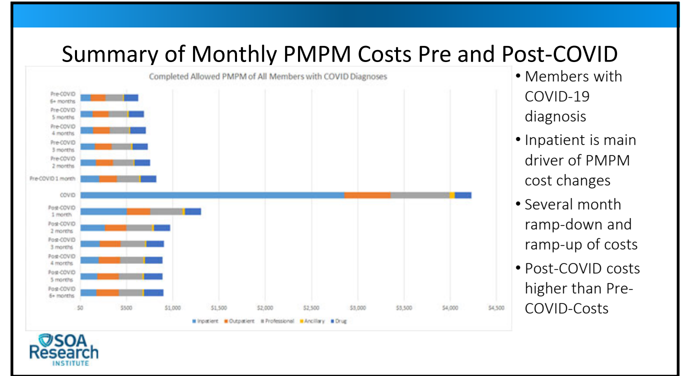

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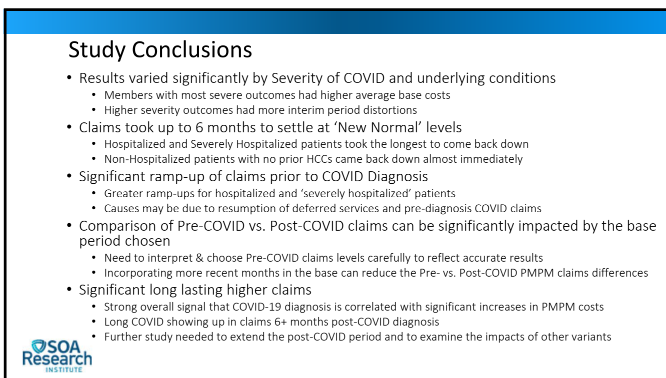

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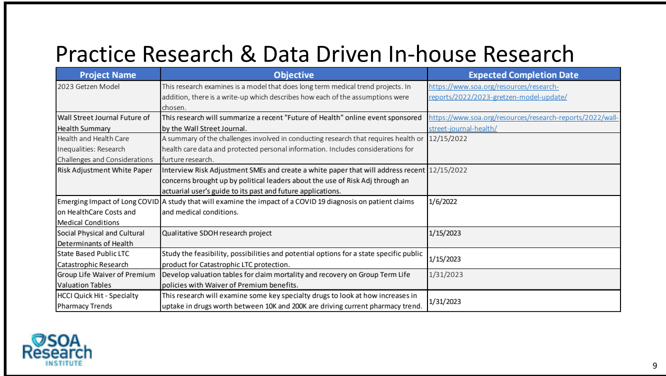

Practice Research & Data Driven In-house Research

Project Name	Objective	Expected Completion Date
2023 Getzen Model	This research examines is a model that does long term medical trend projects. In addition, there is a write-up which describes how each of the assumptions were chosen.	https://www.soa.org/resources/research-reports/2022/2023-gretzen-model-update/
Wall Street Journal Future of Health Summary	This research will summarize a recent "Future of Health" online event sponsored by the Wall Street Journal.	https://www.soa.org/resources/research-reports/2022/wall-street-journal-health/
Health and Health Care Inequalities: Research Challenges and Considerations	A summary of the challenges involved in conducting research that requires health or health care data and protected personal information. Includes considerations for furture research.	12/15/2022
Risk Adjustment White Paper	Interview Risk Adjustment SMEs and create a white paper that will address recent concerns brought up by political leaders about the use of Risk Adj through an actuarial user's guide to its past and future applications.	12/15/2022
Emerging Impact of Long COVID on HealthCare Costs and Medical Conditions	A study that will examine the impact of a COVID 19 diagnosis on patient claims and medical conditions.	1/6/2022
Social Physical and Cultural Determinants of Health	Qualitative SDOH research project	1/15/2023
State Based Public LTC Catastrophic Research	Study the feasibility, possibilities and potential options for a state specific public product for Catastrophic LTC protection.	1/15/2023
Group Life Waiver of Premium Valuation Tables	Develop valuation tables for claim mortality and recovery on Group Term Life policies with Waiver of Premium benefits.	1/31/2023
HCCI Quick Hit - Specialty Pharmacy Trends	This research will examine some key specialty drugs to look at how increases in uptake in drugs worth between 10K and 200K are driving current pharmacy trend.	1/31/2023

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American Academy of Actuaries Health Practice Council—Fall 2022 Updates

Dec. 5, 2022—National Association of Insurance Commissioners (NAIC) Health Actuarial (B) Task Force (HATF) Meeting in Lieu of Fall National Meeting

Barbara Klever, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries

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About the American Academy of Actuaries

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The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy and its boards also set qualification, practice, and other professionalism and ethical standards for actuaries credentialed by one or more of the five U.S.-based actuarial organizations in the United States.

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The Academy, through its public policy work, seeks to address pressing issues that require or would benefit from the application of sound actuarial principles. The Academy provides unbiased actuarial expertise and advice to public policy decision-makers and stakeholders at the state, federal, and international levels in all areas of actuarial practice.

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Health Practice Council—Key Policy Priorities for 2022

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- Health Equity
- COVID-19: Implications for Health Care Utilization and Spending
- Insurance Coverage
- Long-Term Care
- Medicare Sustainability
- Payment and Delivery Reform
- Climate Change and Health

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Health Equity
5
Issue Briefs:
Data Collection for Measurement of Health Disparities (forthcoming)
Health Care and Health Insurance System Risk Assessment and Risk Adjustment in the Context of Health Equity (August 2022)
Comment Letters:
Comment letter to CMS on Medicare Advantage, focused on the health equity aspects of the questions posed within the CMS's RFI. (August 2022)
Presentations:
Presentation to the NAIC Special (EX) Committee on Race and Insurance, Workstream Five by Annette James (August 2022)
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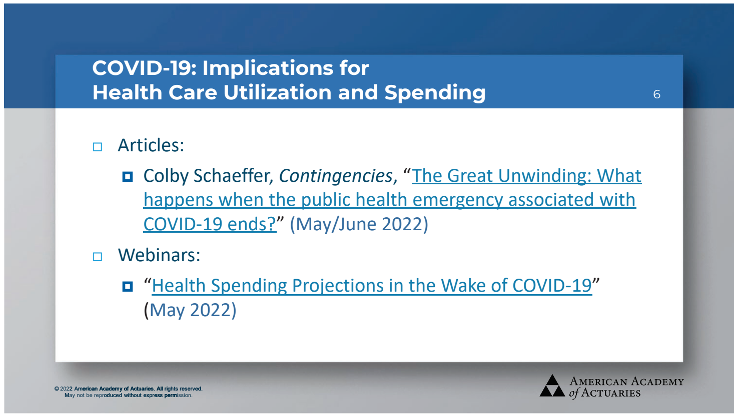
COVID-19: Implications for Health Care Utilization and Spending
6
Articles:
Colby Schaeffer, Contingencies, "The Great Unwinding: What happens when the public health emergency associated with COVID-19 ends?" (May/June 2022)
Webinars:
"Health Spending Projections in the Wake of COVID-19" (May 2022)
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Health Insurance Coverage
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Issue Briefs:
Drivers of 2023 Health Insurance Premium Changes (and infographic) (June 2022)
Medicaid Managed Care State-Directed Payments (September 2022)
Comment Letters:
Comments on Cost-Sharing Reduction Premium Load Factors (September 2022)
Comments on Family Glitch Proposed Rules (June 2022)
Virtual Briefings, Webinars, and Presentations:
"Considerations for Calculating Cost-Sharing Reduction Load Factors" (November 2022)
Academy Annual Meeting Breakout Session, "Regulating the Affordable Care Act: What's New for 2023?" (November 2022)
"Drivers of 2023 Health Insurance Premium Changes" (July 2022)
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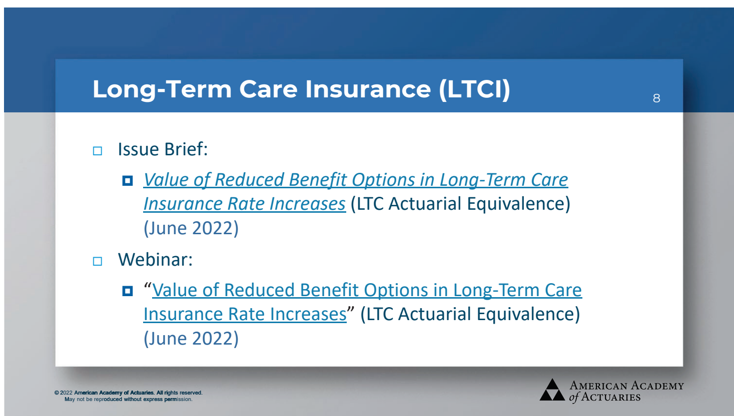
Long-Term Care Insurance (LTCI)
8
Issue Brief:
Value of Reduced Benefit Options in Long-Term Care Insurance Rate Increases (LTC Actuarial Equivalence) (June 2022)
Webinar:
"Value of Reduced Benefit Options in Long-Term Care Insurance Rate Increases" (LTC Actuarial Equivalence) (June 2022)
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Medicare Sustainability

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- Issue Brief:
  - *Medicare's Financial Condition: Beyond Actuarial Balance* (June 2022)
- Essential Elements:
  - "Medicare's Long-Term Sustainability Challenge" (June 2022)
- Capitol Forum Webinar:
  - "Social Security and Medicare Trustees' Reports: A Deep-Dive Discussion With the Programs' Chief Actuaries" (June 2022)

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Payment and Delivery Reform

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- Issue Briefs:
  - *Addressing High Insulin Spending: Moving Beyond Copay Caps* (forthcoming)
  - *Issue brief on Gene Therapy Drug Costs* (forthcoming)
  - *Implications of Hospital Price Transparency on Hospital Prices and Price Variation* (March 2022)
- Webinars and Presentations:
  - Annual Meeting Breakout Session, "Health Care Workforce Shortages" (November 2022)
  - "Hospital Prices: Can Greater Price Transparency Drive Lower Prices and Reduce Price Variation?" (April 2022)
  - "Health Spending Projections in the Wake of COVID-19" (May 2022)

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Climate Change and Health

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- Climate Change Joint Task Force:
  - In November 2021, the Academy launched the Climate Change Joint Task Force. Membership is comprised of members from the health, casualty, life, and pension practice areas and is organized under the Risk Management and Financial Reporting Council (RMFRC).
  - The task force has submitted numerous comment letters to federal agencies on climate-related disclosures and financial risks.
- Presentations:
  - Annual Meeting Session, "Climate Change and Health" (November 2022)

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HPC NAIC Workstreams—HATF

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- Group Life Waiver Valuation Table Work Group—submitted report on updating AG 44 for the NAIC (Report)(Tables). (June/July 2022)
  - Joint project between the Academy and Society of Actuaries Research Institute (SOARI).
  - Presentation to NAIC HATF in May 2022.
  - Status: The revised AG 44 and associated tables have been adopted by B Committee and will now be considered for adoption by Executive & Plenary at the NAIC Fall National Meeting (final step).

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HPC NAIC Workstreams—HRBC

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- Health Risk-Based Capital (E) Working Group (HRBC)
  - Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula.
    - July 2021—Academy comment letter.
    - January 2022—Academy report.
    - July 2022—Timeline letter.
    - November 2022—Academy Health Underwriting Risk Factors Analysis Work Group commences work.
    - December 2022—next update is scheduled to the NAIC HRBC at the Fall National Meeting.

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HPC NAIC Workstreams—LTCAWG

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- NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG)
- Long-Term Care Insurance Mortality and Lapse Study
  - Original request from the NAIC LTCAWG
  - Report released November 2021.
    - Developed by the Long-Term Care Valuation Work Group of the Academy and SOARI.
  - Presentation to NAIC HATF in November 2021.
  - Update presentation to NAIC LTCAWG in June 2022.
  - Exposed by the NAIC LTCAWG until Sept. 5, 2022.
  - Status: LTCAWG is to draft changes to VM 25 and to adopt tables within the report (TBD).

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Academy 2022 Annual Meeting

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- "Envision Tomorrow: 2022 Annual Meeting" in Washington, D.C.
- November 2–3, 2022
- Health-specific breakout sessions:
  - Health Care Workforce Shortages
  - Climate Change and Health
  - Regulating the Affordable Care Act: What's New for 2023?

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Health Practice Council—Key Policy Priorities for 2023

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- Health Equity
- COVID-19 and Other Public Health Challenges
- Insurance Coverage and Benefit Design
- Health Care Costs and Quality
- Medicare Sustainability
- Long-Term Services and Supports (LTSS)
- Financial Reporting and Solvency
- Professionalism

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Thank You

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Questions?

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