HEALTH ACTUARIAL (B) TASK FORCE

Health Actuarial (B) Task Force Dec. 6, 2019, Minutes
   Health Actuarial (B) Task Force Sept. 17, 2019, Conference Call Minutes (Attachment One)
   2020 Proposed Charges (Attachment One-A)
   Health Actuarial (B) Task Force Aug. 27, 2019, Conference Call Minutes (Attachment Two)
      Update from American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Group Life Waiver Valuation Table Work Group (Attachment Two-A)
   Update from SOA on Health Insurance Research (Attachment Three)
   Long-Term Care Actuarial (B) Working Group Dec. 6, 2019, Minutes (Attachment Four)
      Long-Term Care Actuarial (B) Working Group Oct. 24, 2019, Conference Call Minutes (Attachment Four-A)
      Revisions to Long-Term Care Experience Reporting Forms (Attachment Four-A1)
      Annual Financial Statement and Instructions (Four-A2)
      Long-Term Care Actuarial (B) Working Group Sept. 24, 2019, Conference Call Minutes (Attachment Four-B)
      Revisions to Long-Term Care Experience Reporting Forms (Four-B1)
      Annual Financial Statement and Instructions (Four-B2)
      American Council of Life Insurers Comment Letter (Four-B3)
      Long-Term Care Actuarial (B) Working Group Aug. 28, 2019, Conference Call Minutes (Attachment Four-C)
      Update from Academy Long-Term Care Valuation Work Group (Attachment Four-C1)
      Long-Term Care Actuarial (B) Working Group Aug. 20, 2019, Conference Call Minutes (Attachment Four-D)
      Revisions to Long-Term Care Experience Reporting Forms (Attachment Four-D1)
   Update from Academy Long-Term Care Valuation Work Group (Attachment Four-E)
   Update from SOA on Long-Term Care Experience Study (Attachment Four-F)
   Long-Term Care Pricing (B) Subgroup Sept. 12, 2019, Conference Call Minutes (Attachment Four-G)
   Actuarial Guideline 51 Guidance Document (Attachment Four-H)
   Update from Federal Center for Consumer Information and Insurance Oversight on the Affordable Care Act Risk Adjustment Data Validation White Paper (Attachment Five)
   Update from Blue Cross and Blue Shield Association on Academy Health Practice Council (Attachment Six)
The Health Actuarial (B) Task Force met in Austin, TX, Dec. 6, 2019. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jim L. Ridling, Vice Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Ma is represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Marti Hooper (ME); Steve Kelley represented by Grace Arnold (MN); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Anna Krylova (NM); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner and Raja Malkani (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its Sept. 17, Aug. 27 and Summer National Meeting Minutes**

The Task Force met Sept. 17, Aug. 27 and Aug. 2. During its Sept. 17 meeting, the Task Force adopted its 2020 proposed charges. During its Aug. 27 meeting, the Task Force heard a presentation on a replacement for the 2005 Group Term Life Waiver Mortality and Recovery Tables from Willis Towers Watson.

Mr. Lombardo made a motion, seconded by Ms. Miller, to adopt the Task Force’s Sept. 17 (Attachment One), Aug. 27 (Attachment Two), and Aug. 2 (see NAIC Proceedings – Summer 2019, Health Actuarial (B) Task Force) minutes. The motion passed unanimously.

2. **Heard an Update from the SOA on Health Insurance Research**

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Three) on recent SOA health insurance research.

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

Mr. Ostlund said the Long-Term Care Actuarial (B) Working Group met Dec. 6 and took the following action: 1) adopted the reports of the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup; 2) heard an update from the American Academy of Actuaries (Academy) regarding its Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables for long-term care insurance (LTCI); and 3) heard an update from the SOA on recent work on the SOA’s Long-Term Care Experience Study.

Mr. Ostlund made a motion, seconded by Mr. Shea, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Four). The motion passed unanimously.

4. **Adopted the Report of the Health Care Reform Actuarial (B) Working Group**

Mr. Shea said the Health Care Reform Actuarial (B) Working Group has not met since the Summer National Meeting.

Beth Parish (federal Center for Consumer Information and Insurance Oversight—CCIIO) and Allison Yadsko (CCIIO) gave an update (Attachment Five) on the federal Affordable Care Act (ACA) risk adjustment data validation (RADV) white paper published Dec. 6. Ms. Parish asked the Task Force to provide comments on the white paper by Jan. 6, 2020.

Mr. Shea made a motion, seconded by Ms. Eom, to adopt the report of the Health Care Reform Actuarial (B) Working Group. The motion passed unanimously.

5. **Heard an Update from the Academy Council on Professionalism**

Shawna Ackerman (California Earthquake Authority—CEA) said the Academy will publish the *Actuaries Climate Risk Index* soon, which correlates climate index data with economic losses, deaths and injuries.
Kathleen Riley (Actuarial Standards Board—ASB) said the ASB continues work on Actuarial Standard of Practice (ASOP) No. 28, *Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets*. She said ASOP No. 28 was last updated in 2011. She said guidance in the ASOP has been expanded to include actuaries making and reviewing statements of actuarial opinion. She said reviews of ASOP No. 3, *Continuing Care Retirement Communities*, and ASOP No. 18, *Long-Term Care Insurance*, are continuing. She said ASOP No. 56, *Modeling*, will be released soon.

David Ogden (Actuarial Board for Counseling and Discipline—ABCD) said the ABCD has received requests for guidance concerning a client that wanted to censor information in a report provided by an actuary, federal Affordable Care Act (ACA) risk adjustment issues, client modification of a report issued by an actuary, qualifications necessary for pricing a family leave benefit, qualifications necessary for pricing stop-loss insurance, mental health parity issues and the effects of incomplete data used in a rate filing.

6. **Heard an Update from the Academy Health Practice Council**

Barb Klever (Blue Cross and Blue Shield Association—BCBSA) gave an update (Attachment Six) on recent Academy Health Practice Council activities and publications.

Having no further business, the Health Actuarial (B) Task Force adjourned.
Health Actuarial (B) Task Force
Conference Call
September 17, 2019

The Health Actuarial (B) Task Force met via conference call Sept. 17, 2019. The following Task Force members participated:
Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jim L. Ridling, Vice Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Marti Hooper (ME); Mike Causey represented by Jack Childress (NV); Jillian Froment represented by Laura Miller (OH); Jessica Altman represented by Tracey Gray (PA); Kent Sullivan represented by Mike Boerner (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its 2020 Proposed Charges**

Mr. Ostlund made a motion, seconded by Mr. Boerner, to adopt the Task Force’s 2020 proposed charges (Attachment One-A).

The motion passed unanimously.

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

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2020 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 **Health Care Reform Actuarial (B) Working Group** will:
   A. Assist the Health Actuarial (B) Task Force in completing its charge to provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).

3. The **Long-Term Care Actuarial (B) Working Group** will:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      1. 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.
      2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
      3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

4. The **Health Reserves (B) Subgroup** will:
   A. Assist the Health Actuarial (B) Task Force in completing its charge to continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.

NAIC Support Staff: Eric King

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The Health Actuarial (B) Task Force met via conference call Aug. 27, 2019. The following Task Force members participated: Jim L. Ridling, Vice Chair, represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Paul Lombardo and Wanchin Chou (CT); Eric A. Cioppa represented by Marti Hooper (ME); Marlene Caride represented by Seong-min Eom (NJ); John G. Franchini represented by Anna Krylova (NM); Barbara D. Richardson represented by Annette James (NV); Kent Sullivan represented by Raja Malkani (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Heard a Presentation on a Replacement for the 2005 Tables from Willis Towers Watson**

Sue Sames (Willis Towers Watson) gave an update (Attachment Two-A) on work by the joint American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Group Life Waiver Valuation Table Work Group on a replacement for the 2005 Group Term Life Waiver Mortality and Recovery Tables (2005 Tables).

Mr. Chou asked what credibility standard will be used for blending company experience with the proposed replacement tables. Ms. Sames said the Work Group will review the credibility standards used for the 2012 Group Long-Term Disability Valuation Table in *Actuarial Guideline XLVII—The Application of Company Experience in the Calculation of Claim Reserves Under the 2012 Group Long-Term Disability Valuation Table (AG 47)* and for the 2013 Individual Disability Income Valuation Table in *Actuarial Guideline L—2013 Individual Disability Income Valuation Table Actuarial Guideline (AG 50)* to inform its decision. She said the Work Group will also consider other credibility standards for use with the replacement tables.

Having no further business, the Health Actuarial (B) Task Force adjourned.
Group Life Waiver of Premium Valuation Table Update

Presenter
Sue Sames, Group Life Waiver Valuation Table Work Group
Co-chairperson
August 27, 2019

Update

- We are an Academy work group and SOA group collaborating on this project
- Volunteer recruiting is complete
- Work group structures and planning is set
- Work is off to a good start
- We are on target for timing

Plans for 2019–2020

- Data analysis
  - This is a double decrement table (mortality/recovery)
  - Using new techniques to determine appropriate additional dimensions
- Company experience
  - Enhancing approach to Credibility and use of company experience

Plans for 2021

- Address margins and financial impact
- Develop documentation
- Develop proposed update to AG XLIV
Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.
Economic Impact of Non-Medical Opioid Use

Economic Cost of the Opioid Crisis

Economic Cost Estimates By Year

Economic Costs by Component
# Economic Costs by Component

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<th>2017</th>
<th>2018</th>
<th>2016 EST</th>
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<tr>
<td>Workers' compensation</td>
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**Total**

| $10,562 | $10,844 | $11,000 | $10,966 | $10,896 | $10,824 | $10,748 | $10,670 |
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met in Austin, TX, Dec. 6, 2019. The following Working Group members participated: Steve Ostlund, Deputy Chair (AL); Paul Lombardo (CT); John Reilly (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Laura Miller (OH); Tracie Gray (PA); Andrew Dvorine (SC); Mike Boerner and Raja Malkani (TX); and Tomasz Serbinowski (UT).


Ms. Ahrens made a motion, seconded by Mr. Lombardo, to adopt the Working Group’s Oct. 24 (Attachment Four-A), Sept. 24 (Attachment Four-B), Aug. 28 (Attachment Four-C), Aug. 20 (Attachment Four-D), and Aug. 2 (see NAIC Proceedings – Summer 2019, Health Actuarial (B) Task Force, Attachment One) minutes. The motion passed unanimously.

2. **Heard an Update from the Academy on LTC Work Group Activities**

Warren Jones (PricewaterhouseCoopers LLP) gave an update (Attachment Four-E) on the American Academy of Actuaries (Academy) Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables. He said the Academy has published the “Long-Term Care (LTC) Combination Product Valuation Practice Note,” as requested by the Working Group in July 2015.

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

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Four-F) on recent work on the SOA’s Long-Term Care Experience Study.

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

Mr. Lombardo said the Long-Term Care Pricing (B) Subgroup met Sept. 12 and took the following action: 1) discussed group long-term care insurance (LTCI) pricing.

Mr. Lombardo made a motion, seconded by Ms. Ahrens, to adopt the report of the Long-Term Care Pricing (B) Subgroup, including its Sept. 12 minutes (Attachment Four-G). The motion passed unanimously.

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

Mr. Andersen said an Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) guidance document (Guidance Document) (Attachment Four-H) was developed to be used for year-end 2019 AG 51 filings, and it is available on the Subgroup’s webpage. He said a review group composed of Subgroup members has reviewed AG 51 year-end 2018 filings for the 50 largest, based on policyholder exposure, LTCI companies. He said the review group has conducted in-person meetings with 11 insurers to further discuss their AG 51 filings.

Mr. Andersen made a motion, seconded by Mr. Boerner, to adopt the report of the Long-Term Care Valuation (B) Subgroup, and the Guidance Document. The motion passed unanimously.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Oct. 24, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Bill Carmello (NY); Chuck Sha (TX); and Jaakob Sundberg (UT).

1. Discussed a Draft of Revisions to the Forms

Mr. Kupferman presented draft of revisions (Attachment Four-A1) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions (Attachment Four-A2) for the revised forms. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement.

Mr. Kupferman said Form 1 has been modified to make a distinction between direct, assumed and ceded amounts. He said the column to report net reserve has been removed. He said reporting in Form 1 is no longer at the policy form level. Paul Graham (American Council of Life Insurers—ACLI) said column 9, column 10 and column 11 of Form 1 are duplicates of information that is reported in the recently revised Exhibit 6 of the annual financial statement, and he suggested these three columns be eliminated from Form 1. Mr. Kupferman said he will compare Exhibit 6 and the draft Form 1 for duplicate information. He said Form 1 is structured in a way that will show that insurers are responsible for the reserves associated with ceded business. Mr. Graham said he thinks for total inception to date rows, column 1 and column 2 the only columns where this category is applicable. Mr. Kupferman said he will review Form 1 given this suggestion.

Mr. Kupferman asked if Form 1 should, as proposed, be split between individual and group business. Mr. Andersen said this distinction is helpful due to the differences between individual and group business. Mr. Graham said Exhibit 6 of the annual financial does not separate individual and group business.

Mr. Andersen asked why Form 2 reports incurred claims but not earned premium. He said he thinks reporting percent of male lives insured is not necessary, as this number is fairly consistent among insurers. Ms. Ahrens said many insurers offered unisex rates, and reporting percent of male lives insured could help identify companies whose block is disproportionately weighted in subsidized cells. Mr. Ben said that the percent of male lives insured is useful for rate review and that he supports reporting earned premium in Form 2. Ray Nelson (America’s Health Insurance Plans—AHIP) said it will not be burdensome for companies to provide percent of male lives insured for current in-force policies, but this may not be true for total inception-to-date.

Mr. Kupferman said the draft of revisions to the Forms does not propose any changes to the current Form 3.

Mr. Andersen and Mr. Lombardo suggested the addition of earned premium to the draft revisions to Form 4. Mr. Graham said that he does not understand how reporting third-party funding percentages in Form 4 is useful and that reporting an accurate figure for this category will be difficult.

Mr. Kupferman said the draft of revisions to the Forms removes reserve reporting from Form 5. Mr. Graham said the rate increase pending column may be misleading to users of Form 5 and may not be easy for companies to accurately report. He said state insurance regulators can obtain this information directly from rate increase requests received by states. Ms. Ahrens said she does not find it useful to include this in Form 5, as the information can be obtained elsewhere.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
### LTC Experience Reporting Form 1 ($000's)

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<th>$ Incurred Claims</th>
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<th># Claims Closed During Year</th>
<th># Open Claims</th>
<th># Terminations</th>
<th># Policies In-force Year End</th>
<th># Lives In-force Year End</th>
<th>$ Active Life Reserves</th>
<th>$ Claim Reserves</th>
<th>$ Other Reserves</th>
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</tbody>
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#### Individual

**Direct**
- Current
- Total Inception-to-date

**Assumed**
- Current
- Total Inception-to-date

**Ceded**
- Current
- Total Inception-to-date

**Net (Direct + Assumed - Ceded)**
- Current
- Total Inception-to-date

#### Group

**Direct**
- Current
- Total Inception-to-date

**Assumed**
- Current
- Total Inception-to-date

**Ceded**
- Current
- Total Inception-to-date

**Net (Direct + Assumed - Ceded)**
- Current
- Total Inception-to-date
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<th>2</th>
<th>3</th>
<th>4</th>
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<td>Calendar Year of Peak Issues</td>
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<td># Terminations</td>
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<td># New Lives Insured</td>
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**Primarily 2002 and Prior Issue Years**
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

**Primarily 2003 to 2009 Issue Years**
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

**Primarily 2010 and Later Issue Years**
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)
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<tr>
<th>Line</th>
<th>1</th>
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<th>7</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Calendar Year of Peak Issues</td>
<td>Third Party Funding (%)</td>
<td>Average Attained Age</td>
<td>$ Incurred Claims</td>
<td># Lives In-force End of Year</td>
<td># Terminations</td>
<td># New Lives Insured</td>
</tr>
<tr>
<td>Current (Comprehensive)</td>
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<td>Total Inception-to-date (Grand Total)</td>
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<tr>
<td>Line</td>
<td>State Code</td>
<td>$ Earned Premiums</td>
<td># New Lives During Year</td>
<td># Lives Inforce End of Year</td>
<td>Average Attained Age</td>
<td>$ Incurred LTC Claims</td>
<td>$ Incurred Extended Benefits Claims</td>
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<td>1. Stand-alone LTC</td>
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<td>4. Life/LTC Hybrid Policies and Riders</td>
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<td>5. Current (Acceleration only)</td>
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<td>6. Total Inception-to-Date (Acceleration only)</td>
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<td>7. Current (Extended Benefits Policies)</td>
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<td>8. Total Inception-to-Date (Extended Benefits)</td>
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Form 1

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed / Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% reinsured.

Column 1 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 2 - Incurred Claims
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

☐ Paid claims in the year of incurrence are discounted one-quarter year.
☐ Paid claims subsequent to the year of incurrence are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
☐ Outstanding claim reserves for a given incurred year plus transferred reserves from Form 3, Part 3 are discounted from the valuation date to the midpoint of the incurred year.
☐ Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 3 – New Claims During the Year
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed During Year
Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.

Column 5 – Open Claims

Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

Column 6 – Terminations

Total number of policyholders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of reserves held for policyholders who are not currently on claim.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Form 2

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.
<table>
<thead>
<tr>
<th>Column 1 – Calendar Year of Peak Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2 – Male/Female Mix % Male Lives Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of males, / females within the block of policyholders. For example, a block consisting of 60% males would be reported as 60/40, and 40% females would be reported as 60:40.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 3 – Average Attained Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unweighted average of the attained ages of all in force policyholders in the block.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 4 – Annual Net Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Net Premium = \sum\text{(annual valuation net premiums for policies issued in calendar year } n \text{ at the start of calendar duration } t)\cdot \text{Companies may report zero } 0\text{ for the net premiums during the Preliminary Term period. For calendar duration } 0, \text{ the annual net premiums at issue should be reported.}</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 5 – Annual Gross Premium</th>
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</thead>
<tbody>
<tr>
<td>Annual Gross Premium = \sum\text{(Annualized Premium In Force, including mode loadings for policies issued in calendar year } n \text{ at the start of calendar duration } t)\cdot \text{For calendar duration } 0, \text{ the annual gross premiums collected at issue should be reported.}</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 6 – Net/Gross Premium Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>= \frac{\text{Column 4}}{\text{Column 5}}</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 7 – Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 8 – Lives In-force at End of Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 9 – Terminations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

© 2019 National Association of Insurance Commissioners
Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 710 – New Lives InsuredIssues

Total number of new LTC policies issued during the year.
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Comprehensive**
Policy forms that provide a combination of institutional or facility and non-institutional coverage.
These include institutional only policies with non-institutional riders.

**Institutional Only**
Policy forms that provide institutional coverage only.

**Non-Institutional Only**
Policy forms that provide only non-institutional coverage.

<table>
<thead>
<tr>
<th>Column 1 – Calendar Year of Peak Issues</th>
<th>Column 2 – Third Party Funding</th>
<th>Column 3 – Average Attained Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year in which the largest number of policies in the block were sold.</td>
<td>Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.</td>
<td>Unweighted average of the attained ages of all inforce policyholders in the block.</td>
</tr>
</tbody>
</table>

**Column 4 – Annual Net Premium**
\[
\text{Annual Net Premium} = \frac{\text{annual valuation net premiums for policies issued in calendar year } n \text{ at the start of calendar duration } t}{100} \times 100
\]
For calendar duration 0, the annual net premiums at issue should be reported.

**Column 5 – Annual Gross Premium**
\[
\text{Annual Gross Premium} = \frac{\text{Annualized Premium In Force, including mode loadings for policies issued in calendar year } n \text{ at the start of calendar duration } t}{100} \times 100
\]
For calendar duration 0, the annual gross premiums collected at issue should be reported.

**Column 6 – Net/Gross Premium Ratio**
\[
\text{Net/Gross Premium Ratio} = \frac{\text{Column 4}}{\text{Column 5}}
\]

**Column 7 – Incurred Claims**
Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

○ Paid claims in the year of incurral are discounted one-quarter year.
○ Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
○ Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
○ Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 58 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 69 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 710 – New Lives Insured Issues

Total number of new LTC certificates issued during the year.
Form 5
Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state for which data is being reported. Example: CA for California

Column 2 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in
Unearned Premium Reserves.

**Life, Accident & Health, Fraternal and Property/Casualty Only**

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 3 – New Lives During Year

- Total number of new lives that entered the block during the year. Joint policies are to be counted as multiple lives.

Column 4 – Lives In-force at End of Year

- Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 5 – Average Attained Age

- Unweighted average of the attained ages of all inforce policyholders associated with the in the block.

Column 6 – Incurred LTC Claims

- Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

  - Paid claims in the year of incurreal are discounted one-quarter year.
  - Paid claims subsequent to the year of incurreal are assumed to be paid mid-year and discounted back to the midpoint of the incurreal year.
  - Outstanding claim reserves for a given incurreal year are discounted from the valuation date to the midpoint of the incurreal year.
  - Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 7 – Incurred Extended Benefits Claims

- Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

  - Paid claims in the year of incurreal are discounted one-quarter year.
  - Paid claims subsequent to the year of incurreal are assumed to be paid mid-year and discounted back to the midpoint of the incurreal year.
  - Outstanding claim reserves for a given incurreal year are discounted from the valuation date to the midpoint of the incurreal year.
  - Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.
Column 8 – Open Claims End of Year

Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

Column 9 – New Claims During the Year

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 10 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 11 – Accelerated Benefits Available

Maximum amount of remaining death benefit available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 12 – Extended Benefits Available

Maximum amount of remaining extended benefits available to policyholders with extension of benefit riders.

Column 13 – Rate Increases

Indicate whether the company has any rate increase requests pending in that state.
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Sept. 24, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Kristi Bohn (MN); Rhonda Ahrens (NE); Anna Krylova (NM); William Carmello (NY); Laura Miller (OH); Andrew Schallhorn (OK); Andrew Dvorine (SC); Raja Malkani (TX); and Tomasz Serbinowski (UT). Also participating was: William Leung (MO).

1. Discussed a Draft of Revisions to the Forms

Mr. Kupferman presented draft of revisions (Attachment Four-B1) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement, and instructions (Attachment Four-B2) for the revised forms. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement. He presented comments (Attachment Four-B3) from the American Council of Life Insurers (ACLI) on the proposed revisions to the Forms.

Mr. Lombardo suggested that the instructions for completing Form 1 or the exhibit should make a distinction between direct, assumed, and ceded amounts. Mr. Leung suggested that yearly renewable term (YRT) reinsurance amounts be excluded from reporting. Bob Yee (PricewaterhouseCoopers LLP) said YRT amounts should not be excluded. Ms. Ahrens said the definition of the amount to be reported in the Other Reserve column of Form 1 needs to be very clear.

Jan Graeber (American Council of Life Insurers—ACLI) asked to what extent the proposed forms report information that is also reported in revised Form 6 of the annual financial statement. She asked if it is necessary to request duplicate information.

Mr. Kupferman said he will compare the revised Form 6 to the proposed forms to identify any duplicate requests.

Mr. Serbinowski suggested changing the Male/Female Mix (%) column in Form 2 to be reported as percentage male or female.

Ray Nelson (America’s Health Insurance Plans—AHIP) suggested the Annual Net Premium and Net/Gross Premium Ratio columns be removed from Form 2, as this information is reported in Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) filings. Mr. Serbinowski agreed.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
### LTC Experience Reporting Form 1 ($000's)

<table>
<thead>
<tr>
<th>Line</th>
<th>$ Earned Premiums</th>
<th>$ Incurred Claims</th>
<th># New Claims During Year</th>
<th># Claims Closed During Year</th>
<th># Open Claims</th>
<th># Terminations</th>
<th># Policies In-force Year End</th>
<th># Lives In-force Year End</th>
<th>$ Active Life Reserves</th>
<th>$ Claim Reserves</th>
<th>$ Other Reserves</th>
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#### Individual

**Direct**
- Current
- Total Inception-to-date

**Assumed**
- Current
- Total Inception-to-date

**Ceded**
- Current
- Total Inception-to-date

**Net (Direct + Assumed - Ceded)**
- Current
- Total Inception-to-date

#### Group

**Direct**
- Current
- Total Inception-to-date

**Assumed**
- Current
- Total Inception-to-date

**Ceded**
- Current
- Total Inception-to-date

**Net (Direct + Assumed - Ceded)**
- Current
- Total Inception-to-date
### LTC Experience Reporting Form 2 ($000's)

#### Direct Individual Experience

<table>
<thead>
<tr>
<th>Line</th>
<th>Year of Peak Issues</th>
<th>Male/Female Mix (%)</th>
<th>Average Attained Age</th>
<th>$ Annual Net Premium</th>
<th>$ Annual Gross Premium</th>
<th>Net/Gross Premium Ratio</th>
<th>$ Incurred Claims</th>
<th># Lives In-force End of Year</th>
<th># Terminations</th>
<th># New Issues</th>
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<td>Primarily 2002 and Prior Issue Years</td>
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Form 1

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 2 - Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

☐ Paid claims in the year of incurrence are discounted one-quarter year.
☐ Paid claims subsequent to the year of incurrence are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
☐ Outstanding claim reserves for a given incurred year plus transferred reserves from Form 3, Part 3 are discounted from the valuation date to the midpoint of the incurred year.
☐ Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 3 – New Claims During the Year

The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed During Year

Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.

Column 5 – Open Claims

Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

Column 6 – Terminations
Total number of policyholders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of reserves held for policyholders who are not currently on claim.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves.

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Form 2

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Comprehensive**
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

**Institutional Only**
Policy forms that provide institutional coverage only.

**Non-Institutional Only**
Policy forms that provide only non-institutional coverage.

Column 1 – Year of Peak Issues
Year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – Male/Female Mix
Percentage of males/females within the block of policyholders. For example, a block consisting of 60% males and 40% females would be reported as 60/40.

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Annual Net Premium
Annual Net Premium = Σ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t). Companies may report zero (0) for the net premiums during the Preliminary Term period. For calendar duration 0, the annual net premiums at issue should be reported.

Column 5 – Annual Gross Premium
Annual Gross Premium = Σ (Annualized Premium In Force, including mode loadings for policies issued in calendar year n at the start of calendar duration t). For calendar duration 0, the annual gross premiums collected at issue should be reported.
Column 6 – Net/Gross Premium Ratio

\[ \frac{\text{Column 4}}{\text{Column 5}} \]

Column 7 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves

- Paid claims in the year of incurrence are discounted one-quarter year.
- Paid claims subsequent to the year of incurrence are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 10 – New Issues

Total number of new LTC policies issued during the year.
Form 4
Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Year of Peak Issues
Year in which the largest number of policies in the block were sold.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer.
Example: If the level of third party funding is 25%, enter “25” in this column.

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Annual Net Premium
Annual Net Premium = Σ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t). Companies may report zero (0) for the net premiums during the Preliminary Term period. For calendar duration 0, the annual net premiums at issue should be reported.

Column 5 – Annual Gross Premium
Annual Gross Premium = Σ (Annualized Premium In Force, including mode loadings for policies issued in calendar year n at the start of calendar duration t). For calendar duration 0, the annual gross premiums collected at issue should be reported.

Column 6 – Net/Gross Premium Ratio
Column 7 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any outstanding claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Lives In-force at End of Year

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 10 – New Issues

Total number of new LTC policies issued during the year.
Form 5
Definitions and Formulas

**Current**

Current calendar year of reporting.

**Total Inception-to-Date**

Aggregate experience data since issuance of policies.

**Stand-alone LTC**

An LTC product that is sold by itself, not as a rider on another type of insurance.

**Life/LTC Accelerated Benefits Riders**

Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

**LTC Extension of Benefit Riders**

Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

**Column 1 – State Code**

The state for which data is being reported. Example: CA for California

**Column 2 – Earned Premiums**

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

**Life, Accident & Health, Fraternal and Property/Casualty Only**

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

**Column 3 – New Lives During Year**

Total number of new lives that entered the block during the year. Joint policies are to be counted as multiple lives.

**Column 4 – Lives In-force at End of Year**

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 5 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders associated with the in the block.

Column 6 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 7 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any outstanding claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Column 8 – Open Claims End of Year

Open claims are all claims that have not been closed. Include IBNR as well as claims in course of settlement.

Column 9 – New Claims During the Year

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.
Column 10 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 11 – Accelerated Benefits Available

Maximum amount of remaining death benefit available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 12 – Extended Benefits Available

Maximum amount of remaining extended benefits available to policyholders with extension of benefit riders.

Column 13 – Rate Increases

Indicate whether the company has any rate increase requests pending in that state.
September 20, 2019

Perry Kupferman  
Chair, NAIC Long-Term Care Actuarial Working Group (LTCAWG)  

Re: LTC Experience Reporting Forms  

Dear Mr. Kupferman,

Thank you for the time you and other regulators have spent on the proposed revisions to the NAIC Long-Term Care Experience Exhibits. AHIP and ACLI appreciate the opportunity to provide suggestions/comments regarding potential changes to the current LTC Experience Exhibits in the NAIC Annual Statements.

First and foremost, we want to ensure that regulators have the information they need to do their job. We also want to ensure that regulators have the information they need to assess the entire market, including data on hybrid products.

We agree with your statements on the recent Long-Term Care Actuarial Working Group call that the intent of the revisions to the experience exhibits should not be to:

- disclose confidential information,
- disclose information that is better suited for submission through an alternative channel such as an AG51 report or a rate filing, or
- create meaningless work for companies.

While we can provide general comments on the current draft of proposed revision, we ask that you consider approaching this project as outlined below. You mentioned that you receive regular requests from both your commissioner and outside parties, such as the media, for information that you are unable to adequately answer in a timely way because the data is not readily available or currently reported. It would be very helpful to know the specific nature and focus of those questions. With that information, we could then work together to compile a list of common questions that are routinely asked, or could be asked, to better understand the LTC market. Some initial questions that come to mind are:

**Individual Stand-Alone Long-Term Care Market**  
How many carriers are actively marketing (nationwide and in each state)?  
What products are carriers marketing?  
How many policyholders are covered?  
What percentage of policies are marketed through an employer or association relationship?  
What's the distribution of business by:

- Inflation vs non-inflation
- Issue age  
- Attained age  
- Benefit period
**Long-Term Care Hybrid Market**
Identify the various types of hybrid/combo products currently marketed.
Which companies sell each type?
How many policyholders are covered?
What’s the average face amount?
How many claims were death claims?
How many claims were LTC claims?

**Group Long-Term Care Market**
How many carriers currently market group business?
What’s the average issue age?
What’s the average attained age?
What’s the average daily benefit?
What’s the average benefit period?

If the working group prefers to continue moving forward with the current draft, below are some initial comments.

- Due to the low volume of business in many states, a state by state view of (1) Average Age, (2) Claim Counts, and (3) Reserve Balances will not generate meaningful insights or credible conclusions. In fact, it could be counter-productive, potentially provoking cross-state subsidization concerns as have already arisen, and possibly triggering misplaced objections or analysis from individuals who may tie rate increase need (and state rate increase approvals) to state by state claims experience.

- Encouraging focus on single state experience is inconsistent with the fact that LTC products were generally marketed on a nationwide basis and were priced, designed and sold consistent with NAIC models, so coverage features and initial pricing were consistent across states. State by state focus also seems inconsistent with one of the primary charges of the recently formed NAIC LTC EX Task Force, which is to “[develop] a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization.”

**Form Specific Comments:**

**Form 1.**
- Is Form 1 necessary? The Form appears to be designed to address the FAWG request to measure total liabilities. Is this information now adequately captured in the recently changed Exhibit 6 (Aggregate Reserves for Accident and Health Contracts) in the Annual Statement that will take effect in 2019?

- We support the change made in the latest draft to combine the counts for Deaths and Lapses into one data point called Terminations on Forms 1, 2 and 4. The split data would have been problematic to collect and was generally unreliable.
Form 2.

- Question: What is the expected value or intended use of collecting the “Year of Peak Issues”?

- Are the Net Premium and Net/Gross Ratios needed/useful? What is the thinking behind these? Will these continue to be calculated as proxy’s based on current Valuation data?

Form 4.

- Same comments/questions as for Form 2 apply to Form 4.

- Group cases may have different levels of 3rd party funding. It is not clear how this entry should be calculated when this is the case.

Form 5.

- Due to the low volume of business in many states, a state by state view of (1) Average Age, (2) Claim Counts, and (3) Reserve Balances will not generate meaningful insights or credible conclusions. As noted above, it could needlessly provoke cross-state subsidization concerns, and could trigger misplaced objections or analysis from individuals who may tie rate increase need (and state rate increase approvals) to state by state claims experience.

- As also noted above, encouraging focus on single state experience is inconsistent with the fact that LTC products were generally marketed on a nationwide basis and were priced, designed and sold consistent with NAIC models, with coverage features and initial pricing typically consistent across states. State by state focus is also inconsistent with the charge of the recently formed NAIC LTC EX Task Force to “[develop] a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization.”

- Similarly, “Average Attained Age,” “# Open Claims End of Year,” and # New Claims” can be significantly misleading. We believe those items should be removed from Form 5. Company experience can vary, for example across ages and in group versus individual business. Recent examples where commentators have misinterpreted narrow data points (e.g., morbidity improvement) or published flawed conclusions reached by applying their own home grown modeling techniques to select data points, have caused distractions to regulators and companies alike. If regulators consider those data points to be essential, we request that those data points be included in AG 51 filings and that reserves, if required on a state by state basis, be aggregated as “Total Reserves<” not divided between “ALR,” “Claim” and “Other” reserves.

Thank you for the opportunity to comment. Please note that we have not had an opportunity to fully discuss changes made to the forms that were released on September 17, 2019, with our respective...
member companies. As a result, the above comments should be considered as preliminary. We would be happy to answer any questions your working group has with these recommendations.

Sincerely,

Raymond Nelson                         Jan Graeber
Consultant to AHIP                      ACLI
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Aug. 28, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Chuck Sha (TX); and Tomasz Serbinowski (UT).

1. **Heard an Academy Long-Term Care Valuation Work Group Update**

Bob Yee (PricewaterhouseCoopers) gave an update on the American Academy of Actuaries (Academy) Long-Term Care Valuation Work Group’s development of long-term care insurance (LTCI) mortality and lapse valuation tables (Attachment Four-C1).

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

1 Summary
2 Mortality
3 Lapse

Charges to the LTC Valuation Work Group

☐ Develop a replacement mortality table for LTC active life reserves
   ☐ Based on the 2012 Annuitant Mortality Table
   ☐ Recommend a margin for conservatism
☐ Develop a replacement lapse table
   ☐ Recommend a margin for conservatism
☐ Consider developing tables for valuation on total lives basis as well as active lives basis
**Progress to Date**

- Reviewed and selected data from SOA 2000–2011 Intercompany Study
- Develop raw rates
- Smooth rates
- Determined proposed adjustment factors for tables
- Develop adjustment factors
- Compare actual lapses to expected determined from preliminary proposed rates

**Proposed Adjustment Factors for Tables**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mortality</th>
<th>Lapse Individual</th>
<th>Lapse Group</th>
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</thead>
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<tr>
<td>Issue Age</td>
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<td>Policy Duration</td>
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<td>Gender</td>
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<tr>
<td>Marital Status</td>
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<tr>
<td>Risk Class</td>
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<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Factors are applied to the base mortality and lapse rates to reflect the profile of the policyholder.

**Base Mortality Rates**

- Developed from 48,000 deaths among companies with reasonable data ("DEFN 2" companies*) during policy years 15 and beyond for experience period 2008–2011.
- 10 companies’ data were deemed to be reasonably reliable:
  - Identified deaths from lapses, and
  - Less than 25% unknown terminations.

---

**Agenda**

1. Summary
2. Mortality
3. Lapse

---

* 10 companies’ data were deemed to be reasonably reliable:
Base Mortality Rates

- Use 2012 IAM as a guide when data is sparse.
- Generally higher than corresponding 2012 IAM rates.

Data for ages 95 & over is fairly credible with 2,878 and 1,278 deaths for female and male respectively.

Base Mortality Rates

- LTC mortality rates are generally higher than corresponding 2012 IAM Basic and 2015 VBT Unismoker except for female ages past 100.

Durational Factors—Younger Issue Ages

- Durational selection effects extend beyond 20 years.
- Greater selection than aggregate for all issue ages.

Durational Factors—Older Issue Ages

- Durational selection effects shorter than 20 years at issue ages 75 and over.
Background on Data

- Source of data is the 2000-2011 LTC Intercompany Study.
- Select data for DEFN 2 companies and experience years 2008–2011 only.

Select Factors for Lapse

- Key lapse factors were identified using a logistic regression method.

<table>
<thead>
<tr>
<th>Factors for Lapse in Order of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Duration</td>
</tr>
<tr>
<td>Premium Paying Status</td>
</tr>
<tr>
<td>Issue Age</td>
</tr>
<tr>
<td>Underwriting Class</td>
</tr>
<tr>
<td>Periodic Premium Level</td>
</tr>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td>Premium Mode</td>
</tr>
<tr>
<td>Rate Increase Indicator</td>
</tr>
</tbody>
</table>

Select Factors for Lapse

- Based on 2008-2011 experience years and DEFN2 companies (10 of them):

<table>
<thead>
<tr>
<th></th>
<th>Exposure Years</th>
<th>Number of Lapses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>9.4 million</td>
<td>197,000</td>
</tr>
<tr>
<td>Group</td>
<td>4.9 million</td>
<td>302,000</td>
</tr>
</tbody>
</table>

- Minimum 240 lapses in any rate-cell (minimum 50% partial credibility).
Select Factors for Lapse

- To be consistent with the factors selected for Mortality Table, Work Group selected the following factors for lapse:
  - Policy Duration
  - Premium Paying Status
  - Issue Age
  - Underwriting Class
  - Periodic Premium Level
  - Marital Status
  - Premium Mode
  - Rate Increase Indicator

Raw Lapse Rates—Individual

- Raw rates were capped by prior year’s rates to remove increasing patterns.

Smoothed Lapse Rates—Individual

- Capped raw rates for each issue age group were fitted by either an exponential (Expon.) or a power trend line.

Preliminary Proposed Risk Class Factors—Individual

- Unsmoothed adjustment factors were used due to unevenness at the tails.
Preliminary Proposed Marital Factors—Individual

- Raw adjustment factors converted to smoothed factors using 2nd polynomial (Poly.) trend lines.

General Equations:
- Married: $y = 0.0003x^2 - 0.0119x + 0.9009$
- Not Married: $y = -0.0025x^2 + 0.0332x + 1.4385$

Policy Duration:
- 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Actual Lapse to Expected—Individual

- As A/E varies by within 20% by policy duration, a decision has not yet been made to make further adjustments.

Rate Increase Status Ignored

- 48% of total exposures have unknown rate increase status.

Raw Lapse Rates—Group

- Raw rates were not capped since there are only a few instances where the rates are higher than the prior year’s rates.
Smoothed Lapse Rates—Group

- Raw rates for each issue age group were fitted by either an exponential (Expon.) or a 2nd degree polynomial (Poly.) trend line.
- A/E adjustments by policy year needed for proposed rates.

No Other Factors for Preliminary Proposed Group Lapse Table

- Marital status data for Group was minimal.
- Underwriting risk class was deemed to be unreliable (under further review).
- Covered person (employee, spouse, family members, etc.) is not a significant lapse factor.
- Occupational class data is not available.

Actual Lapse to Expected—Group

- The high A/E at policy durations 11–15 was the result of keeping the proposed rates non-increasing.

Next Steps

- Develop proposed active lives tables
- Review reasonableness of total terminations
- Recommend margins
- Update NAIC LTC Actuarial Working Group on any new issues
- Produce report
### Preliminary Proposed Lapse Table—Individual

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60 &amp; Over</th>
</tr>
</thead>
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<td>1</td>
<td>25.4%</td>
<td>18.1%</td>
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<td>18.4%</td>
<td>12.6%</td>
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<td>7.2%</td>
<td>7.1%</td>
<td>6.1%</td>
</tr>
<tr>
<td>60-64</td>
<td>3</td>
<td>15.3%</td>
<td>10.2%</td>
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<tr>
<td>65-69</td>
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<tr>
<td>75 &amp; Over</td>
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### Preliminary Proposed Lapse Table—Group

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-39</th>
<th>40-44</th>
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</tr>
</tbody>
</table>

### Additional Information

**Questions?**

David Linn  
Senior Health Policy Analyst  
American Academy of Actuaries  
Linn@actuary.org  
202-785-6931

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The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Aug. 20, 2019. The following Working Group members participated: Perry Kupferman, Chair (CA); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens and Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Chuck Sha (TX); and Tomasz Serbinowski (UT).

1. Discussed a Draft of Revisions to the Forms

Mr. Kupferman presented a draft (Attachment Four-D1) of revisions to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement. He said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement.

Mr. Andersen asked if the draft contains completely new versions of forms 2 and 4, or if the draft represents suggested edits to the current forms 2 and 4. Mr. Kupferman said forms 1, 2, 4 and 5 in the draft are unrelated to the current respective form numbers, and are all new proposed forms.

Mr. Schallhorn asked if the information requested on draft form 1 is only for stand-alone LTCI policies, or if it also includes LTCI riders on life insurance or annuity policies. Mr. Kupferman said the intention is to collect information only on stand-alone policies. Mr. Schallhorn suggested adding a category for similar information on LTCI riders. Mr. Andersen said a clear definition of “stand-alone policy” and “rider” should be added to the instructions for completing the forms. He said “rider” should be defined as having a specific premium associated with the coverage, as the LTCI component of combination or hybrid life or annuity products with LTCI benefits comingle do not have a specific portion of their total premium clearly allocated to providing LTCI coverage. Mr. Serbinowski said combination or hybrid policies should not be excluded from information gathered in the forms.

Mr. Sha said actual-to-expected calculations should not be deleted from any future versions of the forms.

Jan Graeber (American Council of Life Insurers—ACLI) said a clear understanding of what information state insurance regulators need from the forms will help the ACLI to comment on the development of revisions to the forms. She suggested caveats may need to be included with the forms to prevent information contained in them from being used or applied incorrectly. She said conclusions drawn from state-level information from the forms could be incorrectly extrapolated to a nationwide basis. She said the instructions for completing the forms and what they represent need to be very clear to avoid misuse of the information or invalid conclusions being reached. Mr. Kupferman asked if the forms should be separated into individual and group business. Ms. Graeber said this would be helpful. She said distinctions among types of group business, such as employer-paid versus employee-paid, should be made for reporting group information.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
<table>
<thead>
<tr>
<th>Line</th>
<th>Direct Current</th>
<th>Total Inception-to-date</th>
<th>Assumed Current</th>
<th>Total Inception-to-date</th>
<th>Ceded Current</th>
<th>Total Inception-to-date</th>
<th>Net (Direct + Assumed - Ceded) Current</th>
<th>Total Inception-to-date</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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## LTC Experience Reporting Form 2 ($000's)

<table>
<thead>
<tr>
<th>Year of Peak Issues</th>
<th>Average Attained Age</th>
<th>Male/Female Mix (%)</th>
<th>Net/Gross Premium</th>
<th>$ Gross</th>
<th>$ Net Earned Premium</th>
<th>Net/Gross Premium Ratio</th>
<th>$ Incurred Claims</th>
<th># Lives in Force End of Year</th>
<th># Deaths</th>
<th># Lapses</th>
<th># New Issues</th>
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</thead>
<tbody>
<tr>
<td>Primarily 2002 and Prior Issue Years</td>
<td>Current (Comprehensive)</td>
<td>Total Inception-to-date (Comprehensive)</td>
<td>Current (Institutional only)</td>
<td>Total Inception-to-date (Institutional only)</td>
<td>Current (Non-Institutional only)</td>
<td>Total Inception-to-date (Non-Institutional only)</td>
<td>Current (Grand Total)</td>
<td>Total Inception-to-date (Grand Total)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Primarily 2003 to 2009 Issue Years</td>
<td>Current (Comprehensive)</td>
<td>Total Inception-to-date (Comprehensive)</td>
<td>Current (Institutional only)</td>
<td>Total Inception-to-date (Institutional only)</td>
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<td>Current (Grand Total)</td>
<td>Total Inception-to-date (Grand Total)</td>
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<tr>
<td>Primarily 2010 and Later Issue Years</td>
<td>Current (Comprehensive)</td>
<td>Total Inception-to-date (Comprehensive)</td>
<td>Current (Institutional only)</td>
<td>Total Inception-to-date (Institutional only)</td>
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<td>Current (Grand Total)</td>
<td>Total Inception-to-date (Grand Total)</td>
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Attachment Four-D1
Health Actuarial (B) Task Force
12/6/19
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<tr>
<th>Lin</th>
<th>Year of Issue</th>
<th>Third Party Funding (Y/N)?</th>
<th>Average Age</th>
<th>Gross Premium</th>
<th>Net Premium</th>
<th>Net/Gross Premium Ratio</th>
<th>Incurred Claims</th>
<th>Lives Force End of Year</th>
<th># Lives</th>
<th># Death</th>
<th># Lapse</th>
<th># New Issues</th>
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<td>Line</td>
<td>State Code</td>
<td>$ Earned Premiums</td>
<td># New Lives During Year</td>
<td># Lives Inforce End of Year</td>
<td>Average Attained Age</td>
<td>$ Incurred Claims</td>
<td># Open Claims End of Year</td>
<td># New Claims</td>
<td>$ Active Life Reserve</td>
<td>$ Claim Reserve</td>
<td>$ $ Accelerated Benefits Available</td>
<td>$ Extended Benefits Available</td>
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<td>Stand-alone LTC</td>
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<td>Life/LTC Hybrid Policies and Riders</td>
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<td>LTC EOB Riders</td>
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W:\National Meetings\2019\Fall\TF\HA\Conference Calls\8-20 LTCAWG\A. LTC ERF Sample changes 8-7-2019
Charges to the LTC Valuation Work Group

- Develop a replacement mortality table for LTC active life reserves
  - Based on the 2012 Annuitant Mortality Table
  - Recommend a margin for conservatism
- Develop a replacement lapse table
  - Recommend a margin for conservatism
- Consider developing tables for valuation on total lives basis as well as active lives basis

Progress Since Summer Meeting

- Graduated lapse rates on total lives basis
- Started review of actual-to-expected lapse on total lives basis
- Started review of reasonableness of total terminations on total lives basis
- Developed exposures for active life mortality

Remaining Tasks

- Complete review of actual-to-expected lapse on total lives basis
- Complete review of reasonableness of total terminations on total lives basis
- Develop mortality improvement from mid-point of exposure period, 2008 – 2011, to 2020
- Recommend margins for lapse and mortality
- Develop lapse and mortality on an active lives basis
- Complete Report
Expected Timeline

- Complete development of lapse and mortality on total and active lives bases including margins by Spring 2020 meeting
- Publish Report by Summer 2020 meeting

Additional Information

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Senior Health Policy Analyst
American Academy of Actuaries
Linn@actuary.org
202-785-6931
Society of Actuaries
Long-Term Care Experience Study Update

DALE HALL, FSA, MAAA
Managing Director of Research
December, 2019

Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.

Data

• Data collected on policies exposed between 1/1/2000 and 12/31/2016
• 19 companies submitted data >>> 80% of all 2016 LTC Earned Premium
• Data requested was expanded from the previous study. New data collected:
  • Additional underwriting information
  • Expanded benefit information
  • ICD-9-CM/ICD-10-CM claim information

Status Update

• Completed steps
  • Validation and logic checks defined and programmed
  • Exposure calculations defined and implemented
  • Initial validation reports sent out to contributing companies
• To be completed
  • Contributing companies review data validation reports and resubmit data, if necessary
  • SOA staff and LTC experience committee review of aggregated results
Deliverables

• A database of termination and incidence data including:
  • Data dictionary
  • Summary of data collected
  • High level results
• Data will be HIPAA compliant and follow safe harbor reporting rules
  • Results for ages 90+ grouped
  • Similar level of detail as the prior study
• Expected completion date: May 31, 2020
  • Four year lag between latest data collected and publication
  • Comparable to past LTC studies

Challenges of the current study

• Heightened awareness of HIPAA compliance by participating companies resulted in:
  • Additional contracting between data compiler and contributors
  • Additional research into HIPAA compliance options

>>>> Resulted in delays in data collection phase
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Sept. 12, 2019. The following Subgroup members participated: Paul Lombardo, Chair (CT); Jacob Lauten (AK); Steve Ostlund (AL); Benjamin Ben (FL); Marti Hooper (ME); Fred Andersen (MN); Anna Krylova (NM); Bill Carmello (NY); David Yetter (NC); Andrew Dvorine (SC); Raja Malkani (TX); and Jaakob Sundberg (UT).

1. Discussed Group LTCI Pricing

Mr. Lombardo said the Subgroup will continue its discussion of group long-term care insurance (LTCI) pricing considerations from its July 11 conference call.

Jan Graeber (American Council of Life Insurers—ACLI) said group LTCI can be classified as either true group or multi-life. She said true group LTCI uses a master policy that is issued to the group sponsor or employer, and certificates of coverage are issued to the employees or members of the group. She said true group premiums can be funded entirely by the employer, partially by the employer, or entirely by the employee, but, typically, there is at least partial funding by the employer. She said there is no master policy issued for multi-life LTCI, and individual policies are issued to each member of the multi-life group. She said true group plans that are at least partially employer-funded typically are lower risk than ones with no employer funding. She said the lower risk associated with employer-funded plans is primarily due to the risk being spread over a broader base of insured members. She said lapse rates for employees that leave the employer are higher for employer-funded plans, as the terminating employee will have to pay the portion of premium previously paid by the employer to continue coverage. She said lapse rates for terminating employees associated with plans entirely funded by the employer are similar to those seen for individual LTCI.

Ms. Graeber said employer-funded true group plans typically offer a base plan of benefits and give employees the option of purchasing increased coverage, such as a greater daily benefit. She said the average base plan daily benefit is typically lower than that for individual LTCI policies. She said most group base plans do not include inflation protection, and only a very small percentage have lifetime benefits. She said there are generally not gender-distinct rates or underwriting classes, and the base coverage is guaranteed issue. She said employees that decline coverage during open enrollment can enroll at a later date but will have to submit evidence of insurability. She said members that are not full-time employees or are not actively at work are usually subject to full underwriting. She said the average issue age for true group LTCI is lower than that for individual LTCI. She said the combination of lesser benefits and lower issue ages results in lower average premiums for true group compared to individual LTCI.

Ms. Graeber said rate increases for group LTCI may be lower than those in the individual market due to absence of inflation protection and lifetime benefits in group coverage. She said the lower average issue age for group affords more time for a rate increase to offset ultimate claims experience, resulting in lower rate increases for group.

Ms. Graeber said multi-life LTCI uses individual policies that are issued to members, and there is no contract between the insurer and the plan sponsor. She said the plan sponsor can be an employer or an association, such as the AARP. She said multi-life plan coverage and assumptions are more similar to individual market offerings than true group. She said if the plan sponsor is an employer where the member’s actively-at-work status can be verified, underwriting may be less stringent than that seen in the individual market. She said underwriting for an association plan is similar to individual underwriting. She said multi-life plan premiums reflect a discount from similar individual premiums, due to group administrative efficiencies.

Mr. Lombardo asked if, in a true group setting, an employee applies for enhanced benefits, is the application fully underwritten. Ms. Graeber said the increase is typically fully underwritten. Mr. Lombardo asked what percentage of employees purchase enhanced benefits, and for employees that do purchase enhanced benefits, is the total set of benefits comparable to individual market benefits. Ms. Graeber said she can ask ACLI members for percentages of employees selecting enhanced benefits. She said the richness of total benefit packages available to employees varies by employer.

Mr. Lombardo asked if there is any concern that group policies that use simplified underwriting may present an actual risk profile that differs from that assumed in initial pricing. Ms. Graeber said in the case of true group that uses an actively-at-work...
underwriting provision, the limited nature of the underwriting is accounted for in initial pricing. She said that multi-life plans, where there is no actively-at-work provision, use underwriting that is similar in intensity to that for individual market plans. Dave Plumb (John Hancock) said insurers typically assume higher claims costs for true group plans, given the limited underwriting in place. He said the risk profile for a true group member at a later attained age is similar to that of a fully-underwritten individual policyholder of the same attained age.

Mr. Lombardo asked if the experience associated with true group or multi-life group members that leave the employer or association, but elect coverage under a continuation or portability policy, stays with the original true group or multi-life block, or if this experience is transferred to the insurer’s individual pool. Ms. Graeber said for true group where the employer pays at least part of the premium, terminating employees that continue with the same coverage by paying the entirety of the premium are treated as any other member of the group for experience purposes. Mr. Plumb said he agrees with this. Ms. Graeber said for associations, the policy is already an individual policy, so the policy is completely portable. She said if the association dissolves, association members may be given the option to convert to a new individual policy, and the new policy experience may be placed in a new pool. Mr. Lombardo asked if insurers anticipate that employees who terminate from their employer, but elect to continue coverage, present a different risk profile than an insured who is still working for the employer. Ms. Graeber said she does not think insurers distinguish between the two classes of certificate holders in their pricing but rather consider the group’s experience as a whole when setting rates.

Mr. Lombardo said during the Subgroup’s July 11 conference call, Bonnie Burns (California Health Advocates—CHA) said she was told by a group LTCI company that it has a high percentage of claims that last less than one year. She said the explanation given was the low average age of the company’s block of insureds. Mr. Lombardo asked what reasons there could be that explain this difference. Ms. Graeber said that if there is such a difference, it is likely due to the event that triggered the claim, such as a car accident where long-term care (LTC) is needed during recovery from the accident, rather than conditions more prevalent in older age groups that result in longer-duration claims. Mr. Plumb said he thinks that recovery rates for younger attained ages will be higher than older attained ages for both individual and group coverage. Mr. Lombardo asked if group insurers have enough claims experience for older attained ages to accurately predict claims at older ages, or if they assume that incidence, morbidity and claim continuance for group insureds are the same as for individual insureds at older ages. Mr. Plumb said some group policies allow for family members of the employee to also be insured, which can create differences in group experience.

Mr. Lombardo said allowing family members of the employee to also be insured may increase the average age of group contracts. He asked about the prevalence of insurers offering coverage to family members of employees and if there are estimates of how frequently family members of employees enroll for LTCI when this is an option. Mr. Plumb said his experience has been that the volume of family members insured is low and has little impact on the average age of an insurer’s block. Ms. Graeber said ACLI members have reported that in only 5% to 6% of cases do employers offer coverage to family members, and of these 5% to 6%, roughly only 1% of employees add coverage for a family member.

Mr. Lombardo asked Mr. Plumb if he thinks group pricing should be similar to individual pricing. Mr. Plumb said this is true for older ages but not necessarily for younger ages. Mr. Plumb said for a given younger age, group lapse rates are higher than individual, and group morbidity is lower. He said that these assumptions generally converge at older ages.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
AG 51 GUIDANCE DOCUMENT – YEAR-END 2019

Below is a request for information related to companies’ long-term care insurance (LTC) asset adequacy testing that is being sent to each company filing an Actuarial Guideline 51 (AG 51) Memorandum. The request is related to a Valuation Analysis Review Group of the National Association of Insurance Commissioners project to review AG 51 reserve analysis. For each of the items below, please provide an answer or point to the section and page in the AG 51 filing where the item is addressed. The same confidentiality standards will apply to this information as applied to the AG 51 memorandum. The response should be sent as separate section of the AG 51 filing on the AG 51 filing due date.

I. Inforce

a. Provide charts containing the distribution of business (number of lives) by issue age band, issue year, coverage type, inflation protection, benefit period, and premium payment period. For premium payment period, distinguish between inforce policyholders with lifetime premium periods, inforce policyholders with limited-pay premium periods but still paying premiums, and inforce policyholders no longer paying premiums. In these charts, please exclude policyholders on claim.

II. Morbidity

In this context, morbidity refers to claim incidence rates, length of claim, and claim utilization.

a. Provide the year of the most recent morbidity study applied to support the company’s morbidity assumptions and provide the data period covered in the study. Explain which aspects of morbidity assumptions are reviewed on an annual basis and which are reviewed on a less frequent basis.

b. Discuss the general trend in morbidity experience and expectations over the past year and past several years at the company. If the trend has been in the direction of higher morbidity overall or in certain attained-age ranges, explain the extent to which this finding is reflected in updated assumptions. Also, if the company uses a claims-cost model (as opposed to a first-principles model), explain how company and/or industry trends in incidence and length-of-claim are tracked and reflected in updated assumptions.

c. Discuss the relevance of outside morbidity data applied to support the company’s morbidity assumptions, along with how that data was adjusted to fit the company’s circumstance and how the fit was determined to be appropriate. Explain how validation to historical company experience was performed.

d. Discuss whether and how the morbidity assumptions were compared with industry-average morbidity rates. Is there a reason for company assumptions to be higher or lower than industry average experience, such as benefits provided, policy provisions, underwriting standards, or claims practices? Note that the most recent Society of Actuaries’ (SOA) morbidity study is based on 2000-2011 data and may understate future morbidity in many instances. If the SOA table is relied upon, provide information on how morbidity assumptions used by the company are based on updated experience.
e. Discuss how morbidity assumptions for attained ages 85 and over were set in light of potential gaps in availability, credibility, and relevance of supporting data.

f. Discuss whether the company expects changes in morbidity assumptions in upcoming years as older-age experience develops. Describe how the company added margin to the morbidity assumption to address a potential increase in morbidity expectations. Also, please express a confidence interval of claim-cost-related assumptions for attained ages 90 and 95, including how the interval was determined. Does any sensitivity testing of the impact of adverse developments in morbidity appropriately address the level of potential older-age morbidity assumption increase?

g. Discuss assumed morbidity improvement (if applicable) and the basis for that assumption. Is the assumption supported by company experience? Does justification go beyond studies performed on the population as opposed to studies performed on insureds? Also, explain if the morbidity improvement and mortality improvement assumptions were determined separately. If not, please state the rationale.

h. Where applicable, provide an overview of changes in morbidity assumptions from those used in the previous AG 51 filing, including the basis for any changes.

i. Discuss assumed benefit utilization, including the cost-of-care inflation assumption. Provide the current average daily maximum benefit for policies with 5% compound inflation protection, policies with other inflation protection, and policies with no inflation protection.

j. Discuss the assumed underwriting wear-off pattern, duration in years of the wear-off, and the impact on beyond-select period morbidity assumptions. For policy durations 5, 10, and 20, provide the range of incidence rates for the best and worst underwriting classes for unmarried policyholders.

k. Explain whether incidence rates are determined using a denominator that is based on total lives or active lives. If the projections use a different denominator than the studies used to determine the incidence rate assumptions, please explain how adjustments are made to reconcile the difference and provide an example of this reconciliation, if possible. (If the company uses a total claim cost model, please address this question assuming that “incidence rates” were replaced with “claim costs”).

l. To help in understanding the morbidity assumption, calculate the present value of future benefits as of policy duration 10 of the following set of policies, each with $150 initial daily benefits, 2 ADL or severe cognitive impairment trigger, and 85- to 105-day elimination period:
   i. Female, issue age 55, lifetime benefits, 5% compound inflation
   ii. Female, issue age 55, 3-year benefits, no inflation
   {these cells were retained to provide context for the more-detailed calculation in m.; other 2018 cells are excluded}

   For each calculation, use the following pricing assumptions for the following factors:
   - Ultimate, annual voluntary lapse of 0.5%
- 2012 IAR mortality applied to active lives [Clarification sent 1/9/19]
- 4% discount rate
- Assume the most preferred underwriting classification that contains at least 30% of the lives
- Assume a single female with no partner discount.

Use the company’s assumptions on claims’ incidence, length of claim, benefit utilization, and any other morbidity-related aspect.

m. This request is intended to help in the understanding of differences in companies’ morbidity assumptions underlying the present value amounts calculated in association with item II.1 immediately above.

For the present value calculation associated with two cells:
   i) female, issue age 55, lifetime benefits, 5% compound inflation and
   ii) female, issue age 55, 3-year benefits, no inflation,
please provide the following durational information used in the present value calculation for each cell:

For attained ages 65, 70, 75, 80, 85, 90, 95, and 100:
- 1-year incidence rate assumption
- Maximum Annual Benefit, equal to 365 times Maximum Daily Benefit, inflated at 5% per year for the 5% compound inflation cell
- Utilized Annual Benefit
- Length of stay assumption over an entire claim for a claim starting at the specified attained age
- Total Claim Cost for a claim started at the specified attained age

A preferred format of this information is shown below (Submissions in Excel are preferred):

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>1-year Incidence rate</th>
<th>Maximum Annual Benefit</th>
<th>Utilized Annual Benefit</th>
<th>Length of Stay in years over entire claim</th>
<th>Total Claim Cost for claim started at the specified attained age</th>
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</thead>
<tbody>
<tr>
<td>65</td>
<td>0.5%</td>
<td>$ 90,000</td>
<td>100%</td>
<td>1.5</td>
<td>$ 675</td>
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<tr>
<td>70</td>
<td>1.0%</td>
<td>$ 110,000</td>
<td>95%</td>
<td>2.5</td>
<td>$ 2,613</td>
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<td>75</td>
<td>2.0%</td>
<td>$ 150,000</td>
<td>90%</td>
<td>3.0</td>
<td>$ 8,100</td>
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<td>80</td>
<td>4.0%</td>
<td>$ 190,000</td>
<td>90%</td>
<td>3.0</td>
<td>$ 20,520</td>
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<tr>
<td>85</td>
<td>7.0%</td>
<td>$ 240,000</td>
<td>85%</td>
<td>3.0</td>
<td>$ 42,840</td>
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<td>90</td>
<td>10.0%</td>
<td>$ 300,000</td>
<td>80%</td>
<td>2.5</td>
<td>$ 60,000</td>
</tr>
<tr>
<td>95</td>
<td>15.0%</td>
<td>$ 390,000</td>
<td>75%</td>
<td>2.0</td>
<td>$ 87,750</td>
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<tr>
<td>100</td>
<td>20.0%</td>
<td>$ 490,000</td>
<td>70%</td>
<td>1.5</td>
<td>$ 102,900</td>
</tr>
</tbody>
</table>

The assumptions above should only be provided for one year associated with the specified attained ages, not as the sum or average over a quinquennial range.

It is anticipated that the final column will be the product of the four preceding columns. If this is not the case, then please provide a narrative description of any adjustments.
It is preferred that any adjustments to incidence rates, including morbidity improvement, underwriting, spousal discount, etc., be embedded in the incidence rates in the table.

If the company uses a total claim cost model, please provide the total claim cost data column as well as any other data columns that are available.

Also, if there are any other factors not included in the table above that you believe could potentially lead the company’s present value amounts to be lower or higher than industry averages, then please include a narrative description. Identify if, for any of the cases in the two cells above, you believe the results are impacted by more conservative morbidity assumptions having been selected due to lower-than-average company credibility for that specific issue age and/or benefit type. Please identify whether the company morbidity assumptions used for this exercise were best estimate assumptions or included margins. Also identify if the morbidity assumptions used by the company and reflected in the calculations are unisex or gender-specific. Please explain if the attained age values shown in the table are for total lives or active lives.

In addition, please identify the type of product used as the basis for the calculation, in particular whether it was an expense reimbursement product, an indemnity (also known as cash) product, or another type. If there are other significant product aspects that are unique, please include a description. Identify whether the product is individual or group.

III. Reinsurance treaty information

a. Provide information on any new LTC-related reinsurance transactions or significant changes to existing LTC-related treaties that occurred in 2019.

IV. Sensitivity Tests

If the company performed cash-flow testing, provide the present value of ending surplus in a level interest-rate scenario using baseline assumptions. If the company performed a gross premium valuation, provide the resulting value using baseline assumptions. Also, provide the same values using all baseline assumptions except:

a. No morbidity improvement and no mortality improvement.

b. No morbidity improvement but with mortality improvement.

c. No future, non-approved premium rate increases.

d. Net yield pickup on existing and reinvestment assets capped at 150 basis points above Treasury yields at the time the asset was purchased or will be purchased. This cap applies as an average over the entire portfolio supporting the LTC block.
e. 80% benefit utilization of the projected total daily benefit amounts for products with higher-than 3% annual inflation protection.

1 AG 51 provides uniform guidance for the asset adequacy testing applied to a company’s LTC block of contracts, and is effective for reserves reported with respect to the Dec. 31, 2017, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 3B of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 14B provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 51 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements, and continue to remain confidential in nature.
Risk Adjustment Data Validation (HHS-RADV) Update

Purpose & Background

- HHS-RADV:
  - Serves as an audit of the information used in establishing an enrollee’s risk score for purposes of calculating the issuer’s plan liability risk score (PLRS) under the risk adjustment (RA) program
  - Uses a multi-step process called error estimation to calculate error rates that are used to adjust outlier issuers’ risk scores and RA transfers for the applicable state market risk pool(s)

RADV Updates

<table>
<thead>
<tr>
<th>Recent Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 31, 2019</td>
<td>Released the first error rate summary report (for 2017 HHS-RADV)</td>
</tr>
<tr>
<td>August 1, 2019</td>
<td>Released the first HHS-RADV adjustments to transfers summary report (for 2017 HHS-RADV)</td>
</tr>
<tr>
<td>July-August, 2019</td>
<td>Conducted a series of HHS-RADV listening sessions</td>
</tr>
<tr>
<td>December 6, 2019</td>
<td>RADV White Paper with comment period</td>
</tr>
</tbody>
</table>

Purpose & Background

- White Paper Purpose: is to outline and seek feedback on certain HHS-RADV issues:
  - Enrollee Sampling
  - Outlier Detection
  - Error Rate Calculation
  - Application of HHS-RADV Error Rates
- Comments on the options outlined in this paper will help inform potential future rulemaking
# Enrollee Sampling

Goals for HHS-RADV sample size refinement:

- Ensure samples accurately represent issuer enrollee populations
- Increase the number of samples that meet the 10 percent precision target for a two-sided 95 percent confidence interval
- Minimize the administrative and financial burden on issuers

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# Outlier Detection

- **Issue 1:** The current methodology determines an issuer’s outlier status based on national, static, confidence intervals common to all issuers
  - Examines alternative methodologies to more precisely identify which issuers have failure rates that are very different from the national average
- **Issue 2:** The current methodology allows for HCC hierarchies in RA to be split across HCC failure rate groupings in HHS-RADV
  - Examines alternative methodologies to address the influence of HCC hierarchies

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# Error Rate Calculation

- The RADV White Paper:
  - Examines alternative adjustment thresholds for calculating error rates for issuers that are just outside of the acceptable range of variation (the “payment cliff” or “leap frog effect”)
  - Examines a potential approach to mitigate the impact of HHS-RADV adjustments due to negative error rate issuers with negative failure rates

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# Application of HHS-RADV results

- HHS currently uses an issuer’s HHS-RADV error rate from the prior year to adjust the issuer’s risk score in the current transfer year (with the exception of exiting issuers)
  - Considers options to transition to an approach that applies HHS-RADV results to the same RA benefit year PLRS and transfers for all issuers (e.g., 2021 HHS-RADV results applied to 2021 RA PLRS and transfers)
RADV Updates

• Next Steps
    • Comments should be submitted comments to CCIIOACARADaDataValidation@cms.hhs.gov with the subject line of “December 2019 HHS-RADV White Paper.”
    • White HHS-RADV Paper Education Webinar is scheduled for December 18 at 2pm (ET) – Register at: Registrar@REGTAP.info.
  – Potential Future Rulemaking (TBD)

• Other Upcoming Activities
  – Proposed 2021 Payment Notice
  – Complete 2018 BY RADV
Since the last HATF meeting, the Academy’s Health Practice Council (HPC) has continued to actively engage policymakers and regulators. The HPC has held a number of meetings with various federal agencies and Congressional committees on the topics of long-term care (LTC), social determinants of health, wellness programs, short-term limited duration insurance plans, and health savings accounts. Various committees within the HPC continue to work on publications within these areas. Furthermore, members of the LTC Reform Subcommittee continued discussions with a federal LTC Interagency Task Force organized by the Department of the Treasury’s (Treasury) Federal Insurance Office (FIO) regarding their experience and expertise in the LTC insurance (LTCI) space, including pricing, product development, and regulation. The Task Force participated in the Academy’s Annual Public Policy Forum on November 5-6 to update actuaries on a forthcoming report while staff from the Center for Consumer Information and Insurance Oversight (CCIIO) also participated in a separate session of the meeting to update attendees on recent and forthcoming regulatory changes. A third breakout session focused on examining the proposals to expand public health insurance plans while Commissioner Altman from Pennsylvania also participated as our plenary featured speaker.

Other recent work includes:

**Affordable Care Act (ACA)**
- The Individual and Small Group Markets Committee sent comments on October 3 to Centers for Medicare & Medicaid Services (CMS) on rules finalized in the 2020 Notice of Benefit and Payment Parameters (NBPP) concerning risk adjustment data validation (RADV)-related transfers.

**Long-Term Care**
- On August 30, members of the LTC Reform Subcommittee submitted comments following their discussion with the Federal Interagency Task Force on LTCI earlier this year. These comments reiterate and expand on their original discussion including addressing regulatory hurdles to innovation.
- This week, the LTC Practice Note was published in final form to provide information to actuaries on current and emerging practices in which their peers are engaged with respect to the considerations in the statutory, Generally Accepted Accounting Principles (GAAP) and tax valuation of long-term care combination products.

**Health Care Delivery**
- On September 25, Susan Pantely and Mick Diede of the Telehealth Work Group, presented on the topic of telehealth along with the debut of their new issue brief moderated by Cori Uccello, senior health fellow, to Capitol Hill staff. The brief explores the perspectives of the patients and providers, while analyzing the financial, legal and regulatory aspects associated with telehealth.
- The Health Practice Council released an issue brief on September 10, *Surprise Medical*
Bills: An Overview of the Problem and Approaches to Address It, providing an overview of the surprise-billing problem and insights on how to address it.

**NAIC**

- Two work groups presented detailed briefings to regulators following the NAIC’s national meeting in early August. The Long-Term Care Valuation Work Group presented updates on the mortality and lapse tables development on August 28, and the Group Life Waiver Valuation Table Work Group updated the Health Actuarial Task Force on group life waiver of premium mortality and recovery tables development on August 27.
- On September 4, the Health Solvency Subcommittee submitted comments to the NAIC Health Risk-Based Capital (HRBC) Working Group in response to comment letters received on the exposure of the Draft Bond Structure and Instructions.

**Reminders:**

- All of the materials mentioned are on the Academy's website, actuary.org in the Health section under the Public Policy tab, or contact David Linn, the Academy's Senior Health Analyst.
- *(If Joeff Williams has not already plugged)* Academy reception tonight at 5:30pm in Room 409 of the JW Marriott Austin.