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Revisions to Model 641

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

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Underlining and overstrikes show the changes from the existing model.

LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 4. Definitions

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

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

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

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

- B. (1) “Exceptional increase” means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:
- (a) Due to changes in laws or regulations applicable to long-term care coverage in this state;
or
 - (b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

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

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

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

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

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

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

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

Section 10. Initial Filing Requirements

- A. This section applies to any long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation]- except that Subsection B(2)(d) and Subsection B(3) apply to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].
- B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

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

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

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

- (iv) ~~A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;~~
A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

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

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

~~(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;~~

~~(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection C based on a standard age distribution; and~~

- (e) (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
- (ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

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

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

~~(f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:~~

~~(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and~~

~~(ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.~~

~~(3) An actuarial memorandum prepared, dated and signed by the member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:~~

~~(a) An explanation of the review performed by the actuary prior to making the statements in Paragraph (2)(b) and (c),~~

~~(b) A complete description of pricing assumptions; and~~

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

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

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

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

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

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

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

Section 15. Reporting Requirements

- A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
- B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)
- C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.
- D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)
- E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)
- F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)
- G. For purposes of this section:
- (1) "Policy" means only long-term care insurance;
 - (2) Subject to Paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
 - (3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
 - (4) "Report" means on a statewide basis.

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

I. Annual rate certification requirements.

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

(2) The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this section.

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

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

(I) For the rate schedules currently marketed,

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

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

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

(II) For the rate schedules that are no longer marketed,

a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

b. That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

- (ii) A description of the review performed that led to the statement.
- (b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:
 - (i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (1)(a).
 - (ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

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

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

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

Section 19. Loss Ratio

- A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10, ~~and 20~~ and 20.1.
- B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
 - (1) Statistical credibility of incurred claims experience and earned premiums;
 - (2) The period for which rates are computed to provide coverage;
 - (3) Experienced and projected trends;
 - (4) Concentration of experience within early policy duration;
 - (5) Expected claim fluctuation;
 - (6) Experience refunds, adjustments or dividends;
 - (7) Renewability features;

- (8) All appropriate expense factors;
- (9) Interest;
- (10) Experimental nature of the coverage;
- (11) Policy reserves;
- (12) Mix of business by risk classification; and
- (13) Product features such as long elimination periods, high deductibles and high maximum limits.

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

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
- (3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;
- (4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and
- (5) An actuarial memorandum is filed with the insurance department that includes:
 - (a) A description of the basis on which the long-term care rates were determined;
 - (b) A description of the basis for the reserves;
 - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (f) The estimated average annual premium per policy and the average issue age;
 - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate

whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

- (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

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

Section 20. Premium Rate Schedule Increases

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

- A. This section shall apply as follows:
 - (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] and prior to [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].
 - (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].
- B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

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

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

rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

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

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

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

- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
 - (2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - (a) The accumulated value of the initial earned premium times fifty-eight percent (58%);
 - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
 - (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;
 - (3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and
 - (4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:
- (a) Premium rate schedule adjustments; or
 - (b) Other measures to reduce the difference between the projected and actual experience.

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

- (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.
- G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:
- (1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and
 - (2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).
- H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
- (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
 - (b) The rate increase is not an exceptional increase; and
 - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse
- (2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
- (a) The offer shall:
 - (i) Be subject to the approval of the commissioner;
 - (ii) Be based on actuarially sound principles, but not be based on attained age; and
 - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
 - (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 - (i) The maximum rate increase determined based on the combined experience; and
 - (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).
- I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

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

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

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

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

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

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

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

A. This section shall apply as follows:

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

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

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

- (1) Information required by Section 9:

(2) Certification by a qualified actuary that:

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

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

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

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

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

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

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the lesser of (i) the accumulated value of actual incurred claims, without the inclusion of active life reserves, or (ii) the accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;

(3) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;

(4) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(5) All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

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

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

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

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

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

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section.

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:

(i) Be subject to the approval of the commissioner;

- (ii) Be based on actuarially sound principles, but not be based on attained age; and
- (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 - (i) The maximum rate increase determined based on the combined experience; and
 - (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

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

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

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

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

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

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

Section 27. Right to Reduce Coverage and Lower Premiums

- A. (1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
 - (a) Reducing the maximum benefit; or
 - (b) Reducing the daily, weekly or monthly benefit amount.

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

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

Section 28. Nonforfeiture Benefit Requirement

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:
- (1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture

benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

- (2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.
- C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection D(4) shall still apply.
- D. (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.
- (2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
- (3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

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

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%

79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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

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

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

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

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

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

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

- (b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and
- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forth percent (40%) or more.

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

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

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

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

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

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

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