

RECOMMENDATIONS OF THE IIPRC OFFICE AND PSC FINAL
RECOMMENDATIONS PHASE 6 OF THE FIVE-YEAR REVIEW:
LONG-TERM CARE INSURANCE UNIFORM STANDARDS

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MODEL REGULATION/BULLETIN CHANGE ITEMS

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Model Regulation/Bulletin Change Items

The Interstate Insurance Product Regulation Compact requires that any Uniform Standard established by the Commission for long-term care insurance products must provide the same or greater protections for consumers as contained in the Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation adopted as of 2001. Article IV, Section 2 of the Compact also states that the Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards for long-term care insurance products.

On December 18, 2013, the NAIC adopted a Model Long-Term Care Bulletin developed by the Senior Issues (B) Task Force to address rate increases on in-force long-term care insurance policies, including older policies and closed blocks sold prior to 2000. On August 19, 2014, the NAIC adopted revisions to the Long-Term Care Insurance Model Regulation #641. The Model Regulation revisions primarily address the current regulatory framework regarding the issue of long-term care insurance rate increases prospectively for new policies.

The following items are potential revisions to the Uniform Standards for long-term care insurance products based upon the amendments to the Long-Term Care Insurance Model Regulation or the Model Bulletin.

1. Right to Reduce Coverage and Lower Premium
2. Nonforfeiture Benefits - Contingent Benefit On Lapse
3. Due Date for Annual Submission Requirements Subsequent To Initial Rate Filings
4. Phased In Rate Schedule Increase
5. Actuarial Memorandum Requirements For Rate Schedule Increase Filings
6. Rate Schedule Increases – Requirements for Portion of Business To Which the Increase Applies
7. Personal Worksheet and Rate Increase Disclosure
8. Actuarial Certification Requirements - Composite Margins and Reserves
9. Actuarial Memorandum Requirements

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1. RIGHT TO REDUCE COVERAGE AND LOWER PREMIUM

APPLIES: § 3BB. Right to Reduce Coverage and Lower Premiums of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISIONS:

- (1) This section does not apply to a life insurance policy or rider that provides long-term care benefits only in the form of an acceleration of the death benefit.
- (2) The policy shall include a provision that allows the insured (owner if there is one designated under the policy) to reduce coverage and lower the policy or premium in at least one of the following ways:
 - (a) Reducing the maximum benefit; or
 - (b) Reducing the daily, weekly or monthly benefit amount.
- (3) The company may also offer other reduction options that are consistent with the policy design or the company's administrative processes.
- (4) The policy shall contain the following conditions with respect to the right to reduce coverage and lower premiums benefit, consistent with the requirements of § 27 of the Model Regulation:
 - (a) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
 - (b) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.
 - (c) The company may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
 - (d) If a policy is about to lapse, the company shall provide a written reminder to the policyholder of his or her right to reduce coverage and premiums in the notice required by § 3CC(2) of this standard.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office notes that there were changes made to Section 27 Right to Reduce Coverage and Lower Premiums in NAIC Long-Term

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Care Model Regulation #641 that could impact the requirements in the corresponding provisions of these Uniform Standards.

IIPRC Office Recommendation: The IIPRC Office suggests that the Product Standards Committee (PSC) consider the following revisions to § 3.BB to be consistent with the revisions to Section 27 of the NAIC Long-Term Care Model Regulation:

- (2) The policy shall include a provision that allows the insured (owner if there is one designated under the policy) to reduce coverage and lower the policy or premium in at least one of the following ways:
 - (a) Reducing the maximum benefit; or
 - (b) Reducing the daily, weekly or monthly benefit amount.
- (3) The company may also offer other reduction options that are consistent with the policy design or the company's administrative processes.
- (4) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the company shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.
- (45) The policy shall contain the following conditions with respect to the right to reduce coverage and lower premiums benefit, consistent with the requirements of § 27 of the Model Regulation:
 - (a) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
 - (b) ~~The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.~~ premium for the reduced coverage shall:
 - (i.) be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
 - (ii) be consistent with the approved rate table.
 - (c) The company may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

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(d) If a policy is about to lapse, the company shall provide a written reminder to the policyholder of his or her right to reduce coverage and premiums in the notice required by § 3CC(2) of this standard.

IIPRC staff update following the May 17, 2016 AWG call and AWG recommendation to the PSC: The AWG agreed with the recommended language.

IIPRC staff update following the August 2, 2016 PSC call and PSC final recommendation:
The PSC agrees with the recommended revision.

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2. NONFORFEITURE BENEFITS – CONTINGENT BENEFIT ON LAPSE *

APPLIES: § 3T(4) Nonforfeiture Benefits of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISIONS:

- (1) The contingent benefit on lapse benefit contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
 - (a) (i) The policy shall indicate that a contingent benefit on lapse shall be triggered for an insured every time a company increases the premium rate schedule (issue age or modified) to a level which results in a cumulative increase in the insured's premium equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below, based on the insured's issue age, and the policy lapses within 120 days of the due date of the premium so increased. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium Rate Schedule
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%

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72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

- (ii) In the event any long-term care policy was issued at least 20 years
- (b) The policy shall also indicate that a contingent benefit on lapse will also be triggered for an insured for policies with a fixed or limited premium paying period every time the company increases the premium rate schedule (issue age or modified) to a level that results in a cumulative increase in the premium rate schedule for the insured equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below based on the insured's issue age, the policy lapses within 120 days of the due date of the premium rate schedule so increased, and the ratio in § 2.T(4)(d)(ii) is forty percent (40%) or more. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium Rate Schedule</u>
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by § 2.T(4)(a) above and where both are triggered, the benefit provided shall be at the option of the insured.

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- (c) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 2.T(4)(a) above, the company shall:
- (i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §§ 2.T(4)(d) and (e), if applicable. This option may be elected at any time during the 120-day period referenced in § 2.T(4)(a); and
 - (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 2.T(4)(a) shall be deemed to be the election of the offer to convert in § 2.T(4)(c)(ii) above unless the automatic option in § 2.T(4)(d)(iii) applies.
- (d) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 2.T(4)(b) above, the company shall:
- (i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in § 2.T(4)(b); and
- (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 2.T(4)(b) shall be deemed to be the election of the offer to convert in § 2.T(4)(d)(ii) above if the ratio is forty percent (40%) or more.

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- (e) The policy shall state that the contingent benefit upon lapse shall be effective from the policy issue date.
- (f) The contingent benefit on lapse benefit shall be appropriately captioned in the policy, rider, endorsement, or amendment;

COMMENTS:

Industry Comments: The Industry Advisory Committee (IAC) notes that changes should be made to §3T(4)(a) to reflect recent additions to Section 28D.(7) of NAIC Long-Term Care Model Regulation #641.

IIPRC Office Comments/Observations: The IIPRC Office notes that in addition to the changes noted by the IAC, there were also changes to Section 28 D.(5) and (6) that could impact the requirements in the corresponding provisions of these Uniform Standards.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revisions to § 3.T(4)(a),(c) and (d) to be consistent with the revisions to Section 28D of the NAIC Long-Term Care Model Regulation, and determine if the language adequately addresses the prospective nature of the revisions to § 3.T(4)(d):

- (4) The contingent benefit on lapse benefit contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
 - (a) For policies issued prior to [insert the effective date of the amendments to this standard], ~~the~~ policy shall indicate that a contingent benefit on lapse shall be triggered for an insured every time a company increases the premium rate schedule (issue age or modified) to a level which results in a cumulative increase in the insured's premium equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below, based on the insured's issue age, and the policy lapses within 120 days of the due date of the premium so increased. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>

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	Rate Schedule
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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- (i) For policies issued after [insert the effective date of the amendments to this standard], the above requirements apply, except that all values above 100% shall be reduced to 100%; and
- (ii) In the event any long-term care policy was issued at least 20 years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the table;
- (b) The policy shall also indicate that a contingent benefit on lapse will also be triggered for an insured for policies with a fixed or limited premium paying period every time the company increases the premium rate schedule (issue age or modified) to a level that results in a cumulative increase in the premium rate schedule for the insured equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below based on the insured's issue age, the policy lapses within 120 days of the due date of the premium rate schedule so increased, and the ratio in § 2.T(4)(d)(ii) is forty percent (40%) or more. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium Rate Schedule</u>
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by § 2.T(4)(a) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (c) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 2.T(4)(a) above, the company shall:

 - (i.) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting consistent with the requirements of §3.BB so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §§ 2.T(4)(d) and (e), if applicable. This option may be elected at any time during the 120-day period referenced in § 2.T(4)(a); and
 - (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 2.T(4)(a) shall be deemed to be the election of the offer to convert in § 2.T(4)(c)(ii) above unless the automatic option in § 2.T(4)(d)(iii) applies.
- (d) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 2.T(4)(b) above, the company shall:
- (i) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting consistent with the requirements of § 3.BB~~ so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in § 2.T(4)(b); and
- (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 2.T(4)(b) shall be deemed to be the election of the offer to convert in § 2.T(4)(d)(ii) above if the ratio is forty percent (40%) or more.

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- (e) The policy shall state that the contingent benefit upon lapse shall be effective from the policy issue date.
- (h) The contingent benefit on lapse benefit shall be appropriately captioned in the policy, rider, endorsement, or amendment;

IIPRC staff update following the May 17, 2016 AWG call: Because it appears the Model changes apply to new policy forms, the AWG agreed to review revised language drafted by the IIPRC staff for its next call. Suggested alternative language is as follows:

- (4) The contingent benefit on lapse benefit contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
 - (a) The policy shall indicate that a contingent benefit on lapse shall be triggered for an insured every time a company increases the premium rate schedule (issue age or modified) to a level which results in a cumulative increase in the insured's premium equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below, based on the insured's issue age, and the policy lapses within 120 days of the due date of the premium so increased. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium Rate Schedule
29 and under	200 <u>100</u> %
30-34	190 <u>100</u> %
35-39	170 <u>100</u> %
40-44	150 <u>100</u> %
45-49	130 <u>100</u> %
50-54	110 <u>100</u> %
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%

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65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(i) In the event any long-term care policy was issued at least 20 years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the table;

(b) The policy shall also indicate that a contingent benefit on lapse will also be triggered for an insured for policies with a fixed or limited premium paying period every time the company increases the premium rate schedule (issue age or modified) to a level that results in a cumulative increase in the premium rate schedule for the insured equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below based on the insured's issue age, the policy lapses within 120 days of the due date of the premium rate schedule so increased, and the ratio in § 2.T(4)(d)(ii) is forty percent (40%) or more. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

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Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium Rate Schedule</u>
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by § 2.T(4)(a) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (c) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 2.T(4)(a) above, the company shall:
- (i.) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with the requirements of § 3.BB so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §§ 2.T(4)(d) and (e), if applicable. This option may be elected at any time during the 120-day period referenced in § 2.T(4)(a); and
- (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 2.T(4)(a) shall be deemed to be the election of the offer to convert in § 2.T(4)(c)(ii) above unless the automatic option in § 2.T(4)(d)(iii) applies.
- (d) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 2.T(4)(b) above, the company shall:
- (i) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with the requirements of § 3.BB so that required premium payments are not increased;

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

IIPRC staff update following the June 14, 2016 AWG call and AWG recommendation to the PSC:
The Working group agreed to the drafted changes to the recommendation.

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IIPRC staff update following the August 2, 2016 PSC call and PSC final recommendation:

It was noted that the Industry Advisory Committee suggested in their June 16th comment letter that 4(a) and 4(b) reference contingent benefit on lapse for “an insured (owner if there is one designated under the policy)” for consistency with other sections of the uniform standards and to make those changes in several areas of the standards. The PSC agrees with the recommended revision, including changing the language in 4(a) and 4(b) to “an insured (owner if there is one designated under the policy).”

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3. DUE DATE FOR ANNUAL SUBMISSION REQUIREMENTS SUBSEQUENT TO INITIAL RATE FILINGS

APPLIES: § 3B.(3) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISIONS:

- (3) The actuarial certification required pursuant to § 3.B(1) must be submitted annually no later than December 31st of each year starting in the first full year following the year in which the initial rate schedules as approved by the Interstate Insurance Product Regulation Commission. The actuarial memorandum required pursuant to § 3.B(2) must be submitted every three years no later than December 31st of the reporting year starting in the third full year following the year in which the initial rate schedules as approved by the Interstate Insurance Product Regulation Commission.

Industry Comments: The IAC did not provide comments on this Model revision.

IIPRC Office Comments/Observations: The IIPRC Office notes that new Subsection 15 I.(2)(c) of NAIC Long-Term Care Model Regulation #641 requires that the actuarial certification required under the annual submission requirements subsequent to initial rate filings be based on calendar year data and submitted no later than May 1st.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revisions to § 3.B.(3) to be consistent with the revisions to Subsection 15I.(2)(c) of the NAIC Long-Term Care Model Regulation:

- (3) The actuarial certification required pursuant to § 3.B(1) must be based on calendar year data and submitted annually no later than December 31 May 1st of each year starting in the first full year after following the first full year in which the initial rate schedules as approved by the Interstate Insurance Product Regulation Commission. The actuarial memorandum required pursuant to § 3.B(2) must be submitted every three years no later than December 31st May 1st of the reporting year starting in the third full year after the first full following the year in which the initial rate schedules as approved by the Interstate Insurance Product Regulation Commission.

IIPRC staff update following the May 10, 2016 PSC Member Call and PSC final recommendation: The PSC agreed with the recommendation in the report consistent with

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changes to Model Regulation #641 to amend the due date for the annual actuarial certification and triennial actuarial memorandum to May 1st and to note that this is based on calendar year data.

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4. PHASED IN RATE SCHEDULE INCREASE

APPLIES: § 4.A.(1) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISIONS:

- (1) When a rate schedule increase for a specified individual long-term care insurance policy form does not exceed a rate increase of fifteen percent (15%), the filing shall be subject to the review and approval or disapproval of the Interstate Insurance Product Regulation Commission.

Industry Comments: The IAC suggested language to allow companies to file rate schedule increases that are less than actuarially justified and that may be on a phased-in basis over a specified period of time, such as 5% for the next three years, as permitted by the NAIC Long-Term Care Insurance Model Regulation and Bulletin.

IIPRC Office Comments/Observations: The IIPRC Office notes that the NAIC Long Term Care Rate Increase Model Bulletin adopted in December of 2013 states:

In lieu of a single increase, the [Department] may approve a series of scheduled rate increases that are actuarially equivalent to the single amount requested by the insurer over the lifetime of the policy. The entire series would be approved at one time as part of the current rate increase filing. For pre-rate-stability policy forms, the approval includes a three-year monitoring provision similar to that currently applicable to post-rate-stability rate increases to allow modification of later increases that were not appropriate based on the experience following the initial rate increase. When determining the rate comparison for new business, forms subject to a series of increases shall not be included.

In addition, of Section 20B.(2)(c) of the NAIC Long-Term Care Model Regulation states:

The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

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IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revisions to § 4.A.(1) as suggested by the IAC to be consistent with revisions to Section 20B.(2)(c) of the NAIC Long-Term Care Model Regulation and with the NAIC Long-Term Care Rate Increase Model Bulletin:

- (1) When a rate schedule increase for a specified individual long-term care insurance policy form does not exceed a rate increase of fifteen percent (15%), the filing shall be subject to the review and approval or disapproval of the Interstate Insurance Product Regulation Commission. A company may request a rate schedule increase less than what is required under this section and the Interstate Insurance Product Regulation Commission may approve such rate schedule increase if the actuarial memorandum discloses the rate schedule increase necessary to make the certification required under C(1)(a), the rate schedule increase filing satisfies all other requirements of this section and is, in the opinion of the Interstate Insurance Product Regulation Commission, in the best interest of policyholders.

Drafting Note: The company will be permitted to file a rate schedule increase for a specified individual long-term care insurance policy form on a phased in basis over a specified period of time (such as 5% for the next three years).

IIPRC staff update following the May 17, 2016 AWG call: The group discussed the Model's allowance of approving a rate increase less than a "certified" (or actuarially justified) rate increase. No consensus developed. Some ideas that were discussed ranged from: IIPRC could review and approve all rate increases, especially if phased in such that cumulative rate increases over time didn't exceed x% (say 3 or 5%) a year;

- IIPRC could approve rate increases up to 15% even if less than actuarially justified, as long as the actuarially justified rate was less than say 25% or some other threshold;
- IIPRC could approve justified rate increases up to 15%; IIPRC could approve rate increases less than actuarially justified as long as a process to determine the final approved rate included the member states impacted;
- IIPRC could approve lower increases (up to 15%) as long as there had not been a previously implemented rate increase over the last 3 years (or some other number);
- IIPRC could approve lower increases (up to 15%) as long as the Company certified it would use this new Loss ratio as a benchmark for future rate filings.

It was noted that no rate increases on inforce policies have been submitted to the IIPRC at this time.

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The Group was asked to think about a process that their state would be comfortable with (and similar to the existing allocation of authority to the IIPRC) with respect to handling rate increase requests that were less than “actuarially justified”. They were also encouraged to develop questions for industry input for the first public call.

IIPRC staff update following the June 14, 2016 AWG call: The group discussed the Model’s allowance of approving a rate increase less than a “certified” (or actuarially justified) rate increase. The members on the call agreed that there is no actuarial/technical reason to object to this change or to impose additional restrictions on the rate increase approval process. The group also thought the language was clear that the 15% threshold in the standards would be applied to the requested/approved level of rate increase, not the “certified” level of rate increase.

The group reviewed the draft language and agreed that the Model language referencing “the best interest of the policyholder” was not appropriate for an IIPRC standard and should be stricken.

The drafting note was also reviewed and no concerns were noted. It was confirmed that a “phase-in” relates to a single rate increase request/approval, and does not describe a series of separate rate increase requests.

No other changes are proposed with respect to the language in the IIPRC report.

(1) When a rate schedule increase for a specified individual long-term care insurance policy form does not exceed rate increase of fifteen percent (15%), the filing shall be subject to the review and approval or disapproval of the Interstate Insurance Product Regulation Commission. A company may request a rate schedule increase less than what is required under this section and the Interstate Insurance Product Regulation Commission may approve such rate schedule increase if the actuarial memorandum discloses the rate schedule increase necessary to make the certification required under C(1)(a) and the rate schedule increase filing satisfies all other requirements of this section and is, in the opinion of the Interstate Insurance Product Regulation Commission, in the best interest of policyholders.

Drafting Note: The company will be permitted to file a rate schedule increase for a specified individual long-term care insurance policy form on a phased in basis over a specified period of time (such as 5% for the next three years).

IIPRC staff update following the July 12, 2016 AWG call and AWG recommendations and observations to the PSC: During final review of recommendations, the group discussed the Model’s allowance of approving a rate increase less than a “certified” (or actuarially justified) rate increase. The following observations with respect to the impact of this change were made:

(1) This change could result in more rate increases receiving approval as opposed to advisory opinions than prior to the change given some members’ experience of certified rates increases typically exceeding 15% in state filings. In these situations, uniformity of rate increases would occur as all policyholders received the 15% increases as opposed to the increase decisions that may vary in each member state.

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- (2) It was also observed that in situations where an increase was approved that was less than the certified increase, this information may need to be incorporated into the policyholder disclosure.

Both of these items related to public policy aspects of implementing rate increases.

The drafting note was also discussed. It was observed that:

- (1) The Model Bulletin reference to phased-in increases specified that the phase in should be “actuarially equivalent to the single amount” while the proposed drafting note only gave the example of “such as 5% for the next three years,” which if compounded would exceed 15%.
- (2) The concern was expressed that the Compact review, like in states, is a technical, actuarial review and approval and that in many states, the options added to the NAIC LTC Model Regulation, including both the ability to approve less than an actuarially justified rate increase or to phase in a rate increase, were ones within the purview of the Commissioner so should still stay with the Commissioner and not the Compact.
- (3) Some members had concerns that such a phase in could be difficult to communicate to policyholders.
- (4) Others observed that although a phase-in approach is permitted in the Model, it seemed impractical when rate increase amounts were small, such as the 15% increase to which the IIPRC is limited.

These last two items are related to public policy aspects of implementing rate increases.

No changes from the prior proposed edits were made with respect to the language in the IIPRC report.

IIPRC staff update following the August 2, 2016 PSC Member Call and request for feedback: The Product Standards Committee expressed serious reservations that the proposed language could undermine the explicit 15% threshold for when rate increase requests would be subject to the review and approval or disapproval of Compacting States. The PSC expressed that it would likely not be in favor of the new language if it were intended to allow a rate increase of 15% or less to be submitted, reviewed and approved by the Commission when the rate schedule increase necessary to make the certification, required under Section 4.C(1)(a) of the Rate Filing Standard for Individual Long-Term Care Insurance exceeds 15%. The PSC is contemplating caveating the new language in Section 4.A(1), by clarifying in the existing sentence of this subsection that only when the rate schedule increase necessary to make the certification required under Section 4.C(1)(a) does not exceed 15%, that the increase request will be subject to the review and approval or disapproval of the Commission.

The PSC also recommended adding a provision to the drafting note specifying that it is permitted if the phase in is actuarially equivalent to the approved increase.

Drafting Note: The company will be permitted to file a rate schedule increase for a specified individual long-term care insurance policy form on a phased in basis over a specified period of time (such as 5% for the next three years) if the phase in is actuarially equivalent to the approved increase.

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IIPRC staff update following the August 16, 2016 PSC Member Call and Final PSC

Recommendation: The PSC received no Public Comments regarding this item. The PSC discussed the suggested revision limiting both the amount certified and the amount requested to 15% or less, and decided that this did not eliminate the previously stated concerns. The Committee concluded that the purpose of the amendments to the NAIC Long-Term Care Insurance Model Regulation was to provide states with flexibility and Commissioner discretion for large rate increase requests, and that no change should be recommended to the current provisions, so that requests for premium rate schedule increases less than actuarially justified or for phased in rates should be filed directly with the states.

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5. ACTUARIAL MEMORANDUM REQUIREMENTS FOR RATE SCHEDULE INCREASE FILINGS

APPLIES: § 4.C.(2) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISIONS:

- (2) An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall comply with the Actuarial Standards of Practice (in particular ASOP 18) and providing at least the following information with respect to the form as approved for use in Interstate Insurance Product Regulation Commission states:
 - (a) Lifetime projections of earned premiums and incurred claims based on the filed rate schedule increase and consistent with the requirements of § 3.A(4) and (5) to provide complete experience; and the method and assumptions used in determining the projected values, including a reflection and disclosure of any assumptions that deviate from those used in pricing other policy forms approved by the Interstate Insurance Product Regulation Commission and currently available for sale;
 - (i) Annual values for the five (5) years preceding and the three (3) years following the projection date shall be provided separately;
 - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate schedule increase is an exceptional rate schedule increase;
 - (iii) The projections shall demonstrate compliance with § 4.C(3), below;
 - (iv) For an exceptional rate schedule increase:
 - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional rate schedule increase; and
 - (II) In the event that the Interstate Insurance Product Regulation Commission determines that there are potential offsets to the higher claims costs associated with the exceptional rate schedule increase, the appropriate net projected experience shall be used; and
 - (v) The projections shall be based on the expected premium income and claims experience to which the rate increase will be applied with a

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separate projection for the expected premium income and claims experience to which no rate increase will be applied;

Drafting Note: Projected experience performed according to § 3.B(2) may use actuarial judgment based on the experience of the company or industry using Interstate Insurance Product Regulation Commission, state or national data.

- (b) Disclosure of how reserves have been incorporated into the rate schedule increase whenever the rate schedule increase will trigger a contingent benefit on lapse;
- (c) Disclosure of the analysis performed to determine why a rate schedule increase is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary in providing the certification in § 3.B(1), above. The disclosure should describe the sources and levels of margins incorporated into the premiums after the rate schedule increase that are the basis for the statement in § 3.B(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Significant deviations in margins between ages, sexes, plans or states shall be clearly described. Significant deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating premium schedules;
- (d) A statement that the policy design, underwriting and claims adjudication practices have been taken into consideration; and
- (e) A statement that the rate schedule after the rate schedule increase is not greater than the rate schedule for new business approved for use by the Interstate Insurance Product Regulation Commission except for differences attributable to benefits, unless sufficient information to demonstrate such differences are justified is provided.

IIPRC Office Comments/Observations: The IIPRC Office notes that revisions to Section 20 B(3)(f) of NAIC Long-Term Care Model Regulation #641 add requirements related to demonstration that the actual and projected costs exceed anticipated costs and that the composite margin is projected to be exhausted.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider whether the current provision in §4.C.(2) should be amended as follows to be consistent with the revisions to Section 20B(3)(f) of the NAIC Long-Term Care Model Regulation:

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- (d) A statement that the policy design, underwriting and claims adjudication practices have been taken into consideration; ~~and~~
- (e) A statement that the rate schedule after the rate schedule increase is not greater than the rate schedule for new business approved for use by the Interstate Insurance Product Regulation Commission except for differences attributable to benefits, unless sufficient information to demonstrate such differences are justified is provided; ~~and~~
- (f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in §2 B(1)(d) is projected to be exhausted.

IIPRC staff update following the June 28, 2016 AWG call and AWG recommendation to the PSC: The AWG agreed with the recommended language.

IIPRC staff update following the August 2, 2016 PSC call and PSC final recommendation: The PSC agreed with the recommended language.

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6. RATE SCHEDULE INCREASES – REQUIREMENTS FOR PORTION OF BUSINESS TO WHICH THE INCREASE APPLIES

APPLIES: §4.C.(3) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISIONS:

- (3) All rate schedule increases shall comply with the following requirements with respect to the portion of the business to which the rate schedule increase is to apply:
 - (a) Exceptional rate schedule increases shall provide that seventy percent (70%) of the present value of projected additional premiums resulting from the exceptional increase will be returned as benefits;
 - (b) Rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, excluding active life reserves, and the present value of future projected incurred claims, excluding active life reserves, are not less than the sum of:
 - (i) The accumulated value of the initial earned premium times fifty-eight percent (58%);
 - (ii) Eighty-five percent (85%) of the accumulated value of prior rate schedule increases filed with the Interstate Insurance Product Regulation Commission under this standard on an earned basis;
 - (iii) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
 - (iv) Eighty-five percent (85%) of the present value of projected premiums not included in (iii), above, on an earned basis;
 - (c) In the event that the rate filing incorporates an exceptional rate schedule increase and other increases, the values in § 3.B(3)(b)(ii) and § 3.B(b)(iv) shall also include seventy percent (70%) for exceptional rate schedule increase amounts; and
 - (d) All present and accumulated values used in the determination of any rate schedule increase shall use the maximum valuation interest rate for contract reserves specified in Appendix A of the NAIC Health Insurance Reserves Model Regulation (Model #10).

Industry Comments: The IAC suggested amending §4.C.(3) to apply to rate schedule increases for policy forms filed prior to six months after the adoption date of the amended

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uniform standards and adding a new subsection for rate schedule increases for policy forms filed on or after six months from the adoption date of the amended uniform standards to be consistent with the addition of Section 20.1 C of NAIC Long-Term Care Model Regulation #641.

IIPRC Office Comments/Observations: The IIPRC Office notes that there were additions to NAIC Long-Term Care Model Regulation #641 in Section 20.1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings that could impact the requirements in the corresponding provisions of these Uniform Standards.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revisions to §4.C.(3) and (4) as proposed by the IAC to be consistent with the revisions to Section 27 of the NAIC Long-Term Care Model Regulation:

- (3) All rate schedule increases applicable to policies issued under policy forms filed prior to [date six months after the date these changes are adopted by the Interstate Insurance Product Regulation Commission] shall comply with the following requirements with respect to the portion of the business to which the rate schedule increase is to apply:

[No other change to (3)]

- (4) All rate schedule increases applicable to policies issued under policy forms filed on or after [date six months after the date these changes are adopted by the Interstate Insurance Product Regulation Commission] shall comply with the following requirements with respect to the portion of the business to which the rate schedule increase is to apply:
- (a) Exceptional rate schedule increases shall provide that seventy percent (70%) of the present value of projected additional premiums resulting from the exceptional increase will be returned as benefits;
- (b) Rate schedule increases shall be calculated such that the sum of the lesser of (i) accumulated value of actual incurred claims, excluding active life reserves, and (ii) the accumulated value of historic incurred claims, excluding active life reserves, plus the present value of future projected incurred claims, excluding active life reserves, are not less than the sum of:
- (i) The accumulated value of the initial earned premium times the greater of (A) fifty-eight percent (58%) and (B) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

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- (ii) Eighty-five percent (85%) of the accumulated value of prior rate schedule increases filed with the Interstate Insurance Product Regulation Commission under this standard on an earned basis;
 - (iii) The present value of future projected initial earned premiums times the greater of (A) fifty-eight percent (58%) and (B) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
 - (iv) Eighty-five percent (85%) of the present value of projected premiums not included in § 4.B(3)(b)(iii), above, on an earned basis;
 - (v) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing.
- (c) In the event that the rate filing incorporates an exceptional rate schedule increase and other increases, the values in § 3.B(3)(b)(ii) and (iv) shall also include seventy percent (70%) for exceptional rate schedule increase amounts; and
- (d) All present and accumulated values used in the determination of any rate schedule increase shall use the maximum valuation interest rate for contract reserves specified in Appendix A of the NAIC Health Insurance Reserves Model Regulation (Model #10).
- (45) For guaranteed renewable policies, if the company has guaranteed premiums will not increase after the insured has attained a specified age, the actuary shall certify that the basis for the proposed rate increase does not include adverse experience for such insureds.

IIPRC staff update following the June 28, 2016 AWG call and AWG recommendation to the PSC: The AWG agreed with the recommended language.

IIPRC staff update following the August 2, 2016 PSC Call: IIPRC staff noted that the Industry Advisory Committee suggested that (4)(b) should say “the accumulated value of historic expected claims” since otherwise it would say that that a company takes the lesser of actual

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claims and historic claims, and both of these are the same. Staff reviewed the revisions to Model 641 and suggests the following changes to be consistent with the Model language:

- 4 (b) Rate schedule increases shall be calculated such that the sum of the lesser of (i) accumulated value of actual incurred claims, excluding active life reserves, ~~and or~~ (ii) the accumulated value of historic ~~incurred expected~~ claims, excluding active life reserves, plus the present value of future ~~projected- expected~~ incurred claims, excluding active life reserves, **will not be** less than the sum of:

IIPRC staff update following the August 2, 2016 PSC call and PSC final recommendation:

The PSC agreed with the recommended language including the revision to 4(b) to be consistent with Model Regulation #641.

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**7. PERSONAL WORKSHEET AND POTENTIAL RATE INCREASE
DISCLOSURE FORMS**

APPLIES: Appendix A (Personal Worksheet) and Appendix C (Potential Rate Increase Disclosure) of the [Standards for Forms Required To Be Used With an Individual Long-Term Care Insurance Application](#)

COMMENTS:

Industry Comments: The IAC suggests that Appendix A – Personal Worksheet and Appendix C – Potential Rate Increase Disclosure be replaced by Appendices B and F recently adopted by the NAIC Senior Issues (B) Task Force.

IIPRC Office Comments/Observations: The IIPRC Office notes the NAIC revised appendices were finalized as a result of changes to the NAIC Long-Term Care Model Regulation.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider replacing Appendix A – Personal Worksheet and Appendix C – Potential Rate Increase Disclosure with Appendices B and F as adopted by the NAIC Senior Issues (B) Task Force.

New APPENDIX A (NAIC Appendix B)

Drafting Note: Companies shall at a minimum provide all of the information shown below and in the same order. The company may include additional information related to this long-term care insurance coverage in relevant and readable language. Bracketed statements indicate the companies should choose the applicable statement, are allowed flexibility in inserting numerical ranges, etc.

Long-Term Care Insurance Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

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The premium for the coverage you're considering will be [\$ _____ per [insert payment interval] or a total of [\$ _____ per year] [a one-time single premium of \$ _____].

The premium quoted in this worksheet isn't guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.

Drafting Note: Companies will insert payment interval – monthly, quarterly, etc. and the appropriate dollar amount.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

[[Noncancellable - The company **can't** increase your premiums on this [policy] [certificate] [rider]].

[Guaranteed renewable - The company **can** increase your premiums on this [policy] [certificate] [rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider].]

Drafting Note: Companies will insert the appropriate policy type and the associated bracketed statement. Premium guarantees shall not be shown on this form.

Premium Increase History

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.]

Drafting Note: If the summary of premium increases is extensive, the company may disclose the required premium increase history via an addendum attached to this worksheet. The company may substitute the language below for the last sentence in the paragraph above and include the full summary as an attachment to this worksheet.

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“Over the past 3 years, the company has increased premiums by ___%.” “A summary of premium increases in the last 10 years is attached to this worksheet.”

Companies that have increased premiums by 30% or more in the last ten years must include the following statement: “There was a 30% or greater premium increase in _____ (insert year).” “A summary of premium increases in the last 10 years is attached to this worksheet.”

Questions About Your Income

You do **not** have to answer the questions that follow. They’re intended to make sure you’ve thought about how you’ll pay premiums and the cost of care your insurance doesn’t cover. If you don’t want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?

Current income from employment Current income from investments Other current income
 Savings Sell investments Sell other assets Money from my family Other

If you’ll be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy] [certificate] [rider] if the premiums will be more than 7% of your income.

Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?

Yes No Hadn’t thought about it Don’t know Doesn’t apply

[What would you do if the premiums went up, for example, by 50%?

Pay the higher premium Call the company/agent Reduce benefits Drop the [policy] [certificate] [rider] Don’t know]

Drafting Note: The company is not required to use the bracketed question above if the coverage is fully paid up or is noncancellable.

What is your household annual income from all sources? (check one)

[Less than \$10,000] [\$10-19,999] [\$20-29,999] [\$30-50,000] [More than \$50,000]

Drafting Note: The companies may choose the income ranges to put in the brackets to fit its suitability standards.

Do you expect your income to change over the next 10 years? (check one)

No Yes, expect increase Yes, expect decrease

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If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?

Yes No Don't know

Will you buy inflation protection? (check one)

Yes No

Inflation may increase the cost of long-term care in the future.

If you don't buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?

From my income From savings From investments Sell other assets Money from my family Other

The national average annual cost of long-term care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. This figure should also be used when calculating the cost of long-term care in the "approximate cost \$ _____ for that period of care" question found below. In the above statement, the second figure will equal 163% of the first figure.

What [elimination period][waiting period][cash deductible] are you considering?

[Number of days _____ in [elimination period][waiting period]

Approximate cost of care for this period: \$ _____
(\$xxx per day times number of days in [elimination period][waiting period], where "xxx" represents the most recent estimate of the national daily average cost of long-term care)]

[Cash Deductible \$ _____]

How do you plan to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)

From my income From my savings/investments My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

[Less than \$20,000] [\$20,000-\$29,999] [\$30,000-\$49,999] [More than \$50,000]

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Drafting Note: Companies may choose the asset ranges to put in the brackets to fit its suitability standards.

Do you expect the value of your assets to change over the next ten years? (check one)

No Yes, expect to increase Yes, expect to decrease

If you're buying this [policy] [certificate] [rider] to protect your assets and your assets are less than \$50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

The answers to the questions above describe my financial situation.

Or

I choose not to complete this information.

(Check one.)

I agree that the company and/or its agent (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)

Drafting Note: For direct mail situations, the lead in sentence should be changed to "I agree that I have reviewed this worksheet including the premium...."

Signed: _____
(Applicant) (Date)

I explained to the applicant the importance of answering these questions.

Signed: _____
(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed worksheet to [name of company], along with your application.]

[My agent has advised me that this long-term care insurance [policy] [certificate] [rider] doesn't seem to be suitable for me. However, I still want the company to consider my application.]

Signed: _____]
(Applicant) (Date)

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Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

Someone from the company may contact you to discuss your answers and the suitability of this [policy] [certificate] [rider] for you.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading “Disclosure Statement” to the end of the page may be removed.

New APPENDIX C (NAIC Appendix F)

Instructions: Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as noted below. This form does not need to be provided in the event the policy does not reserve the right to increase rates.

As used in this Appendix:

“Policy” shall mean policy, certificate, or rider, as applicable.

“Premium” shall include premium schedules, as applicable.

Companies may substitute whichever term is appropriate to reflect the long-term care insurance for which the applicant is applying.

Long-Term Care Insurance Potential Premium Increase Disclosure Form

Important Notice: Your long-term care insurance company may increase the premium for your policy every year. You have certain rights and it’s important that you understand them before you buy a long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

*This policy is guaranteed renewable. Companies can increase the premiums for guaranteed renewable policies in the future. The company **cannot** increase your premiums because **you’re** older or **your** health declines. It can increase premiums based on the experience of all individuals with a policy like yours.*

1. What Is Your Premium?

The agent/company has quoted you a premium of [\$ _____] for this policy. This is **not** a final premium. The premium might change during the underwriting process or if you choose

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different benefits. The premium you'll be required to pay for your policy will be [shown on the schedule page of] [will be attached to] your policy.

2. How Will I Know If My Premium Is Changing?

The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

IIPRC staff update following the May 10, 2016 PSC Member Call and PSC final recommendation: The PSC agreed to update the personal worksheet (Appendix A) and potential rate increase disclosure (Appendix C) in the Standards for Forms Required to be Used with an Individual Long-term Care Insurance Application to reflect the updated forms adopted by the NAIC.

8. ACTUARIAL CERTIFICATION REQUIREMENTS – COMPOSITE MARGINS AND RESERVES

APPLIES: §2B.(1) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISIONS:

B. ACTUARIAL SUBMISSION REQUIREMENTS

- (1) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:
 - (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - (d) A set of statements relating to contract reserves and their relation to gross premiums:
 - (i) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
 - (ii) A statement that the net valuation premium for renewal years does not increase;
 - (iii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur shall be provided in the actuarial memorandum supplied pursuant to § 2B(3)(d); and
 - (iv) A statement as to whether or not the reserve morbidity assumptions used include any provision for morbidity improvement.

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- (e) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms with issue age rate schedules and comparable premium-paying periods also available from the company except for reasonable differences attributable to benefits; or, if there are situations where one or some rates in a premium rate schedule are less than those in the premium rate schedule for existing products having similar benefits, a statement to that effect. In either case, details of the differences and the comparison work performed should be provided as part of § 2B(3)(f).

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office notes that §2B.(1)(d) should be considered for amendment due to the revisions to Section 10B(2)(d) and (f) of NAIC Long-Term Care Model Regulation #641. §2.B.(1)(d) of the Rate Filing Standards is similar to the referenced section of the Model, but does not include requirements to provide detail or sample calculations of reserve amounts or the new clarifying language with respect to the methodology of performing the net/gross ratios.

Industry Comments: The IAC submitted the following draft revisions related to the composite margins, but suggested that they be added to the end of §2B.(3)(c):

For policy forms filed on or after [six months after the date these changes are adopted by the Interstate Insurance Product Regulation Commission], there is an expectation that the margin will be at least 10% of the present value of incurred claims. A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted. A composite margin lower than otherwise considered appropriate for a stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revisions to §2B.(1)(d) to be consistent with the revisions to Section 10B(2)(d) and (f) of the NAIC Long-Term Care Model Regulation addressing composite margins and reserve requirements:

- (d) A ~~set of statements relating to contract reserves and their relation to gross premiums:~~

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- ~~(i) A statement that the premiums assumptions used for reserves contain reasonable margins at least the minimum margin for moderately adverse experience defined in (i) or the specification of and justification for a lower margin as required by (ii).~~;
- ~~(i) A composite margin shall not be less than 10% of lifetime claims.~~
- ~~(ii) A statement that the net valuation premium for renewal years does not increase;~~
- ~~(ii) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.~~
- ~~(iii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur shall be provided in the actuarial memorandum supplied pursuant to § 2B(3)(d); and~~
- ~~(iii) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.~~

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

- ~~(iv) A statement as to whether or not the reserve morbidity assumptions used include any provision for morbidity improvement.~~
- ~~(iv) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.~~

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

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- (e) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms with issue age rate schedules and comparable premium-paying periods also available from the company except for reasonable differences attributable to benefits; or, if there are situations where one or some rates in a premium rate schedule are less than those in the premium rate schedule for existing products having similar benefits, a statement to that effect. In either case, details of the differences and the comparison work performed should be provided as part of § 2B(3)(f).
- (f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
- (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
- (ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

IIPRC staff update following the June 28, 2016 AWG call and AWG recommendation to the PSC: The AWG agreed with the recommended language.

IIPRC staff update following the August 2, 2016 PSC call and PSC final recommendation:
The PSC agreed with the recommended language.

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9. ACTUARIAL MEMORANDUM REQUIREMENTS

APPLIES: §2.B.(3) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISION:

- (3) An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall address and support each specific item required as part of the actuarial certification, comply with Actuarial Standard of Practice (ASOP) 18 and provide at least the following information:
 - (a) An explanation of the review performed by the actuary prior to making the statements in § 2.B.(1)(b) and § 2.B.(1)(c);
 - (b) A complete description of pricing assumptions;

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

- (c) Sources and levels of margins, incorporated into the gross premiums determined in § 2.B.(3)(b) above that are the basis for the statement in § 2.B.(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Significant deviations in margins between ages, sexes, plans or states shall be clearly described. Significant deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales;
- (d)
 - (i) A complete description of those situations, if any, where the difference between the gross premium and the net valuation premium for renewal years is not sufficient to cover expected renewal expenses; and
 - (ii) A table of sample ages and coverages (including inflation and non-inflation) demonstrating the extent and the results of this review;
- (e) A complete description of any morbidity improvement assumption used in pricing or reserves for the product together with the rationale for the assumption and its effect on premium and reserve levels; and

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Drafting Note: At the time of drafting these standards, the Interstate Insurance Product Regulation Commission generally does not believe that sufficient credible data on insured experience is available to justify the use of morbidity improvements in pricing or reserve assumptions but cannot be sure that it cannot be produced in the future. As noted in the NAIC Health Insurance Minimum Reserve Model Regulation (Model #10), “Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction in [premiums or] reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred, and that is able to be evaluated and quantified. This last sentence is intended to provide allowances for a known event, such as a new drug release, but at the time of this writing, there are no specific examples that could be pointed to in the recent past that would have met this standard. **This is intended to be an extremely rare event.**” [emphasis supplied]

- (f) A comparison of the premium rates with issue age rate schedule rates, at a reasonable selection of ages, for similar policy forms and comparable premium-paying periods also available from the company. The actuary should describe the situations where the premium rate schedules are less than those for existing products and detail the differences and testing done by the actuary to determine that the filed premiums are not inadequate.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office notes that §2.B.(3)(c) and a new (d) should be considered for amendment due to the revisions to Section 10B(3)(c) and (d) of NAIC Long-Term Care Model Regulation #641. The revision in Section 10.B(3)(c) does not limit disclosure of deviations to “significant” deviations and Model provision (3)(d) is not currently listed in the standards. The addition of the suggested new (d) would align with the revisions suggested under Clarification Item 3.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revisions to §2.B.(3)(c) and a new (d) to be consistent with the revisions to Section 10.B(3)(c) and (d) of the NAIC Long-Term Care Model Regulation. The current §2.B.3(d) – (f) would then be lettered (e)–(g).

- (c) Sources and levels of margins, incorporated into the gross premiums determined in § 2.B.(3)(b) above that are the basis for the statement in § 2.B.(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. **Significant D**eviations in margins between ages, sexes, plans or states shall be clearly described. **Significant D**eviations in margins are other than those

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produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales;

- (d) A demonstration that the gross premiums include the minimum composite margin specified in § 2.B.(1)(d);

IIPRC staff update following the June 28, 2016 AWG call and AWG recommendation to the PSC: The AWG agreed with the recommended language.

IIPRC staff update following the August 2, 2016 PSC call and PSC final recommendation:
The PSC agreed with the recommended language.

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Substantive Change Items

Substantive change items are proposed amendments to the Uniform Standards that would change or alter the meaning, application or interpretation of the provision. Substantive change items would likely impact not only the Uniform Standards but product filings submitted to the IIPRC and would be the equivalent to a change in an individual state's laws or regulations. When looking at the substantive change items, the scope of review should consider whether circumstances or underlying assumptions have changed since the last time the rule was adopted, amended or reviewed.

List of Substantive Change Items

1. Revision of Misstatement of Age Provision
2. Allowance for Non-Duplication of Benefits
3. Rate Requirements for Dollar-for-Dollar Long-Term Care Benefits
4. Scope of Partnership Certification or Approval of Compact-approved Policy

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1. REVISION OF MISSTATEMENT OF AGE PROVISION

APPLIES: §3.S. Misstatement of Age or Sex of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISION:

- (1) The policy shall contain a misstatement of age provision or, if the policy is written on a sex distinct basis, a misstatement of age or sex provision, providing that the amount payable as a benefit shall be such as the premium paid would have purchased at the correct age or the correct age and sex.

COMMENTS:

Industry Comment: The IAC requested that the IIPRC amend the Misstatement of Age or Sex provision to provide that a company may terminate coverage and refund premiums if the correct issue age of the insured is misstated at the time the policy is issued and is outside the issue age ranges of the policy. The commenters stated that for long-term care insurance, rate schedules are based on issue age ranges and if the correct age is beyond that age range, there is no benefit available to associate with the corrected issue age. Companies establish issue age limits due to such factors as ages beyond the issue age range do not provide sufficient funding periods, increased claim exposure and greater probability of adverse health conditions.

The IAC provided an example of a company that has approved rates only to issue age 79. Two applicants age 80 apply for a policy and the first discloses his age and is declined coverage, while the other lists his age as 77 and coverage is issued. They note that this situation penalizes the applicant who discloses his correct age.

The IAC suggests the following addition to this provision:

- (2) The company may terminate coverage and refund premiums if the correct age, at the time of policy issue, is outside the issue age ranges of the policy.

IIPRC Office Comments/Observations: The IIPRC Office notes that this issue was brought to the PSC's attention shortly after the original adoption of the individual Long-Term Care Uniform Standards. During that time, Industry representatives indicated they did not notice that the provision did not allow for termination and refund for misstatement of age but that such provision are common in state-approved individual long-term care insurance products and that the Misstatement of Age and Sex provision in the individual Life Uniform Standards was likely used in the drafting process. The IAC explained that long-term care premiums are based on age at the time of issue and if there is no approved premium on file

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for individuals who misstate age, it would result in a rate deficiency and a potential for the need for rate increases. The IIPRC Office notes this issue was raised to the Product Standards Committee in 2011 and some regulators expressed concern that adding this termination provision for misstatement of age could result in the insured losing coverage at the time when it is needed most – when long-term care services are rendered. The PSC did not take action at the time to allow for a period of time for the uniform standards to be in effect as adopted. The IIPRC Office does receive inquiries from current and potential long-term care filers noting that this provision is different than what they have approved in individual long-term care insurance policies approved by states and in the marketplace.

IIPRC Office Recommendation: The IIPRC Office does not have a specific recommendation, but suggests that the PSC review whether member states allow policies to include a provision for termination and refund for misstatement of age and discuss the companies operational concerns that the current provision has affected the administration of products with approved issue age rate schedules.

IIPRC staff update following the May 10, 2016 and May 24 PSC Member Calls: The Committee discussed concerns with allowing termination of the policy at a time when the insured may need coverage most and questioned why the information could not be discovered during underwriting. PSC members note that as written, the provision allows for cancellation regardless of whether the age is incorrect due to a technical error, producer error or actual misrepresentation. The members also discussed whether there should be a time limit on when a company could cancel and refund premium. It was noted that actuaries may be able to provide some thoughts on how premiums and coverage could be calculated if the correct issue age was found to be beyond the issue age range.

The PSC has the following questions for which they seek Public Comment:

1. What is generally the maximum issue age for Long-term Care products?
2. How often do companies encounter circumstances where issue age is misstated?
3. What are usually the circumstances surrounding such misstatements (typographical error, agent error, knowing misrepresentation, etc.)
4. What underwriting practices are used to verify age? Is MIB used to verify age? What other processes are used?

The PSC is also requesting comment on the following proposed revision to the IAC suggestion:

For a policy that has been in force for less than two years, and prior to receiving notice of a claim, the company may terminate coverage and refund premiums if the correct age, at the time of policy issue, is outside the issue age ranges of the policy.

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IIPRC staff update following the June 25 PSC Public Call: The Industry Advisory Committee (IAC) noted that maximum issue age for long-term products that have a maximum issue age is generally between ages 75-79. They observed that it is a rare occurrence for the companies to not catch a misstatement of age beyond the maximum age during underwriting, but the companies believe it should be permissible to rescind coverage if the age is misstated and it is beyond the maximum issue age. It was noted that the provision is contained in some state approved products.

The Consumer Advisory Committee (CAC), commented that the Industry response included reasons for the misstatement of age that are due to circumstances beyond the applicant's control such as a company error and producer action, and therefore the consumer would bear the cost of their error. The CAC voiced opposition for this amendment.

When asked why insurers do not require proof of age as part of the application process. The IAC responded that the application asks for both date of birth and age in order to address potential errors. The IAC has discussed adding a disclosure on the application that states that if the age is misstated on the application, the company has a right to rescind coverage and suggested this as an alternative to explore

IIPRC Staff update following the July 5 PSC Member Call and PSC Final Recommendation: Following further discussion, members noted that the request from the IAC appears to address a concern that industry has not documented as actually occurring, that the provision as proposed by the IAC would hurt policyholders in situations where the insurer or agent was responsible for the error, and that the Incontestability provision already allows the insurer to rescind coverage and deny an otherwise valid claim if, for a policy in effect for less than 6 months, they can demonstrate a misrepresentation that is material to the acceptance for coverage. For these reasons, the PSC is not recommending any change to the Misstatement of Age or Sex provision.

IIPRC Staff update following the August 11 PSC Public Call: The Industry Advisory Committee withdrew their request for this change.

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2. ALLOWANCE FOR NON-DUPLICATION OF BENEFITS

APPLIES: § 3R. Limitations and Exclusions of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISION:

(1) The policy shall contain a provision indicating that benefits may not be limited or excluded by type of illness, treatment, medical condition or accident, except under conditions no less favorable to the insured than the following:

(a) Loss occurring within six months with respect to a preexisting condition or disease. A “preexisting condition” means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of an insured’s coverage.

(b) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as “Preexisting Condition Limitations.”

(c) Alcoholism and drug addiction.

(d) Illness, treatment or medical condition arising out of any of the following

(i) Declared or undeclared war or act of war;

Drafting Note: Companies may consider additional language and in that case the Interstate Insurance Product Regulation Commission shall use the following guidelines: Declared or undeclared war or act of war is understood to be military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by the insured, or civil war or community faction. Civil activity as a whole cannot be excluded, except for direct participation or instigation by the insured.

(ii) Participation in a felony, riot or insurrection or involvement in an illegal occupation;

Drafting Note: Companies may consider additional language and in that case the Interstate Insurance Product Regulation Commission shall use the following guidelines: an exclusion for riot or insurrection is limited to instigators and those pursuing participation and does not include civil commotion, disorder, injury as an innocent bystander, or injury for self-defense.

(iii) Active duty in the armed forces of any nation or international governmental authority or units auxiliary thereto or the National Guard or similar

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government organizations (except that this limitation or exclusion shall not be construed to deny an insured any statutory or regulatory rights to suspend coverage while serving in the armed forces of any nation or international governmental authority or units auxiliary thereto or the National Guard or similar government organizations and to resume coverage after such service on terms more favorable than an initial applicant for coverage, with a refund of the pro rata portion of any premium collected for the period of suspension). The company will refund any pro rata portion of any premium paid for the period that the insured was on active duty in the armed forces of any nation or international governmental authority or units auxiliary thereto or the National Guard or similar government organizations;

- (iv) Suicide, attempted suicide or intentionally self-inflicted injury;
- (v) Aviation (this exclusion applies only to non-fare-paying passengers).
- (e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
- (f) In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.
- (g) Sections 2.R(1)(a) through (h) are not intended to prohibit exclusions and limitations by type of provider.
- (h) Section 2.R(1)(a) through (h) are not intended to prohibit territorial limitations.

COMMENTS:

Industry Comment: The IAC and Northwestern Mutual Life Insurance Company requested that a provision for non-duplication of benefits be added to the Limitations and Exclusions in the Core Standards for Individual Long-Term Care Insurance Policies. Industry notes that it is becoming increasingly common for consumers to own or purchase more than one standalone or combination long-term care product, particularly because consumers need to stage their purchases or combine different kinds of coverage to fit within limited budgets. Multiple policies are also common when employees wish to supplement employer-sponsored coverage. They note that the growing need and increasing costs for long-term

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care and increased popularity of long-term care combination products may also make the practice of owning multiple long-term care products more prevalent.

In Northwestern Mutual's comments, the company notes that the sale of long-term care insurance has become part of the financial planning process to protect retirement assets and by purchasing multiple policies over time, consumers may benefit from increased flexibility in designing coverage that meets their specific needs and level of affordability. Allowing the sale of multiple policies also acts as an alternative to a replacement of inforce coverage. The company states that most long-term care insurance policies provide a pool of benefits so multiple policies can work together to extend coverage, since the combined benefit pools can be conserved for later use in a claim.

Under the Core Standards for Individual Long-Term Care Insurance Policies, a provision for coordination of benefits or non-duplication of benefit cannot currently be included in the policy and can lead to an insured being reimbursed in excess of expenses incurred and therefore will have less coverage available for future long-term care services. By not being able to coordinate the benefits available through more than one policy, the insured is more likely to exhaust coverage prematurely while there is still a need for long-term care. Industry indicates that there could be potential tax issues if insureds are receiving tax-free benefits from multiple tax qualified expense long-term care insurance reimbursement policies that exceed actual incurred expenses. Additionally, under Partnership long-term care policies, for every dollar of long-term care insurance benefits received, a Medicaid applicant is able to retain a dollar of additional assets and still qualify for Medicaid. If Partnership long-term care insurance policies do not provide for non-duplication of benefits, then in those cases where a claimant is paid benefits by multiple policies which are more than the actual expenses incurred, that difference results in a higher amount of assets protected. This means that these individuals could inappropriately shelter more assets from Medicaid with a greater amount of assets protected at a cost to the state Medicaid programs. And finally, the IAC notes that providing incentives where insureds will receive cash in addition to expense reimbursement could have a significant impact on morbidity results that could require future rate increases.

The IAC states that companies have implemented practices to provide consumer protections and avoid inappropriate sales of multiple policies including suitability standards, underwriting limits on the amount of total coverage that can be purchased by one insured and limiting commission payments for multiple policy sales.

The IAC notes that multiple policy sales are not prohibited in the NAIC Long-term Care Insurance Model Regulation #641. Section 6.B. Limitations and Exclusions of the Model allows for exclusion or limitation for "(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy."

IIPRC Office Comments/Observations: The IIPRC Office notes that the exclusion or limitation for expenses for services paid under another long-term care insurance policy was deleted from the Uniform Standards based on a comment from a Commission Member, prior to adoption. At that time, the PSC noted that they believed that generally there was

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no need for a coordination of benefits between individual policies since the premiums paid were intended to be based on the benefits provided under that policy. The PSC noted at that time, that the application and underwriting processes provide means to address fraud.

IIPRC Office Recommendation: The IIPRC Office notes that it appears underlying assumptions and circumstances have changed since the Uniform Standards were adopted. As noted by the IAC, there have been shifts in the types of long-term care products sold and consumers are purchasing multiple policies to provide broader benefits as their financial situation allows and as the cost of long-term care needs grow. The IAC and Northwestern Mutual have identified critical reasons that non-duplication of benefits contract language would protect consumers and allow for continued benefits when most needed. The NAIC Long-Term Care Model Regulation #641 allows for exclusions or limitations for services paid under another health insurance or long-term care insurance contract. The IIPRC Office recommends that PSC review their current state practices and consider the following revision to Section 3. R. Limitations and Exclusions as suggested by the IAC:

- (f) expenses for services or items available or paid under another long-term care or health insurance policy. A policy form may include a non-duplication of benefits provision that states that the benefits provided for allowable expenses under all long-term care insurance policy forms covering the insured do not exceed the actual expenses incurred for the covered services or items. If included, the provision shall describe how the ratio will be calculated to determine the proportional benefits that would be paid on a pro-rata basis under the policy form

IIPRC staff update following the May 10, May 24 and June 7, 2016 PSC Member Calls:

The Committee raised concerns about how non-duplication provisions would be coordinated, given the broad proposed language for the standard stating that “the provision shall describe how the ratio will be calculated to determine the proportional benefits that would be paid on a pro-rata basis under the policy form.” They questioned what would happen if two companies had very different methods of determining the pro-rata benefit or if one company had a provision and the other company did not, and whether the proposed language allowed the company to require the consumer to submit a claim for benefits under other policies or riders. Some members expressed the view that proper underwriting at the point of sale and suitability would be the preferred way to address instances where more than one policy is in effect, while others stated that they understood the concern expressed by Industry; however as written, the consumer is caught in the middle. The Committee noted that if the provision applied to long-term care riders as well as policies, the consumer might be forced to utilize rider provisions that decrease the death benefits on a life policy because another company had a provision allowing for only a pro-rata portion of a long-term care expense.

Some members commented that they would consider a provision that established more specific parameters, allowed the consumer the option of submitting a claim to more than one insurer so

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the consumer could control when benefits are exhausted and planning for future long-term care needs, and was limited to the same or affiliated insurers so the provisions in the policy would be more likely to coordinate.

The PSC seeks more specific detail about how benefits are coordinated and how Industry would address the concerns expressed by the PSC. In addition to the concerns noted above, the PSC seeks input on the following:

1. Does the suggested non-duplication provision apply to both indemnity and reimbursement (expense incurred) policies? The PSC has concerns with non-duplication provisions applying to a policy that pays a set amount regardless of expenses. If this is included, why would it be appropriate?
2. Can you provide more specific, non-anecdotal data/information on the frequency of policyholders having more than one LTC policy? How often are there two or more reimbursement policies?
3. Do companies require the insured to submit the claim to all insurers or does the insured have a choice? (for example if the second policy is a life rider, can the insured choose not to present a claim to the second insurer so the death benefit is not lowered)
4. Why can't the concern with excessive coverage be addressed via application questions, suitability requirements and underwriting review?
5. What feedback does the IAC have regarding the suggested language from the Consumer Advisory Committee dated April 7, 2016? (Listed below)

Section 3. R. Limitations and Exclusions

(f) Expenses for services available or paid for under a similar policy form issued by this company but only if: 2

1. This policy permits accumulation of benefits deferred due to this exclusion;
2. The application non-duplication of benefit provisions does not reduce benefits provided under this policy and the similar policy form to less than the total amount of expenses for services or items for which benefits are otherwise available or payable for under both policies; and
3. The similar policy form complies with the following:
 - a. It has no non-duplication of benefits provision or has a non-duplication provision that reciprocates with this policy provision on a prorated basis.
 - b. It permits accumulation of benefits deferred due to application of a non-duplication of benefits provision, if any.

IIPRC staff update following the June 21 PSC public call: The IAC provided written responses to the PSC's questions. When asked if there was a refund of premium if a carrier was

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not going to pay benefits due to non-duplication of benefits, they noted that there is no refund of premium, since the purpose is to pay no more than 100% of the eligible incurred expense, and the insurer still pays its pro-rata share. In follow up, the IAC said they would verify whether premiums reflect savings for adding a non-duplication provision. Senator Hackett, Ohio, noted that controlling costs in long-term care insurance is very important and consumers should have a choice to purchase as much coverage as they believe is needed. At the same time, both consumers and companies must be protected. The CAC, urged the PSC to consider the CAC's January comment letter and refer the matter to the NAIC for consideration. They are opposed to adding a non-duplication of benefits provision and did not agree with the language proposed in the IAC's most recent letter.

IIPRC staff update following the July 5 PSC member call and PSC recommendation:

IIPRC staff summarized two revised options following the public call; one suggested by the IAC that limited the provision to the same insurer or its affiliates and specifically states that the provision does not reduce the maximum total amount of benefits payable, and the second, to address regulator concerns regarding including riders in the proposal, that additionally adds a provision that the company cannot require the use of long-term care benefits only in the form of an acceleration of the death benefit rider. Several members noted that the request for this provision did not contain any indication that prorating benefits would result in lower rates. It was noted that although the proposed new provision is labeled a Non-duplication of Benefits provision, it does not look like normal non-duplication of benefits, which usually relates to not selling duplicative coverage rather than coordinating benefits at the time of claim. The PSC agreed that the requested provision is more of a coordination of benefits, but lacks specificity. It was noted that the suggested language states that "the provision shall describe how the ratio will be calculated," rather than including a required method of calculation in standards. It was also noted that under Other Insurance with this Insurer provision of accident and sickness coverage, there is a refund of premiums for the excess insurance and this proposed standard contains no such premium adjustment. When asked whether states prohibit coordinating benefits in long-term care, some members responded that they did prohibit and others indicated that they look at coordination for the medical services aspects of long-term care as in the Coordination of Benefits Model, but there is nothing specific for non-duplication or for coordination of custodial care benefits in long-term care.

The PSC observed that there was insufficient documentation of the need for such a provision; the purpose of the nonduplication provision in the NAIC Model did not appear to be to coordinate benefits; the request was more of a coordination of benefits than a limitation or exclusion for duplicative benefits; the recommended language did not detail how benefits would be coordinated, and the issue of coordination of benefits for long-term care has not been fully vetted through regulators and the NAIC Long-term Care Models at this point. For those reasons, the PSC is not recommending the IAC requested change.

SUBSTANTIVE CHANGE ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

3. RATE REQUIREMENTS FOR DOLLAR-FOR-DOLLAR LONG-TERM CARE BENEFITS

APPLIES: Scope of the [Rate Filing Standards for Individual Long-Term Care Insurance -Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISION:

Scope: These standards apply to initial rates and subsequent filings to increase premium rate schedules for individual long-term care insurance. Any product advertised, marketed or offered as long-term care insurance shall be subject to these standards when only issue age rate schedules are available. Long-term care insurance shall provide benefits for one or more of the following: nursing home care, assisted living care or home health care and adult day care. These standards apply to all policies, riders, endorsements and amendments subject to the Core Standard for Individual Long-Term Care Insurance Policies adopted by the Interstate Insurance Product Regulation Commission, except for the following long-term care products to which no specific rate standards apply:

(1) Life insurance policies that permit payment of all or part of the death benefit when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of reduction in death benefits (for flexible premium adjustable life products, the death benefit may be one of the death benefit options described in the Interstate Insurance Product Regulation Commission standards for such products); and

(2) Annuity contracts that provide for the waiver of any applicable surrender or withdrawal charges upon payment of all or part of the account value when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of permanent reduction in the account value.

COMMENTS:

Regulator Comment: The Kentucky Department of Insurance commented that in contrast to the IIPRC Standards' requirements, the NAIC Long-Term Care Insurance Model Regulation #641 requires an Actuarial Certification and Memorandum for the initial rate filing of dollar-for-dollar long-term care insurance. Further, the Model Regulation requires an Actuarial Memorandum for subsequent filings for premium rate schedule increases on incidental long-term care benefits (Section 20. Subsection J. and Section 20.1 Subsection J.). Similar initial filing requirements are found in Kentucky Regulation 806 KAR 17:081 Section 7. and subsequent filing requirements in 806 KAR 17:081 Section 17. Subsection 10.

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Kentucky noted that in their opinion circumstances have changed since the IIPRC Standards were adopted and these changes cause concern over the exemption for dollar-for-dollar long-term care insurance from Actuarial Submission Requirements. These changes in circumstances include:

- The availability of dollar-for-dollar long-term care insurance which utilizes distinct maximum guaranteed rates that are subject to company discretion as opposed to falling under the maximum cost of insurance (COI) of the underlying insurance.
- The need for rate increases to sustain long-term care insurance coverage has become more and more the reality.
- Dollar-for-dollar long-term care insurance is being increasingly purchased as a lower cost alternative to stand-alone long-term care coverage.
- An extended low interest rate environment has caused lower policy crediting rates and hence lower policy values thereby increasing the policyowners' cost above that which was anticipated at the time of issue.

Kentucky states that this last change in circumstances is evidenced by the problem they have experienced on Universal Life (UL) insurance products. There have been a number of complaints about UL to Kentucky's consumer protection division. Even though the policyowner made the planned premium payments, when interest rates declined the policies that were sold based on minimum or underfunded premium patterns began to lapse and policyowners lost valuable life insurance protection. Kentucky believes that thinly funded ULs are very typical in the marketplace. By the time the policy enters the grace period, the required premiums to keep the policy in force are typically out of reach for most policyowners. This situation can be exacerbated by inadequate initial dollar-for-dollar long-term care insurance rates. Whether the dollar-for-dollar long-term care insurance rates are explicit or implicit (i.e. embedded within the COI rates), if such rates need to be increased on in-force policies due to an underestimation of the utilization of this form of acceleration of the death benefit, these policies will lapse earlier and possibly at a time when the coverage is needed most.

Kentucky notes that no consumer buys insurance with an expectation that the rates being charged are unsustainable. It is therefore important to have Standards in place that promote rate sustainability. They believe the rates for dollar-for-dollar long-term care coverage will be more sustainable when they are subject to the same Actuarial Submission Requirements as the Standards that apply to the rates for other Long-term Care insurance. It is this belief that drives their need to request this amendment to no longer exempt dollar-for-dollar long-term care insurance from IIPRC Standards.

Industry Comments: In their written comments, the IAC noted Kentucky's concerns and indicated they were continuing to work with the state on recommendations and suggests that the Scope language be revised to say these specific standards do not apply.

IIPRC Office Comments/Observations: The IIPRC Office notes that recent revisions to Model 641 did not impact these products, and the Model does not address specific

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requirements for dollar-for-dollar products. The Office is not aware of any issues or concerns that have been raised previously related to the exemption. At the time of adoption of this provision in 2011, the PSC believed that the current rate standards were not appropriate for these products.

IIPRC Office Recommendation: The IIPRC Office does not have a specific recommendation but suggests the PSC, with input from the Actuarial Working Group, consider whether the concept of “Incidental,” as used in Sections 20J and 20.1J of the NAIC Model Regulation #641 would address the concerns or if separate standards should be developed based upon common state requirements and practices with respect to dollar-for-dollar products with rates. If separate standards are considered, the PSC may also wish to consider the following revision suggested by the IAC:

These standards apply to all policies, riders, endorsements and amendments subject to the Core Standard for Individual Long-Term Care Insurance Policies adopted by the Interstate Insurance Product Regulation Commission, except for the following long-term care products to which ~~no~~ specific rate standards do not apply:

IIPRC staff update following the June 7 PSC Member Call: Representatives from Kentucky provided an overview of their comments and presented a draft of proposed new uniform rate standards for dollar-for-dollar products that they worked on with the IAC. IIPRC staff questioned whether it might be less confusing to add a section to the existing rate standards to address the concerns, and also suggested seeking input from the Actuarial Working Group. IIPRC staff drafted revisions to the Rate Filing Standards for Individual Long-Term Care Insurance -Issue Age Rate Schedules Only that included Kentucky’s suggested changes for the AWG to review.

IIPRC staff update following the July 12 and July 26, 2016 AWG calls: IIPRC staff drafted revisions to the Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only that included Kentucky’s suggested changes for the AWG to review and the AWG discussed the revisions and additional changes with representatives from the Kentucky Department of Insurance. The PSC is seeking comment on the draft revisions to the Rate Filing Standards for Individual Long-Term Care Insurance -Issue Age Rate Schedules Only that has been distributed for the August 11, 2016 Public Call. To assist in the review, the redline draft also includes the proposed amendments based on Model Regulation #641 revisions that are recommended as part of this Five Year Review.

IIPRC Staff Update Following the August 11th PSC Public Call: The PSC received written suggested edits from the Kentucky Department of Insurance and the Industry Advisory Committee (IAC). Following receipt of oral comments from representatives of

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the Kentucky Department of Insurance, the IAC withdrew all of their comments except 3\$ in the written document.

IIPRC Staff Update Following the August 16th PSC and AWG Member Call and final PSC recommendation: The PSC reviewed the draft revisions to the Rate Filing Standards for Individual Long-Term Care Insurance -Issue Age Rate Schedules Only and the revision to the Scope of the Rate Filing Standards For Individual Long-Term Care Insurance - Modified Rate Schedules to state that the Rate Filing Standards for Individual Long-term Care Insurance Issue Age Rate Schedules Only apply to dollar-for-dollar long-term care insurance products, and agreed to recommend to the Management Committee that these proposed amendments be considered. The detailed revisions to the Rate Filing Standards for Individual Long-Term Care Insurance -Issue Age Rate Schedules Only, including the suggested amendments due to the Model Regulation Change Items, are included as Appendix 2 to this report.

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4. SCOPE OF PARTNERSHIP CERTIFICATION OR APPROVAL OF COMPACT-APPROVED POLICY

APPLIES: Scope of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISIONS:

Scope: These standards apply to individual long-term care insurance. Any product advertised, marketed or offered as long-term care insurance shall be subject to these standards. Long-term care insurance shall provide benefits for one or more of the following: nursing home care, assisted living care or home health care and adult day care. Only those policies, riders, endorsements or amendments that provide all such benefits may be titled “long-term care insurance” without further clarification. Policies, riders, endorsements or amendments that provide less than all such benefits shall be titled appropriately to indicate to the owner the types of coverages available under the policy, and may be filed and approved under these standards.

Partnership: Approval by the Interstate Insurance Product Regulation Commission (“IIPRC”) of long-term care insurance product filings in compliance with one or more of the Uniform Standards for Individual Long-Term Care Insurance shall not be deemed as approval to use or provide any component of the product filing pursuant to any federal or state Individual Long-Term Care Insurance Partnership

COMMENTS:

Regulator Comment: The State of Oregon Insurance Division stated that specific State partnership content requirements for Individual Long-term Care Partnership policies should apply to Individual Long-term Care Partnership policy forms submitted to the IIPRC for review and approval and policy review standards should align with the NAIC Model Act #640 and related Model Regulation #641.

IIPRC Office Comments/Observations: During the initial drafting of the long-term care insurance Uniform Standards, there was considerable discussion about partnership policies as well as a survey of state practices in approving Partnership policies. Ultimately the PSC concluded that the IIPRC is not authorized to approve a policy for use as a federal or state Partnership form, but will approve the product content. An IIPRC approved policy may be eligible for use as a Partnership form, provided that the policy meets the Partnership coverage requirements of each state where it is intended for use as a Partnership form. Filing companies use variability to conform an IIPRC-approved policy to state-specific Partnership requirements and continue to make all required single-state filings necessary to achieve Partnership status.

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IIPRC Office Recommendation: The IIPRC Office has not received indications from other member states that the product content approved by the IIPRC is problematic for approving partnership policies. Allowing for different product content requirements based on state requirements would be contrary to the uniformity goals of the IIPRC. The IIPRC Office suggests soliciting feedback from Compacting States and industry filers to understand if the current approach for certifying or approving Compact-approved products for use in partnership programs has caused non-compliance with the requirements of a state's partnership program requirements.

IIPRC staff update, May 26, 2016 and final PSC recommendation: Upon further review, Oregon has determined that the state has a process in place to address the matter and is not seeking a change to the partnership provisions in the Uniform Standards. For this reason, the PSC is not recommending any change.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

Clarification Items

Clarification items are proposed edits to clarify the meaning, application, and/or intent of a provision in the Uniform Standard. Clarification items would not change the meaning or effect of the provision or the current application and interpretation of the provision or Uniform Standard but would provide further or detailed explanation, description, or specification to the language in the Uniform Standard. The clarification items are compiled not only from suggestions or issues in the Comments but also from questions, issues, and circumstances that have arisen in the application and interpretation of the Uniform Standards by the IIPRC product and actuarial reviewers.

List of Clarification Items

1. Long-term Care and Accelerated Death Benefits
2. Definition of Long-term Care
3. Rate Schedule Increase Filings
4. Premium Variances and Administrative Expenses
5. Actuarial Memorandum Content
6. Annual Rate Certification Requirements – Period Of Sales
7. Shoppers Guide to Long Term Care Insurance
8. Similar Policy Forms – Definition
9. Outline of Coverage – Definitions of Policy and Rider
10. Outline of Coverage – Use of the Term “Form”

CLARIFICATION ITEMS

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1. LONG-TERM CARE AND ACCELERATED DEATH BENEFITS

APPLIES: Scope of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISION:

Scope: These standards apply to individual long-term care insurance. Any product advertised, marketed or offered as long-term care insurance shall be subject to these standards. Long-term care insurance shall provide benefits for one or more of the following: nursing home care, assisted living care or home health care and adult day care. Only those policies, riders, endorsements or amendments that provide all such benefits may be titled “long-term care insurance” without further clarification. Policies, riders, endorsements or amendments that provide less than all such benefits shall be titled appropriately to indicate to the owner the types of coverages available under the policy, and may be filed and approved under these standards.

COMMENTS:

Industry Comment: The IAC suggests adding a new paragraph following the first paragraph in the Scope of the Core Standards for Individual Long-Term Care Insurance Policies to clarify that for accelerated death benefits that are advertised, marketed, offered or designed as providing coverage for long-term care services, these standards apply but in addition Additional Standards for Accelerated Death Benefits will apply as applicable. They note that the Scope of the Additional Standards for Accelerated Death Benefits states that “if the payment of accelerated death benefit is contingent upon receipt of long-term care services or supports” those standards do not apply. The IAC states that it is their understanding that a combination product using an accelerated death benefit to fund long-term care insurance would have to comply with both standards as applicable. Some standards from each product may not apply but both sets of standards would be used for guidance. The IAC used rate standards not applying to such products as an example.

IIPRC Office Comment/Observation: The IIPRC Office notes that its practice is to review product filings using the specific applicable uniform standards. A long-term care accelerated death benefit rider is reviewed using the applicable long-term care uniform standards. If the payment of accelerated death benefit is not contingent upon receipt of long-term care services or supports and the product is not advertised as long-term care insurance, than the filing would be reviewed under the Additional Standards for Accelerated Death Benefits.

IIPRC Office Recommendation: The IIPRC Office recommends the following additional language be added to the Scope of the Standard for clarification. The IIPRC Office does not recommend the additional language suggested by the IAC that says the Additional

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

Standards for Accelerated Death Benefits may also apply as the applicability of this Uniform Standard and the individual long-term care insurance Uniform Standards are mutually exclusive and the Additional Standards for Accelerated Death Benefits is for the incidental life benefit feature.

With regard to accelerated death benefits that are advertised, marketed, offered or designed as providing coverage for long-term care services, these standards shall apply.

IIPRC staff update following the July 5, 2016 call and final PSC recommendation:

Pennsylvania asked if the words “or designed” could be eliminated for consistency with other Uniform Standards and the NAIC Long-term Care Model Act. The PSC agreed to the following revision to the recommendation:

With regard to accelerated death benefits that are advertised, marketed or offered ~~or designed~~ as providing coverage for long-term care services, these standards shall apply.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

2. DEFINITION OF LONG-TERM CARE

APPLIES: Definitions in the [Core Standards for Individual Long-Term Care Insurance Policies](#)

CURRENT PROVISION:

“Long-term care insurance” is any insurance policy, rider, endorsement or amendment advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, unless the area of the hospital or unit where the services are provided is licensed or certified as a nursing care facility and the insured is receiving long-term care services and not acute care. The term includes:

- individual annuities, disability income and life insurance policies, riders, endorsements or amendments that provide directly or supplement long-term care insurance;
- policies, riders, endorsements or amendments that provide for payment of benefits based upon cognitive impairment or the loss of functional capacity; and
- qualified long-term care insurance policies.

The term shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to disability income, this term does not include disability income policies, riders, endorsements or amendments having indemnity benefits that are triggered by activities of daily living unless (1) the benefits are dependent upon or vary in amount based on the receipt of long-term care services; (2) the policy or rider, endorsement or amendment is advertised, marketed offered or designed as coverage for long-term care services; or (3) benefits under the policy, rider, endorsement or amendment may commence after the insured has reached Social Security’s normal retirement age, unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

With regard to life insurance, this term shall not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or

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permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

With regard to annuities, this term shall not include annuity contracts that include a waiver of surrender charges for an annuitant who needs long-term care services, provided that the waiver is unrelated to the amount of charges incurred for the long-term care services, there is no separate premium for the waiver, and the annuity contract or waiver of surrender charges benefit is not advertised, marketed offered or designed as coverage for long-term care services.

COMMENTS:

Industry Comment: The IAC suggests that based on revisions made to the Additional Standards for Accelerated Death Benefits, the definition of individual long-term care insurance should be further refined to state that it does not include life insurance policies that accelerate the death benefit for chronic illness, with specific definitions of chronic illness taken from the accelerated death benefit uniform standard. They further suggest that the definition specify that for annuities the term does not include guaranteed living benefits with guaranteed withdrawal increase for certain qualifying events to reflect revisions to the Additional Standards for Guaranteed Living Benefits. The IAC has suggested the following changes:

With regard to life insurance, this term shall not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness; ~~medical conditions requiring extraordinary medical intervention; or permanent institutional confinement;~~ chronic illness defined as permanent inability to perform a specified number of activities of daily living, or permanent severe cognitive impairment and similar forms of dementia; chronic illness as prescribed in the requirements of IRC Section 7702B and IRC Section 101(g); and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

With regard to annuities, this term shall not include annuity contracts that include: (a) a waiver of surrender charges for an annuitant who needs long-term care services, provided that the waiver is unrelated to the amount of charges incurred for the long-term care services, there is no separate premium for the waiver, and the annuity contract or waiver of surrender charges benefit is not advertised, marketed offered or designed as coverage for long-term care services; and (b) a guaranteed living benefit (GLB) with a guaranteed withdrawal increase for specifically one or more qualifying events of medical condition that is reasonably expected to result in a drastically limited life span; receipt of care in a health care facility; inability to perform a specified number of activities of daily living; cognitive impairment; and

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where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

IIPRC Office Comments/Observations: The IIPRC Office notes that during Phase One of the five-year review process, amendments were adopted for the Additional Standards for Accelerated Death Benefits on August 15, 2014 that incorporated current Internal Revenue Code provisions regarding chronic illness definitions for federally tax-qualified products. Chronic illness was included as a qualifying event at the time of original adoption of the Uniform Standard; however this type of chronic illness qualifying event was not listed in the exceptions to the definition of long-term care insurance. The amendments to the Additional Standards for Guaranteed Living Benefits as proposed December 9, 2015 include the qualifying events referenced in the IAC's request.

IIPRC Office Recommendation: The IIPRC Office recommends the following revisions to the definition of long-term care insurance to provide clarity regarding which products are subject to the long-term care insurance uniform standards and which products are treated as incidental life and/or annuity benefit features. Since the other qualifying event triggers for accelerated death benefits were not defined within the exception, the IIPRC Office does not believe detailed definitions are required for chronic illness.

“Long-term care insurance” is any insurance policy, rider, endorsement or amendment advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, unless the area of the hospital or unit where the services are provided is licensed or certified as a nursing care facility and the insured is receiving long-term care services and not acute care. The term includes:

- individual annuities, disability income and life insurance policies, riders, endorsements or amendments that provide directly or supplement long-term care insurance;
- policies, riders, endorsements or amendments that provide for payment of benefits based upon cognitive impairment or the loss of functional capacity; and
- qualified long-term care insurance policies.

The term shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection

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coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to disability income, this term does not include disability income policies, riders, endorsements or amendments having indemnity benefits that are triggered by activities of daily living unless (1) the benefits are dependent upon or vary in amount based on the receipt of long-term care services; (2) the policy or rider, endorsement or amendment is advertised, marketed offered or designed as coverage for long-term care services; or (3) benefits under the policy, rider, endorsement or amendment may commence after the insured has reached Social Security's normal retirement age, unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

With regard to life insurance, this term shall not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, chronic illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

With regard to annuities, this term shall not include (a) annuity contracts that include a waiver of surrender charges for an annuitant who needs long-term care services, provided that the waiver is unrelated to the amount of charges incurred for the long-term care services, there is no separate premium for the waiver, and the annuity contract or waiver of surrender charges benefit is not advertised, marketed offered or designed as coverage for long-term care services.; and (b) a guaranteed living benefit (GLB) with a guaranteed withdrawal increase for qualifying events of medical condition that is reasonably expected to result in a drastically limited life span; inability to perform two or more activities of daily living; cognitive impairment; and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care services.

IIPRC Staff Update following the July 5 PSC member call: PA suggests the revision below, which they believe would be more in line with the recently revised GLB scope language:

With regard to annuities, this term shall not include (a) annuity contracts that include a waiver of surrender charges for an annuitant who needs long-term care services, provided that the waiver is unrelated to the amount of charges incurred for the long-term care services, there is no separate premium for the waiver, and the annuity contract or waiver of surrender charges benefit is not advertised, marketed offered or designed as coverage for long-term care services.; and (b) a guaranteed living benefit (GLB) with a guaranteed withdrawal increase for qualifying events permitted under the applicable IIPRC annuity standard. ~~of medical condition that is reasonably~~

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~~expected to result in a drastically limited life span; inability to perform two or more activities of daily living; cognitive impairment; and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care services.~~

IIPRC staff update following the July 19, 2016 call and final PSC recommendation: The PSC agreed to the following modified language:

With regard to life insurance, this term shall not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, chronic illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

With regard to annuities, this term shall not include (a) annuity contracts that include a waiver of surrender charges for an annuitant who needs long-term care services, provided that the waiver is unrelated to the amount of charges incurred for the long-term care services, there is no separate premium for the waiver, and the annuity contract or waiver of surrender charges benefit is not advertised, marketed offered or designed as coverage for long-term care services; and (b) a guaranteed living benefit (GLB) with a guaranteed withdrawal increase for qualifying events permitted under the applicable IIPRC annuity standard.

CLARIFICATION ITEMS

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3. RATE SCHEDULE INCREASE FILINGS

APPLIES: Preface to §4 Additional Submission Requirements for [Rate Schedule Increase Filings of the Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISION:

The following additional submission requirements apply to rate schedule increase filings that apply to in-force policies for individual long-term care insurance:

COMMENTS:

Industry Comments: The IAC suggests adding a parenthetical to this provision clarifying what a rate schedule increase filing is.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any questions or filer comments regarding this provision.

IIPRC Office Recommendation: The IIPRC Office is not opposed to the following parenthetical for clarity:

For Rate Filing Standards for Individual Long-Term Care Insurance Issue Age Rate Schedules Only:

The following additional submission requirements apply to rate schedule increase filings [\(i.e. a change to an approved Issue Age Rate Schedule that results in a new, higher Issue Age Rate Schedule\)](#) that apply to in-force policies for individual long-term care insurance:

For Rate Filing Standards for Individual Long-Term Care Insurance Modified Rate Schedules:

The following additional submission requirements apply to rate schedule increase filings [\(i.e. a change to an approved Modified Rate Schedule that results in a new, higher Modified Rate Schedule\)](#) that apply to in-force policies for individual long-term care insurance:

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:
The PSC agreed to the recommendation.

CLARIFICATION ITEMS

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4. PREMIUM VARIANCES AND ADMINISTRATIVE EXPENSES

APPLIES: §1A.(2) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISION:

A. GENERAL

The Interstate Insurance Product Regulation Commission will review rate filings for individual long-term care insurance policies and may disapprove any rate filing for one or more of the following reasons:

- (1) The premiums charged are unreasonable in relation to the benefits provided, excessive, inadequate, or unfairly discriminatory;
- (2) The provisions permit the company to vary premiums for insureds, and the variances are not based upon sound underwriting and sound actuarial principles reasonably related to actual or reasonably anticipated loss experience;

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office notes that generally, rates are not unfairly discriminatory if the rate differentials reflect differences in expected losses or expenses. The IIPRC Office has permitted discounts based on administrative savings and adding this to the general criteria for rate review would provide further clarity. The IIPRC Office notes that this clarification was added to the recently adopted Group Disability Income Insurance Rate Uniform Standards.

IIPRC Office Recommendation: The IIPRC Office recommends that the PSC consider adding “or expenses” to the end of §1A.(2) to clarify variances in premiums are based on sound underwriting and sound actuarial principles that are reasonably related to actual or reasonably anticipated loss experience and also to expenses.

- (2) The provisions permit the company to vary premiums for insureds, and the variances are not based upon sound underwriting and sound actuarial principles reasonably related to actual or reasonably anticipated loss experience or expenses;

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:
The PSC agreed to the recommendation.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

5. ACTUARIAL MEMORANDUM CONTENT

APPLIES: §2.B.(3) of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#)

CURRENT PROVISION:

B. ACTUARIAL SUBMISSION REQUIREMENTS

- (3) An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall address and support each specific item required as part of the actuarial certification, comply with Actuarial Standard of Practice (ASOP) 18 and provide at least the following information:
- (a) An explanation of the review performed by the actuary prior to making the statements in § 2B(1)(b) and § 2B(1)(c);
 - (b) A complete description of pricing assumptions;

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

- (c) Sources and levels of margins, incorporated into the gross premiums determined in § 2B(3)(b) above that are the basis for the statement in § 2B(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Significant deviations in margins between ages, sexes, plans or states shall be clearly described. Significant deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales;
- (d)
 - (i) A complete description of those situations, if any, where the difference between the gross premium and the net valuation premium for renewal years is not sufficient to cover expected renewal expenses; and
 - (ii) A table of sample ages and coverages (including inflation and non-inflation) demonstrating the extent and the results of this review;

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- (e) A complete description of any morbidity improvement assumption used in pricing or reserves for the product together with the rationale for the assumption and its effect on premium and reserve levels; and

Drafting Note: At the time of drafting these standards, the Interstate Insurance Product Regulation Commission generally does not believe that sufficient credible data on insured experience is available to justify the use of morbidity improvements in pricing or reserve assumptions but cannot be sure that it cannot be produced in the future. As noted in the NAIC Health Insurance Minimum Reserve Model Regulation (Model #10), “Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction in [premiums or] reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred, and that is able to be evaluated and quantified. This last sentence is intended to provide allowances for a known event, such as a new drug release, but at the time of this writing, there are no specific examples that could be pointed to in the recent past that would have met this standard. **This is intended to be an extremely rare event.**” [emphasis supplied]

- (f) A comparison of the premium rates with issue age rate schedule rates, at a reasonable selection of ages, for similar policy forms and comparable premium-paying periods also available from the company. The actuary should describe the situations where the premium rate schedules are less than those for existing products and detail the differences and testing done by the actuary to determine that the filed premiums are not inadequate.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office notes that new filers frequently overlook the certifications that are required under the Core Standards for Individual Long-term Care Insurance Policies related to nonforfeiture and inflation protection requirements and this can delay the review process. These certifications, when received, are normally from the company actuary. It would clarify the requirements and speed review if the actuarial memorandum requirements include information related to these certifications.

IIPRC Office Recommendation: The IIPRC Office recommends that the PSC consider adding the following provisions to the actuarial memorandum requirements in § 2.B.(3):

- (g) Descriptions supporting the certification prepared, dated and signed by a member of the American Academy of Actuaries, required under §1B.(2) of the Core Standards for Individual Long-term Care Insurance Policies, that the nonforfeiture and contingent nonforfeiture benefits offered or provided under the policy are in compliance with the requirements of § 8, Nonforfeiture Benefits, of the Model Act and with § 28D and E,

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Nonforfeiture Benefit Requirement, of the Model Regulation or § 28K thereof. This requirement shall not apply to life insurance policies that provide long-term care benefits only in the form of an acceleration of the death benefit.

- (h) Descriptions supporting the certification prepared, dated and signed by a member of the American Academy of Actuaries or a company officer required under §1.B.(3) of the Core Standards for Individual Long-term Care Insurance Policies, that an inflation protection benefit offered or provided under the policy is in compliance with the requirements of § 13A and F, Requirement to Offer Inflation Protection, of the Model Regulation. This requirement does not apply to life insurance policies that provide long-term care benefits only in the form of an acceleration of the death benefit.

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:

The PSC agreed to the recommendation.

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6. ANNUAL SUBMISSION REQUIREMENTS – PERIOD OF SALES

APPLIES: § 3B. of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

CURRENT PROVISION:

B. ACTUARIAL SUBMISSION REQUIREMENTS

- (1) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:
 - (a) A statement of the sufficiency of the premium rate schedule approved by the Interstate Insurance Product Regulation Commission including:
 - (i) For the rate schedules currently marketed,
 - a. The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or
 - b. If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the company shall provide to the IIPRC, within 60 days of the date the actuarial certification is submitted to the IIPRC, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience. Failure to submit a plan of action to the IIPRC within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the IIPRC to withdraw or modify its approval of the Product Filing pursuant to Section 108 of the Operating Procedure for the Filing and Approval of Product Filings.

Drafting Note: When a company files a statement that margins for moderately adverse experience may no longer be sufficient, the IIPRC will immediately notify each Compacting State where the premium rate schedule applies.

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

CLARIFICATION ITEMS

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- a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or
 - b. That the premium rate schedule may no longer be sufficient. In this situation, the company shall provide to the IIPRC, within 60 days of the date the actuarial certification is submitted to the IIPRC, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.
- (b) A description of the review performed that led to the statement and disclosure of any planned management action relating to this statement.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office notes that it is difficult to identify and review the annual rate certification and statement of sufficiency of the premium rate schedule if the policy form to which the statement applies and the start and where applicable, end issue dates are not identified. The period of sales is particularly important when rates have been refreshed since the initial filing, since separate certifications are required for currently marketed and previously marketed products.

IIPRC Office Recommendation: The IIPRC Office recommends that the PSC consider adding the following provisions to the actuarial certification requirements in § 2.B.(3):

B. ACTUARIAL SUBMISSION REQUIREMENTS

- (1) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:
 - (a) A statement of the sufficiency of the premium rate schedule approved by the Interstate Insurance Product Regulation Commission including: the policy form to which the statement applies, including the start and if applicable, end date of issue, and:

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:
The PSC agreed to the recommendation.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

7. SHOPPER’S GUIDE TO LONG-TERM CARE INSURANCE

APPLIES: § 3.L.(1)(a)(v) of the [Individual Long-Term Care Insurance Application Standards](#) and Appendix A (15) of the [Individual Long-Term Care Insurance Standards for the Outline Of Coverage](#)

CURRENT PROVISION:

L. AGREEMENTS

- (1) The application shall include the following statements agreed to by the applicant(s):
 - (a) That the applicant has received the following items, as applicable:
 - (i) Outline of Coverage;
 - (ii) Long-Term Care Insurance Personal Worksheet;
 - (iii) Things You Should Know Before You Buy Long-Term Care Insurance;
 - (iv) Potential Rate Increase Disclosure Form; and
 - (v) Shopper’s Guide to Long-Term Care Insurance;

APPENDIX A

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER’S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE

COMMENTS:

Industry Comments: The IAC suggests that “NAIC” be added to the beginning of item (1)(a)(v) in the Individual Long-Term Care Insurance Application Standards and to Appendix A of the Outline of Coverage Standards for consistency with other IIPRC standards, such as Appendix B of the Standards for Forms Required To Be Used With The Application. They note that both HIPAA and the Deficit Reduction Act (DRA) point to the NAIC Long-Term Care Model Regulation #641 APPENDIX C where “NAIC” is included when referring to the Shopper’s Guide, and the standards are intended to be based on the Model.

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Additionally, the APPENDIX B of the Standards for Forms Required to Be Used with the Application which refers to “NAIC” may be filed on a self-certification basis. When the Long-term care standards were first adopted, there was no discussion or contemplation of state variations for the Shopper’s Guide, and state variation requirements would put a wrinkle to the self-certification process for the Appendix, as well as opening up the other forms required to be used with the application to similar state variations, thus nullifying the self-certification process for these forms. The IAC does not believe that this is what was contemplated and urges clarification.

IIPRC Office Comments/Observations: The IIPRC Office agrees that the addition would provide clarification and promote uniformity and consistency. By adding the term NAIC, it would clarify that the uniform NAIC Shopper’s Guide to Long-Term Care Insurance would be delivered with the Compact-approved product which is based on Uniform Standards that reflect the requirements in the NAIC Long-Term Care Model Regulation.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider specifying that the referenced shopper’s guide is the NAIC Shopper’s Guide to Long-Term Care Insurance.

(v) NAIC Shopper’s Guide to Long-Term Care Insurance;

15. CONTACT THE STATE AGENCY LISTED IN THE NAIC’S A SHOPPER’S GUIDE TO LONG-TERM CARE INSURANCE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:
The PSC agreed to the recommendation.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

8. SIMILAR POLICY FORMS - DEFINITION

APPLIES: Definitions in Standards for Forms Required To Be Used With an Individual Long-Term Care Insurance Application

CURRENT PROVISION:

“Similar policy forms” means all of the long-term care insurance policies and certificates issued by the company in the same long-term care benefit classification as the policy being considered. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

COMMENTS:

Industry Comments: The IAC suggests that the reference to certificates is not appropriate for long-term care insurance. They also note that the long-term care benefit may be included as a rider attached to a life insurance policy or annuity, and such riders are subject to the long-term care standards, so referencing amendments, riders or endorsements would be more appropriate.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any questions from filers regarding this provision, but agrees that the addition suggested would add clarity.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revision to the definition of “Similar policy forms”:

“Similar policy forms” means all of the long-term care insurance policies and amendments, riders or endorsements ~~certificates~~ issued by the company in the same long-term care benefit classification as the policy being considered. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:
The PSC agreed to the recommendation.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

9. OUTLINE OF COVERAGE – DEFINITION OF POLICY AND RIDER

APPLIES: Definitions in [Individual Long-Term Care Insurance Standards for the Outline of Coverage](#)

CURRENT PROVISION:

There are currently no definitions of “Policy” and “Rider” in the Individual Long-Term Care Insurance Standards for the Outline of Coverage

COMMENTS:

Industry Comments: The IAC suggests adding definitions of “Policy” and “Rider” to the Individual Long-Term Care Insurance Standards for the Outline of Coverage so that it is clear that the requirements apply to a standalone long-term care policy as well as a long-term care rider issued with a life policy or an annuity. The IAC suggests the following definitions:

“Policy” means a long-term care insurance policy or rider providing long-term care insurance.

“Rider” means an endorsement, rider or amendment which provides long-term care insurance.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any questions from filers regarding this provision, but agrees that the addition suggested could add clarity.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the adding the following definitions of “Policy” and “Rider” to the Individual Long-Term Care Insurance Standards for the Outline of Coverage for clarity:

“Policy” means a long-term care insurance policy or contract providing long-term care insurance.

“Rider” means an endorsement, rider or amendment to a life insurance or annuity policy or contract which provides long-term care insurance.

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:

The PSC agreed to the recommended language proposed by the IIPRC office.

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

10. OUTLINE OF COVERAGE – USE OF THE TERM FORM

APPLIES: Appendix A of the [Individual Long-Term Care Insurance Standards for the Outline of Coverage](#)

CURRENT PROVISION:

Appendix A – Standard Format Outline of Coverage

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Form Number or Policy Number or Group Master Policy and Certificate Number]

Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied][will be attached to any issued policy][will be enclosed with any issued policy]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company.

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Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE.** This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–“free look” provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

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5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities and provider;
- (c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions and exceptions;
- (e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER’S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer’s disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

- [(a) Provide the premium rate schedule for the policy;
- (b) If the premium varies with an applicant’s choice among benefit options, indicate separately the annual premium that corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER’S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

COMMENTS:

Industry Comments: The IAC notes that in Appendix A, there are numerous errors in the references to group master policy and certificate. While these show up as options, this is not done consistently. The IAC suggests that the generic term “form” be used so that the Appendix is clearly applicable to standalone long-term care polices, group long-term care policies and certificates, and long-term care riders issued with life policies and annuity contracts.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any questions from filers regarding this provision. The Outline of Coverage in Appendix A follows the

CLARIFICATION ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

format prescribed in Section 33 of the NAIC Long-Term Care Insurance Model Regulation #641.

IIPRC Office Recommendation: The IIPRC Office has no specific recommendation, but suggests that the PSC discuss whether they wish to define the term “form” as suggested by the IAC for the Outline of Coverage in Appendix A and use the term in lieu of references to policy or certificate, or maintain the format prescribed by the NAIC Model. The following is the definition suggested by the IAC:

As used in this Outline, “form” means an individual long-term care insurance policy, a rider which provides individual long-term care insurance and which is issued with an individual life insurance policy or an annuity contract, or a group long-term care insurance policy or certificate.

Wherever “[form]” appears below, the company shall substitute the appropriate type of form for which the Outline is provided. For group insurance, the Outline is only provided for a certificate.

Form Number:

Policyholder or Certificateholder Number:

IIPRC staff update following the July 19, 2016 call and final PSC recommendation:

The PSC noted that the language in the Appendix comes directly from format prescribed in Section 33 of the NAIC Long-term Care Insurance Model Regulation #641. The references are variable items, just as the reference to group and contracts are included because the Model provisions apply to more than the uniform standards. Noting that the use of the Model language has not resulted in any confusion by filers, and observing that the addition of a new definition just to this Appendix could cause confusion, the PSC is not recommending any changes as a result of this request.

CONFORMING AMENDMENTS ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

Conforming Amendments

Pursuant to Article III of the Bylaws of the Interstate Insurance Product Regulation Commission, the Commission established procedures for Conforming Amendments to Uniform Standards. A conforming amendment is an amendment to an existing Uniform Standard where the substantive provisions of the amendment are included in another adopted Uniform Standard and the amendment will have the same substantive effect on the application of the existing Uniform Standard as it does on in the other adopted Uniform Standard. As part of the Five-Year Review process, the applicable changes adopted by the Commission in the Phases One through Five will be presented as conforming amendments to standards subject to Phase 6. These items will be presented to the Management Committee as Conforming Amendments.

List of Conforming Amendments

1. Conformity with Interstate Insurance Product Regulation Commission
2. Legal Actions
3. Fairness

CONFORMING AMENDMENTS ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

1. CONFORMITY WITH INTERSTATE INSURANCE PRODUCT

REGULATION COMMISSION (*Cross-Reference to IIPRC Office Report 8/13/13–
Clarification Item #1*)

APPLIES: §3 Policy Provisions H. in the [Core Standards for Individual Long Term
Care Insurance Policies](#)

CONFORMING AMENDMENT

§ 3 POLICY PROVISIONS

H. CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

The policy shall state that it was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. The policy shall also state that any provision of the policy that on the provision's effective date is in conflict with the applicable Interstate Insurance Product Regulation Commission standards for this product type in effect as of the provision's effective date of Commission policy approval is hereby amended to conform to the applicable Interstate Insurance Product Regulation Commission standards in effect as of the provision's effective date of Commission policy approval ~~for this product type as of the provision's effective date.~~

CONFORMING AMENDMENTS ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

2. LEGAL ACTION (*Cross-Reference to IIPRC Office Report 8/13/13– Clarification Item #4*)

APPLIES: §3 Policy Provisions Q. in the Core Standards for Individual Long Term Care Insurance Policies

CONFORMING AMENDMENT

§ 3 CONTRACT PROVISIONS

Q. LEGAL ACTION

- (1) Any A policy ~~that contains a~~ may include a legal action provision. ~~relating to a~~ If included, the provision shall state that a legal cause of action related to the policy shall comply with ~~shall conform to~~ the laws of the state in which the policy was delivered or issued for delivery

CONFORMING AMENDMENTS ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

3. FAIRNESS (*Cross-Reference to IIPRC Office Report 8/13/13– Clarification Item #25*)

APPLIES: Individual Long-Term Care Insurance Application Standards

CONFORMING AMENDMENT

§ 2 GENERAL FORM REQUIREMENTS

B. FAIRNESS

- (1) The application shall not contain inconsistent, ambiguous, unfair, inequitable or misleading clauses, provisions that are against public policy as determined by the Interstate Insurance Product Regulation Commission, nor shall it contain exceptions and conditions that unreasonably affect the risk purported to be assumed in the general coverage of the policy forms with which the application will be used.
- (2) The application questions shall be presented as single direct questions, not as declaratory statements.
- (3) The application questions shall not require the applicant to make a diagnosis of a medical condition of the proposed insured. Questions such as “Are you in good health,” “Do you have symptoms of,” “Do you have any known indication of,” **“Have you ever had,”** **“Any history of,”** or “Do you think you have” are not acceptable.

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

Technical Items

Technical items are proposed changes and corrections to the Uniform Standards to make formatting, typographical, and/or drafting corrections that would not change the meaning or effect of the provision, or the current application and interpretation of the provision or applicable Uniform Standards. Technical items would also encompass changes that would make the Uniform Standards consistent with one another where appropriate, in terms of formatting and wording. The IIPRC Office will insert and clearly distinguish technical items in the Uniform Standards. As has been the practice when making technical changes to the Uniform Standards during the rulemaking process, these technical items will not be specifically discussed unless there is a concern or question raised by members, regulators, or interested parties.

List of Technical Change Items

1. Inclusion of Standard Title in Header
2. Benefit Triggers – Correction of Reference
3. Nonforfeiture Benefits – Correction of Reference
4. References to IIPRC
5. Additional Submission Requirements for Rate Schedule Increase Filings – Correct References
6. Requirements Subsequent To Approval of a Rate Schedule Increase Filing – Correct References

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

1. INCLUSION OF STANDARD TITLE IN HEADER

APPLIES: All Uniform Standards subject to Phase 6 of the Five Year Review

COMMENTS:

IIPRC Office Comment/Observation: The IIPRC Office notes that the header currently provides the effective date of the standard, but does not identify the standard. It is sometimes difficult to identify the standard when multiple standards are viewed at the same time.

IIPRC Office Recommendation: The IIPRC Office recommends adding the title of the standard to the header of all Uniform Standards subject to this Five-Year Review.

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

2. BENEFIT TRIGGERS – CORRECTION OF REFERENCE

APPLIES: § 3. F. Benefit Triggers of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

IIPRC Office Comment/Observation: The IIPRC Office notes that all references to § 2.F in this subsection should be references to § 3.F.

IIPRC Office Recommendation: The IIPRC Office recommends that the references should be corrected to refer to proper provision within the standards.

- (3) Companies may use activities of daily living in addition to those contained in § ~~23~~.F(2) to trigger covered benefits as long as they are defined in the policy.
- (4) Companies may use additional provisions for the determination of when benefits are payable under a policy; however, the provisions shall not restrict, and are not in lieu of, the requirements of § ~~23~~.F(1) and ~~23~~.F(2) above.
- (5) For purposes of this § ~~23~~.F, the determination of a deficiency shall not be more restrictive than:
 - (a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 - (b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- (6) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.
- (7) Notwithstanding § ~~23~~.F(1) above, policies that are intended to be tax-qualified policies shall comply with § 3.G of these standards.

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

3. NONFORFEITURE BENEFITS – CORRECTION OF REFERENCE

APPLIES: § 3.T. 2. Nonforfeiture Benefits of the [Core Standards for Individual Long-Term Care Insurance Policies](#)

COMMENTS:

IIPRC Office Comment/Observation: The IIPRC Office notes that all references to § 2.T in this subsection should be references to § 3.T.

IIPRC Office Recommendation: The IIPRC Office recommends that the references should be corrected to refer to proper provision within the standards.

- (2) The nonforfeiture benefit provision contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
 - (e) The nonforfeiture benefit shall be appropriately captioned in the policy, rider, endorsement, or amendment;
 - (f) The policy shall state that the nonforfeiture benefit shall begin not later than the end of the third year following the policy issue date;
 - (g) A policy offered with the nonforfeiture benefit shall have coverage elements, eligibility, benefit triggers and benefit lengths that are the same as those offered in an otherwise similar policy issued without nonforfeiture benefits;
 - (h) The nonforfeiture benefit shall be described in the policy and shall provide paid-up long-term care insurance coverage after lapse or termination by the insured (owner if there is one designated under the policy). Unless the nonforfeiture benefits is a shortened benefit period with the same benefits (amount and frequency in effect at the time of lapse but not increased thereafter) as described in § 23.T(3) below, the inclusion of another nonforfeiture benefit shall not eliminate the requirement for a contingent benefit on lapse provision in the policy as provided in § 23.T(4) below.
 - (i) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to policy issue, as long as the policy is in force and a nonforfeiture benefit is not in effect only as necessary to reflect changes in claims, persistency and interest as reflected in changes in claims in the premium rate schedule for premium paying policies approved by the Interstate Insurance Product Regulation Commission for the same policy form; and

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

- (j) The nonforfeiture provision shall provide at least one of the following:
 - (i) Reduced paid-up insurance
 - (ii) Extended term insurance
 - (iii) Shortened benefit period, or
 - (iv) Other similar offerings approved for use by the Interstate Insurance Product Regulation Commission.
- (3) A shortened benefit period nonforfeiture benefit shall provide paid-up long-term care insurance coverage after lapse as follows:
 - (a) The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in § 23.T(3)(b), below;
 - (b) The standard nonforfeiture credit shall be described in the policy and shall be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The company may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit shall be subject to the limitation in § 23.T(4), below;
 - (c) The policy shall state that nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy, up to the limits specified in the policy;
- (4) The contingent benefit on lapse benefit contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
 - (a) The policy shall indicate that a contingent benefit on lapse shall be triggered for an insured every time a company increases the premium rate schedule (issue age or modified) to a level which results in a cumulative increase in the insured's premium equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below, based on the insured's issue age, and the policy lapses within 120 days of the due date of the premium so increased. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium Rate Schedule
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

- (b) The policy shall also indicate that a contingent benefit on lapse will also be triggered for an insured for policies with a fixed or limited premium paying period every time the company increases the premium rate schedule (issue age or modified) to a level that results in a cumulative increase in the premium rate schedule for the insured equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below based on the insured's issue age, the policy lapses within 120 days of the due date of the premium rate schedule so increased, and the ratio in § 23.T(4)(d)(ii) is forty percent (40%) or more. The owner shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

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

This provision shall be in addition to the contingent benefit provided by § 23.T(4)(a) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (c) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 23.T(4)(a) above, the company shall:
- (i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §§ 23.T(4)(d) and (e), if applicable. This option may be elected at any time during the 120-day period referenced in § 23.T(4)(a); and
- (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 23.T(4)(a) shall be deemed to be the election of the offer to convert in § 23.T(4)(c)(ii) above unless the automatic option in § 23.T(4)(d)(iii) applies.

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

- (d) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 23.T(4)(b) above, the company shall:
 - (i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

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

- (ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in § 23.T(4)(b); and
 - (iii) Notify the policyholder that a default or lapse at any time during the 120-day period referenced in § 23.T(4)(b) shall be deemed to be the election of the offer to convert in § 23.T(4)(d)(ii) above if the ratio is forty percent (40%) or more.
- (e) The policy shall state that the contingent benefit upon lapse shall be effective from the policy issue date.
- (f) The contingent benefit on lapse benefit shall be appropriately captioned in the policy, rider, endorsement, or amendment;
- (5) The policy shall state that all benefits paid by the company while the policy is in premium paying status and in the paid up status shall not exceed the maximum benefits which would be payable if the policy had remained in premium paying status.
- (6) If the policy has a fixed or limited premium paying period and contains a nonforfeiture benefit, the policy shall contain the contingent benefit on lapse described in § 23.T(4)(a) and (b).

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

4. ANNUAL SUBMISSION REQUIREMENTS - REFERENCES TO IIPRC

APPLIES: § 3 B. of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

COMMENTS:

Industry Comments: The IAC notes that references to the Interstate Insurance Product Regulation Commission are sometimes abbreviated to IIPRC in this provision, inconsistent with other Uniform Standards

IIPRC Office Comment/Observation: The IIPRC Office agrees with the IAC comment.

IIPRC Office Recommendation: The IIPRC Office recommends that the references to the IIPRC in these provisions be revised to Interstate Insurance Product Regulation Commission for consistency:

C. ACTUARIAL SUBMISSION REQUIREMENTS

- (1) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:
 - (a) A statement of the sufficiency of the premium rate schedule approved by the Interstate Insurance Product Regulation Commission including:
 - (i) For the rate schedules currently marketed,
 - a. The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or
 - b. If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the company shall provide to the [IIPRC Interstate Insurance Product Regulation Commission](#), within 60 days of the date the actuarial certification is submitted to the IIPRC, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience. Failure to submit a plan of action to the [IIPRC Interstate Insurance Product Regulation Commission](#) within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the [IIPRC](#)

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

Interstate Insurance Product Regulation Commission to withdraw or modify its approval of the Product Filing pursuant to Section 108 of the Operating Procedure for the Filing and Approval of Product Filings.

Drafting Note: When a company files a statement that margins for moderately adverse experience may no longer be sufficient, the ~~IIPRC~~ Interstate Insurance Product Regulation Commission will immediately notify each Compacting State where the premium rate schedule applies.

- (ii) For the rate schedules that are no longer marketed,
 - a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or
 - b. That the premium rate schedule may no longer be sufficient. In this situation, the company shall provide to the ~~IIPRC~~ Interstate Insurance Product Regulation Commission, within 60 days of the date the actuarial certification is submitted to the IIPRC, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

Drafting Note: When a company files a statement that the premium rate schedule may no longer be sufficient, the ~~IIPRC~~ Interstate Insurance Product Regulation Commission will immediately notify each Compacting State where the premium rate schedule applies.

- (b) A description of the review performed that led to the statement and disclosure of any planned management action relating to this statement.

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

5. ADDITIONAL SUBMISSION REQUIREMENTS FOR RATE SCHEDULE INCREASE FILINGS – CORRECT REFERENCES

APPLIES: § 4.C. of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

COMMENTS:

IIPRC Office Comment/Observation: The IIPRC Office notes that several of the references to other provisions were not updated when the standards were revised.

IIPRC Office Recommendation: The IIPRC Office recommends that the references in these provisions be revised as follows to cite the applicable provisions in the Uniform Standards:

- (2) An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall comply with the Actuarial Standards of Practice (in particular ASOP 18) and providing at least the following information with respect to the form as approved for use in Interstate Insurance Product Regulation Commission states:
 - (a) Lifetime projections of earned premiums and incurred claims based on the filed rate schedule increase and consistent with the requirements of § ~~3-A.4.B.~~(4) and (5) to provide complete experience; and the method and assumptions used in determining the projected values, including a reflection and disclosure of any assumptions that deviate from those used in pricing other policy forms approved by the Interstate Insurance Product Regulation Commission and currently available for sale;
 - (i) Annual values for the five (5) years preceding and the three (3) years following the projection date shall be provided separately;
 - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate schedule increase is an exceptional rate schedule increase;
 - (iii) The projections shall demonstrate compliance with § 4.C(3), below;
 - (iv) For an exceptional rate schedule increase:
 - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional rate schedule increase; and

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

- (II) In the event that the Interstate Insurance Product Regulation Commission determines that there are potential offsets to the higher claims costs associated with the exceptional rate schedule increase, the appropriate net projected experience shall be used; and
- (v) The projections shall be based on the expected premium income and claims experience to which the rate increase will be applied with a separate projection for the expected premium income and claims experience to which no rate increase will be applied;

Drafting Note: Projected experience performed according to § 34.B(2) may use actuarial judgment based on the experience of the company or industry using Interstate Insurance Product Regulation Commission, state or national data.

- (b) Disclosure of how reserves have been incorporated into the rate schedule increase whenever the rate schedule increase will trigger a contingent benefit on lapse;
 - (c) Disclosure of the analysis performed to determine why a rate schedule increase is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary in providing the certification in § 34.BC(1), above. The disclosure should describe the sources and levels of margins incorporated into the premiums after the rate schedule increase that are the basis for the statement in § 34.BC (1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Significant deviations in margins between ages, sexes, plans or states shall be clearly described. Significant deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating premium schedules;
 - (d) A statement that the policy design, underwriting and claims adjudication practices have been taken into consideration; and
 - (e) A statement that the rate schedule after the rate schedule increase is not greater than the rate schedule for new business approved for use by the Interstate Insurance Product Regulation Commission except for differences attributable to benefits, unless sufficient information to demonstrate such differences are justified is provided.
- (3) All rate schedule increases shall comply with the following requirements with respect to the portion of the business to which the rate schedule increase is to apply:

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

- (a) Exceptional rate schedule increases shall provide that seventy percent (70%) of the present value of projected additional premiums resulting from the exceptional increase will be returned as benefits;
- (b) Rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, excluding active life reserves, and the present value of future projected incurred claims, excluding active life reserves, are not less than the sum of:
 - (i) The accumulated value of the initial earned premium times fifty-eight percent (58%);
 - (ii) Eighty-five percent (85%) of the accumulated value of prior rate schedule increases filed with the Interstate Insurance Product Regulation Commission under this standard on an earned basis;
 - (iii) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
 - (iv) Eighty-five percent (85%) of the present value of projected premiums not included in (iii), above, on an earned basis;
- (c) In the event that the rate filing incorporates an exceptional rate schedule increase and other increases, the values in § ~~3-B4C~~(3)(b)(ii) and § ~~3-B4C~~ (3)(b)(iv) shall also include seventy percent (70%) for exceptional rate schedule increase amounts; and

TECHNICAL ITEMS

5-Year Review, Phase 6 (Long-term Care Insurance Uniform Standards)

6. REQUIREMENTS SUBSEQUENT TO APPROVAL OF A RATE SCHEDULE INCREASE FILING – CORRECT REFERENCES

APPLIES: § 5.D(2). of the [Rate Filing Standards for Individual Long-Term Care Insurance - Issue Age Rate Schedules Only](#) and [Rate Filing Standards for Individual Long-Term Care Insurance - Modified Rate Schedules](#)

COMMENTS:

IIPRC Office Comment/Observation: The IIPRC Office notes that some of the references in this provision are not correct.

IIPRC Office Recommendation: The IIPRC Office recommends that the references in this provision be revised as follows to cite the correct applicable provisions in the Uniform Standards:

- D. If the majority of policies to which the rate schedule increase filing is applicable are eligible for the contingent benefit on lapse, as defined in the policy, the company shall file:
- (1) A plan, subject to Interstate Insurance Product Regulation Commission approval, for improved administration or claims processing procedures, or both, designed to eliminate the potential for a further deterioration of experience that would require future rate schedule increases (or demonstrate that appropriate administrative and claims processing procedures have been implemented); otherwise the Interstate Insurance Product Regulation Commission may impose the condition in § 5.E below; and
 - (2) The original anticipated lifetime loss ratio, and the rate schedule increase that would have been calculated according to § 34.B(3), above, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculation in § 34.B(3)(b)(i) and (iii), above.

Phase Six Five-Year Review Uniform Standards

IIPRC-LTC-I-3-APP

Individual Long-Term Care Application Standards

IIPRC-LTC-I-3-APPFORMS

Standards for Forms Required to be Used with an Individual Long-Term Care Application

IIPRC-LTC-I-3-APPCH

Standards for Individual Long-Term Care Application Change Form

IIPRC-LTC-I-3-CORE

Core Standards for Individual Long-Term Care Insurance Policies

IIPRC-LTC-I-3-OC

Individual Long-Term Care Insurance Standards for the Outline of Coverage

IIPRC-LTC-I-3-RATEI

Rate Filing Standards for Individual Long-Term Care – Issue Age Rate Schedules Only

IIPRC-LTC-I-3-RATEM

Rate Filing Standards for Individual Long-Term Care – Modified Rate Schedules

IIPRC-LTC-I-3-ADV

Standards for Individual Long-Term Care Insurance Advertising Material

IIPRC-LTC-I-3-BEN

Standards for Long-Term Care Insurance Benefit Features

IIPRC-LTC-I-3-AMEND

Standards for Riders, Endorsements or Amendments Used to Effect Individual Long-Term Care Policy Changes

RATE FILING STANDARDS FOR INDIVIDUAL LONG-TERM CARE INSURANCE

ISSUE AGE RATE SCHEDULES ONLY

Drafting Note: The initial rate filing and rate increase filing standards are combined so that applicable standards for initial rate and rate increase filings are located in one place and rate increase filings are handled consistently with initial rate filings across Interstate Insurance Product Regulation Commission member states.

Scope: These standards apply to initial rates and subsequent filings to increase premium rate schedules for individual long-term care insurance. Any product advertised, marketed or offered as long-term care insurance shall be subject to these standards when only issue age rate schedules are available. All dollar-for-dollar long-term care insurance rates are considered to be, for purposes of this standard, Issue Age Rate Schedules. Long-term care insurance shall provide benefits for one or more of the following: nursing home care, assisted living care or home health care and adult day care. These standards apply to all policies, riders, endorsements and amendments subject to the Core Standard for Individual Long-Term Care Insurance Policies adopted by the Interstate Insurance Product Regulation Commission, ~~except for the following long-term care products to which no specific rate standards apply:~~

~~(1) — Life insurance policies that permit payment of all or part of the death benefit when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of reduction in death benefits (for flexible premium adjustable life products, the death benefit may be one of the death benefit options described in the Interstate Insurance Product Regulation Commission standards for such products); and~~

~~(2) — Annuity contracts that provide for the waiver of any applicable surrender or withdrawal charges upon payment of all or part of the account value when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of permanent reduction in the account value.~~

Mix and Match: These standards are not available to be used in combination with State Product Components as described in § 110(b) of the Operating Procedure for the Filing and Approval of Product Filings.

Self-Certification: These standards are not available to be filed using the Rule for the Self-Certification of Product Components Filed with the Interstate Insurance Product Regulation Commission.

All terms used in these standards shall have the same meaning as defined in the Core Standards for Individual Long-Term Care Insurance Policies.

As used in these standards the following definitions apply:

“Dollar-for-Dollar Long-term Care Insurance” is long-term care insurance provided under:

- (1) Life insurance policies that permit payment of all or part of the death benefit when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of reduction in death benefits (for flexible premium adjustable life products, the death benefit may be one of the death benefit options described in the Interstate Insurance Product Regulation Commission standards for such products); and
- (2) Annuity contracts that provide for the waiver of any applicable surrender or withdrawal charges upon payment of all or part of the account value when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of permanent reduction in the account value.

“Issue age rate schedules” are rate schedules where premiums are based on issue age and where premiums are not expected to change during the premium-paying period due to attained age or duration since issue. Single premium and limited pay plans (e.g., 20-pay policy) are allowed under this definition. The addition of increases in the benefit level that require additional premium, based on the issue age rate schedule applied at an insured’s current age at the time of each increase in the benefit level, are allowed under this definition.

“Exceptional rate schedule increase” means only those rate schedule increases where the Interstate Insurance Product Regulation Commission determines that the need for the rate schedule increase is justified, and may be applicable to only one or more states as determined by the Interstate Insurance Product Regulation Commission:

- (1) Due to changes in laws or regulations applicable to individual long-term care coverage;
or
- (2) Due to increased and unexpected utilization that affects the majority of companies of similar products to that for which the rate schedule increase filing applies.

Drafting Note: As appropriate, the Interstate Insurance Product Regulation Commission may refer to the *NAIC Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation* in reviewing filings under these standards.

§ 1 CRITERIA FOR REVIEW FOR ALL RATE FILINGS

A. GENERAL

The Interstate Insurance Product Regulation Commission will review rate filings for individual long-term care insurance policies and may disapprove any rate filing for one or more of the following reasons:

- (1) The premiums charged are unreasonable in relation to the benefits provided, excessive, inadequate, or unfairly discriminatory;
- (2) The provisions permit the company to vary premiums for insureds, and the variances are not based upon sound underwriting and sound actuarial principles reasonably related to actual or reasonably anticipated loss experience;
- (3) The premiums unfairly discriminate between individuals of the same actuarial risk class, or between risks of essentially the same degree of hazard;
- (4) The premiums discriminate on the basis of race, color, creed, national origin, or sexual orientation;
- (5) The premiums unfairly discriminate on the basis of marital status or civil union status in states where civil union relationships are recognized; however, this does not prohibit actuarially justified spousal, couple, partner, or civil union discounts; or
- (6) The rate filing fails to comply with the standards.

§ 2 ADDITIONAL SUBMISSION REQUIREMENTS FOR INITIAL RATE FILINGS

The following additional submission requirements apply to initial rate filings for individual long-term care insurance policies:

A. GENERAL

- (1) If the initial rate filing is being submitted on behalf of the company, include a letter of authorization from the insurance company submitted by the party authorized to submit the filing.
- (2) A filing of a premium rate schedule for an existing policy form that increases one or more premium rates and does not decrease any premium rate and is to be applicable only to policies issued after a defined issue date is not considered an increase to a premium rate schedule but is considered a new initial rate schedule.
- (3) For guaranteed renewable policies, if the company has guaranteed premiums that will not increase after the insured has attained a specified age, the company shall certify that the basis for future rate increases will not include adverse experience for such insureds. However, this certification does not preclude the company from utilizing the actual experience of the insureds beyond the specified age in projecting the experience of any other segments of the insured population for which rate increases are permitted.

B. ACTUARIAL SUBMISSION REQUIREMENTS

- (2) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:
- (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - (d) For other than dollar-for-dollar long-term care insurance, statement that the premiums assumptions used for reserves contain reasonable margins at least the minimum margin for moderately adverse experience defined in (i) or the specification and justification for a lower margin as required by (ii);
 - (i) A composite margin shall not be less than 10% of lifetime claims.
 - (ii) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted. A statement that the net valuation premium for renewal years does not increase;
 - (iii) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

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

~~A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur shall be provided in the actuarial memorandum supplied pursuant to § 2B(3)(d); and~~

- (iv) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

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

~~statement as to whether or not the reserve morbidity assumptions used include any provision for morbidity improvement.~~

- (e) For other than dollar-for-dollar long-term care insurance, a ~~A~~ A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms with issue age rate schedules and comparable premium-paying periods also available from the company except for reasonable differences attributable to benefits; or, if there are situations where one or some rates in a premium rate schedule are less than those in the premium rate schedule for existing products having similar benefits, a statement to that effect. In either case, details of the differences and the comparison work performed should be provided as part of § 2B(3)(f).
 - (f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
 - (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
 - (ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
- (2) The document containing the premium rate schedules shall contain a statement that the premium rate schedules are those to which the information in the actuarial memorandum applies.

- (3) An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall address and support each specific item required as part of the actuarial certification, comply with Actuarial Standard of Practice (ASOP) 18 and provide at least the following information:
- (a) An explanation of the review performed by the actuary prior to making the statements in § 2B(1)(b) and § 2B(1)(c);
 - (b) A complete description of pricing assumptions;

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

- (c) Sources and levels of margins, incorporated into the gross premiums determined in § 2B(31)(b) above that are the basis for the statement in § 2B(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. ~~Significant~~ Deviations in margins between ages, sexes, plans or states shall be clearly described. ~~Significant~~ Deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales;
- (d) For other than dollar-for-dollar long-term care insurance, a demonstration that the gross premiums include the minimum composite margin specified in §2.B(1)(d);
- (e)
 - (i) For other than dollar-for-dollar long-term care insurance, a ~~A~~ complete description of those situations, if any, where the difference between the gross premium and the net valuation premium for renewal years is not sufficient to cover expected renewal expenses; and
 - (ii) For other than dollar-for-dollar long-term care insurance, a ~~A~~ table of sample ages and coverages (including inflation and non-inflation) demonstrating the extent and the results of this review;
- (f) A complete description of any morbidity improvement assumption used in pricing or reserves for the product together with the rationale for the assumption and its effect on premium and reserve levels; and

Drafting Note: At the time of drafting these standards, the Interstate Insurance Product Regulation Commission generally does not believe that sufficient credible data on insured experience is available to justify the use of morbidity improvements in pricing or reserve assumptions but cannot be sure that it cannot be produced in the future. As noted in the NAIC Health Insurance Minimum Reserve Model Regulation (Model #10), “Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected

claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction in [premiums or] reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred, and that is able to be evaluated and quantified. This last sentence is intended to provide allowances for a known event, such as a new drug release, but at the time of this writing, there are no specific examples that could be pointed to in the recent past that would have met this standard. **This is intended to be an extremely rare event.**” [emphasis supplied]

- (f) For other than dollar-for-dollar long-term care insurance, a A comparison of the premium rates with issue age rate schedule rates, at a reasonable selection of ages, for similar policy forms and comparable premium-paying periods also available from the company. The actuary should describe the situations where the premium rate schedules are less than those for existing products and detail the differences and testing done by the actuary to determine that the filed premiums are not inadequate.
- (4) After reviewing the initial rate filing, the Interstate Insurance Product Regulation Commission may request an actuarial demonstration that benefits are reasonable in relation to the premiums charged. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other sources, or both.
- (5) For other than dollar-for-dollar long-term care insurance:
 - (a) Rate guarantee periods applicable to initial, new or additional long-term care coverage in excess of five years from the effective date of such coverage shall not be permitted. This provision does not preclude a noncancellable policy or a guaranteed renewable policy that guarantees premiums will not increase after an insured has attained a specified age as defined in the policy;
 - (b) A separate additional premium for rate guarantee periods applicable to initial, new or additional long-term care coverage shall not be permitted.

§ 3 ANNUAL SUBMISSION REQUIREMENTS SUBSEQUENT TO INITIAL RATE FILINGS AND PRIOR TO APPROVAL OF RATE SCHEDULE INCREASES FOR OTHER THAN DOLLAR-FOR-DOLLAR LONG-TERM CARE INSURANCE

The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies. These requirements do not apply after the approval of rate schedule increase filings, at which time the requirements of § 4 apply.

Drafting Note: In accordance with § 2A(2), these submission requirements apply to rate schedules initially filed with the Interstate Insurance Product Regulation Commission, including revised rate schedules that increase premium rates only with respect to new business issued under a policy form.

A. GENERAL

- (1) If the items are being submitted on behalf of the company, include a letter of authorization from the insurance company.

B. ACTUARIAL SUBMISSION REQUIREMENTS

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

- (a) A statement of the sufficiency of the premium rate schedule approved by the Interstate Insurance Product Regulation Commission including:

- (i) For the rate schedules currently marketed,

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

- d. If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the company shall provide to the IIPRC, within 60 days of the date the actuarial certification is submitted to the IIPRC, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience. Failure to submit a plan of action to the IIPRC within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the IIPRC to withdraw or modify its approval of the Product Filing pursuant to Section 108 of the Operating Procedure for the Filing and Approval of Product Filings.

Drafting Note: When a company files a statement that margins for moderately adverse experience may no longer be sufficient, the IIPRC will immediately notify each Compacting State where the premium rate schedule applies.

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

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

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

Drafting Note: When a company files a statement that the premium rate schedule may no longer be sufficient, the IIPRC will immediately notify each Compacting State where the premium rate schedule applies.

- (b) A description of the review performed that led to the statement and disclosure of any planned management action relating to this statement.
- (3) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and shall comply with ASOP 18 and provide at least the following information:
 - (a) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in § 3.B(1)(a).
 - (b) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

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

- (c) A description of the credibility of the experience data.
 - (d) An explanation of the analysis and testing performed in determining the current presence of margins.
- (4) The actuarial certification required pursuant to § 3.B(1) must be based on calendar year data and submitted annually no later than May 1st December 31st of each year starting in the first full year after following the first full year in which the initial rate schedules as approved by the Interstate Insurance Product Regulation Commission. The actuarial memorandum required pursuant to § 3.B(2) must be submitted every three years no later than May 1st December 31st of the reporting year starting in the third ~~full~~ year after the first full following the year in which the initial rate schedules as approved by the Interstate Insurance Product Regulation Commission.

Drafting Note: The Product Standards Committee is comfortable with requiring the filing of the actuarial memorandum on a triennial basis only with the company performing analysis and monitoring experience annually. The company must be able to provide the actuarial memorandum supporting the actuarial certification upon request by any member state included in the filing.

§ 4 ADDITIONAL SUBMISSION REQUIREMENTS FOR RATE SCHEDULE INCREASE FILINGS

Drafting Notes:

1. These requirements do not apply when a company files for a revised rate schedule that increases premium rates only with respect to new business issued under a policy form or for initial rate filings.

2. For dollar-for-dollar long-term care insurance, these requirements do not apply to changes in premium rates for benefits that occur under an existing premium rate schedule where premiums are scheduled to change during the premium-paying period according to a specified pattern due to attained age or duration since issue.

3. These requirements do not apply where a company has previously provided a certification, as described in §6 A.2(a)(ii), that the basis for any base policy rate increase does not incorporate adverse experience for the dollar-for-dollar long-term care insurance.

The following additional submission requirements apply to rate schedule increase filings that apply to in-force policies for individual long-term care insurance:

A. APPLICABLE AUTHORITY, REVIEW AND APPROVAL OF RATE SCHEDULE INCREASES

- (1) When a rate schedule increase for a specified individual long-term care insurance policy form does not exceed a rate increase of fifteen percent (15%), the filing shall be subject to the review and approval or disapproval of the Interstate Insurance Product Regulation Commission.
- (2) When a rate schedule increase filing request exceeds a rate increase of fifteen percent (15%), the filing shall be subject to the review and approval of each Compacting State. If a rate schedule increase filing does not request a rate increase above fifteen percent (15%), but the Interstate Insurance Product Regulation Commission determines that a rate increase exceeding fifteen percent (15%) is necessary in order to comply with the Rate Filing Standards for Individual Long-Term Care Insurance, the filing shall be subject to the review and approval or disapproval of each Compacting State.
- (3) When a rate schedule increase filing is subject to the approval of the Interstate Insurance Product Regulation Commission, as provided in § 4A(1), the Rate Filing Standards for Individual Long-Term Care Insurance and other applicable Rules, Uniform Standards and Operating Procedures apply. When a rate schedule increase filing is subject to the

approval of each Compacting State as provided in § 4A(2), each Compacting State's applicable state laws and regulations apply to the entire rate schedule increase filing.

- (4) For rate schedule increase filings subject to the approval of each Compacting State as provided in § 4A(2), the Interstate Insurance Product Regulation Commission shall review the rate schedule increase filing, including corresponding with the filer to address objections, and provide to each applicable Compacting State an advisory finding regarding compliance with the Rate Filing Standards for Individual Long-Term Care Insurance and other applicable Uniform Standards. Such review and advisory finding shall not be considered an approval of the rate schedule increase filing nor shall it be binding on the Compacting States or the filing company.
- (5) Once the Interstate Insurance Product Regulation Commission transmits the advisory finding to each applicable Compacting State, the rate schedule increase filing, including the applicable Member State Filing Fee, shall be considered a filing of each applicable Compacting State and a withdrawn filing of the Interstate Insurance Product Regulation Commission.
- (6) Any future rate schedule increase requests on rate schedule increase filings subject to the approval of each Compacting State as provided in § 4A(2) shall be filed directly with each applicable Compacting State and subject to the review and approval or disapproval of each Compacting State under its respective state laws and regulations.

B. GENERAL

- (1) If the rate schedule increase filing is being submitted on behalf of the company, include a letter or other document authorizing the firm to file on behalf of the company.
- (2) The request for approval of a rate schedule increase filing shall be submitted to the Interstate Insurance Product Regulation Commission at least 30 days prior to the required rate increase notice period as provided in the policy.
- (3) Include the Long-Term Care Insurance Potential Rate Increase Disclosure Form required by § 9, Required Disclosure of Rating Practices of the NAIC Long-Term Care Insurance Model Regulation (Model #641).
- (4) A rate schedule increase with the same percentage increase applicable to all policies may be filed with the Interstate Insurance Product Regulation Commission based on the experience of such policy form in all states where the Interstate Insurance Product Regulation Commission has approved the form for use. If requested by the reviewer, the company shall detail the basis for its determination not to vary the rate increase percentage.
- (5) (a) Where the same percentage rate schedule increase is not to be applied to all policies in force under an Interstate Insurance Product Regulation Commission filed policy form, for other than dollar-for-dollar long-term care insurance, the

overall rate schedule increase shall be consistent with the loss ratio requirements of §4C(3) when applied to such policy form in all states where the Interstate Insurance Product Regulation Commission has approved the form for use.

- (b) The company shall detail the basis for its determination to vary the rate increase (e.g., certain states as an exceptional increase, certain level of benefits, and certain ages). Such basis shall be generally consistent with the experience under the Interstate Insurance Product Regulation Commission filed policy form, but may rely on credible experience from other sources (e.g., company's national experience, industry experience).
- (6) A rate schedule increase shall not introduce a new rating characteristic that was not included as a rating characteristic in the initial rate filing.

Drafting Note: At the time of drafting these standards, the Interstate Insurance Product Regulation Commission generally does not believe that sufficient data on insured experience is available to vary a rate schedule increase by state or region, but cannot be sure sufficient data cannot be produced in the future. To the extent a company desires to vary a rate schedule increase by state or region, it should recognize that any lack of sufficient data for the form in each state or region may present a significant hurdle to the approval of such a rate schedule increase request. However, it is recognized that any industry or actuarial study that indicates a clear and substantiated basis for varying the level or length of incurred claims by state or region could provide support for varying a rate schedule increase consistent with such study. If industry or actuarial study indicating a clear and substantiated basis to vary a rate schedule increase by state or region becomes available subsequent to adoption of these standards, the Interstate Insurance Product Regulation Commission will revisit the appropriateness of varying a rate schedule increase by state or region for future issues.

Drafting Note: The use of "policy form" is not intended to eliminate the filing of a consistently based premium rate schedule increase to multiple policy forms with similar benefits and underwriting based on the same assumptions and their total experience to date.

C. ACTUARIAL SUBMISSION REQUIREMENTS

- (1) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:
 - (a) A statement that, if the requested rate schedule increase is implemented, and the underlying assumptions, which reflect moderately adverse conditions, are realized, no future rate schedule increases are anticipated;
 - (b) A statement that the rate schedule increase filing is in compliance with the requirements of these standards;

- (c) A statement that the rate schedules submitted are those to which the information in the actuarial memorandum applies; and

Drafting Note: The inclusion of both § 4.C(1)(a) and § 4.C(1)(c) above is intended to preclude the ability of the Interstate Insurance Product Regulation Commission and the company to agree, independently of the actuary's certification, to a rate schedule increase other than that to which the certification applies.

- (3) For other than dollar-for-dollar long-term care insurance, ~~a~~An actuarial memorandum prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall comply with the Actuarial Standards of Practice (in particular ASOP 18) and providing at least the following information with respect to the form as approved for use in Interstate Insurance Product Regulation Commission states:

- (f) Lifetime projections of earned premiums and incurred claims based on the filed rate schedule increase and consistent with the requirements of § 3.A(4) and (5) to provide complete experience; and the method and assumptions used in determining the projected values, including a reflection and disclosure of any assumptions that deviate from those used in pricing other policy forms approved by the Interstate Insurance Product Regulation Commission and currently available for sale;

- (i) Annual values for the five (5) years preceding and the three (3) years following the projection date shall be provided separately;

- (ii) The projections shall include the development of the lifetime loss ratio, unless the rate schedule increase is an exceptional rate schedule increase;

- (iii) The projections shall demonstrate compliance with § 4.C(3), below;

- (iv) For an exceptional rate schedule increase:

- (III) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional rate schedule increase; and

- (IV) In the event that the Interstate Insurance Product Regulation Commission determines that there are potential offsets to the higher claims costs associated with the exceptional rate schedule increase, the appropriate net projected experience shall be used; and

- (vi) The projections shall be based on the expected premium income and claims experience to which the rate increase will be applied with a

separate projection for the expected premium income and claims experience to which no rate increase will be applied;

Drafting Note: Projected experience performed according to § 3.B(2) may use actuarial judgment based on the experience of the company or industry using Interstate Insurance Product Regulation Commission, state or national data.

- (g) Disclosure of how reserves have been incorporated into the rate schedule increase whenever the rate schedule increase will trigger a contingent benefit on lapse;
 - (h) Disclosure of the analysis performed to determine why a rate schedule increase is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary in providing the certification in § 3.B(1), above. The disclosure should describe the sources and levels of margins incorporated into the premiums after the rate schedule increase that are the basis for the statement in § 3.B(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Significant deviations in margins between ages, sexes, plans or states shall be clearly described. Significant deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating premium schedules;
 - (i) A statement that the policy design, underwriting and claims adjudication practices have been taken into consideration; and
 - (j) A statement that the rate schedule after the rate schedule increase is not greater than the rate schedule for new business approved for use by the Interstate Insurance Product Regulation Commission except for differences attributable to benefits, unless sufficient information to demonstrate such differences are justified is provided; ~~and-~~
 - ~~(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in §2 B(1)(d) is projected to be exhausted.~~
- (3) For other than dollar-for-dollar long-term care insurance, aAll rate schedule increases applicable to policies issued under policy forms filed prior to [date six month after the date these changes are adopted by the Interstate Insurance Product Regulation Commission] shall comply with the following requirements with respect to the portion of the business to which the rate schedule increase is to apply:
- (e) Exceptional rate schedule increases shall provide that seventy percent (70%) of the present value of projected additional premiums resulting from the exceptional increase will be returned as benefits;

- (f) Rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, excluding active life reserves, and the present value of future projected incurred claims, excluding active life reserves, are not less than the sum of:
 - (v) The accumulated value of the initial earned premium times fifty-eight percent (58%);
 - (vi) Eighty-five percent (85%) of the accumulated value of prior rate schedule increases filed with the Interstate Insurance Product Regulation Commission under this standard on an earned basis;
 - (vii) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
 - (viii) Eighty-five percent (85%) of the present value of projected premiums not included in (iii), above, on an earned basis;
 - (g) In the event that the rate filing incorporates an exceptional rate schedule increase and other increases, the values in § 3.B(3)(b)(ii) and § 3.B(b)(iv) shall also include seventy percent (70%) for exceptional rate schedule increase amounts; and
 - (h) All present and accumulated values used in the determination of any rate schedule increase shall use the maximum valuation interest rate for contract reserves specified in Appendix A of the NAIC Health Insurance Reserves Model Regulation (Model #10).
- (4) For other than dollar-for-dollar long-term care insurance, all rate schedule increases applicable to policies issued under policy forms filed on or after [date six months after the date these changes are adopted by the Interstate Insurance Product Regulation Commission] shall comply with the following requirements with respect to the portion of the business to which the rate schedule increase is to apply:
- (a) Exceptional rate schedule increases shall provide that seventy percent (70%) of the present value of projected additional premiums resulting from the exceptional increase will be returned as benefits;
 - (b) Rate schedule increases shall be calculated such that the sum of the lesser of (i) accumulated value of actual incurred claims, excluding active life reserves, or (ii) the accumulated value of historic expected claims, excluding active life reserves, plus the present value of future expected incurred claims, excluding active life reserves, will not be less than the sum of:
 - (v) The accumulated value of the initial earned premium times the greater of (A) fifty-eight percent (58%) and (B) the lifetime loss

- ratio consistent with the original filing including margins for moderately adverse experience;
- (vi) Eighty-five percent (85%) of the accumulated value of prior rate schedule increases filed with the Interstate Insurance Product Regulation Commission under this standard on an earned basis;
 - (vii) The present value of future projected initial earned premiums times the greater of (A) fifty-eight percent (58%) and (B) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
 - (viii) Eighty-five percent (85%) of the present value of projected premiums not included in § 4.B(3)(b)(iii), above, on an earned basis;
 - (v) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing.
- (c) In the event that the rate filing incorporates an exceptional rate schedule increase and other increases, the values in § 3.B(3)(b)(ii) and (iv) shall also include seventy percent (70%) for exceptional rate schedule increase amounts; and
- (d) All present and accumulated values used in the determination of any rate schedule increase shall use the maximum valuation interest rate for contract reserves specified in Appendix A of the NAIC Health Insurance Reserves Model Regulation (Model #10).
- (5) For guaranteed renewable policies, if the company has guaranteed premiums will not increase after the insured has attained a specified age, the actuary shall certify that the basis for the proposed rate increase does not include adverse experience for such insureds.

§ 5 REQUIREMENTS SUBSEQUENT TO APPROVAL OF A RATE SCHEDULE INCREASE FILING APPROVED BY THE INTERSTATE INSURANCE

PRODUCT REGULATION COMMISSION FOR OTHER THAN DOLLAR-FOR-DOLLAR LONG-TERM CARE INSURANCE

- A. For each rate schedule increase that is implemented, the company shall file with the Interstate Insurance Product Regulation Commission for review updated projections, as defined in § 3.B4C(2)(a) above, annually for the next three (3) years and include a comparison of actual results to projected values. The Interstate Insurance Product Regulation Commission may extend the period to greater than three years if actual results are not consistent with projected values from prior projections.
- B. If any premium rate in an implemented rate schedule increase is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in § 3.B4C(2)(a) above, shall be filed with the Interstate Insurance Product Regulation Commission for review every five (5) years following the end of the required period in § 5.A, above.
- C. If the Interstate Insurance Product Regulation Commission determines that the actual experience following a rate schedule increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed the proportions of premiums specified in § 3.B4C(3) or 4C(4) above as applicable, the Interstate Insurance Product Regulation Commission may require the company to implement either of the following:
- (1) Premium rate schedule adjustments; or
 - (2) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: It is expected that actual experience will not exactly match projected. During the period when projections are monitored as indicated in Items (1) and (2) above, the Interstate Insurance Product Regulation Commission shall determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction or the difference as a percentage of the projected is not of the same order.

- D. If the majority of policies to which the rate schedule increase filing is applicable are eligible for the contingent benefit on lapse, as defined in the policy, the company shall file:
- (1) A plan, subject to Interstate Insurance Product Regulation Commission approval, for improved administration or claims processing procedures, or both, designed to eliminate the potential for a further deterioration of experience that would require future rate schedule increases (or demonstrate that appropriate administrative and claims processing procedures have been implemented); otherwise the Interstate Insurance Product Regulation Commission may impose the condition in § 5.E below; and

- (2) The original anticipated lifetime loss ratio, and the rate schedule increase that would have been calculated according to 3.B-4C(3), above, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculation in § 3.B-4C (3)(b)(i) and (iii), above.
- E. For a rate schedule increase filing that meets the following criteria, the Interstate Insurance Product Regulation Commission shall review, for all policies subject to the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each rate schedule increase to determine if significant adverse lapsation has occurred or is anticipated:
- (1) The rate schedule increase is not the first rate schedule increase requested for the subject policy form(s);
 - (2) The rate schedule increase is not an exceptional rate schedule increase; and
 - (3) The majority of the policies to which the rate schedule increase is applicable are eligible for the contingent benefit on lapse, as defined in the policy.
- F. In the event that significant adverse lapse experience has occurred, is anticipated in the rate schedule increase filing, or is evidenced in the actual results as presented in the updated projections provided by the company following the requested rate schedule increase, the Interstate Insurance Product Regulation Commission may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Interstate Insurance Product Regulation Commission may require the company to offer, without underwriting, to all in force insureds subject to the rate schedule increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the company or its affiliates.
- (1) The offer shall:
 - (a) Be subject to the approval of the Interstate Insurance Product Regulation Commission;
 - (b) Be based on sound actuarial principles and be based on an issue age rate schedule; and
 - (c) Provide that the maximum benefits payable under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
 - (2) The company shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate schedule increase on the policy form, the rate schedule increase shall be limited to the lesser of:

- (a) The maximum rate schedule increase determined based on the combined experience; and
- (b) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

§6. ADDITIONAL STANDARDS FOR DOLLAR-FOR DOLLAR LONG-TERM CARE INSURANCE

Drafting Note: As used in these standards, “premium rate schedule” or premium rate” or “rate schedule” shall include but not be limited to the following:

- 1) the separately identifiable premium charged for the dollar-for-dollar long-term care insurance, or
- 2) charges that are expressed as an amount per \$1,000 of insurance (charges that are expressed as a per \$1,000 net amount of insurance or as a percentage rate applied to the policy cost of insurance rates are included in this category), or
- 3) charges that are expressed as a percentage of the life policy or annuity contract account.

The following additional filing submission requirements shall apply:

A. INITIAL RATE FILINGS

(1) GENERAL

- (a) If a filing of a rate schedule for an existing policy form includes a decrease in any premium rate only on policies issued after a defined issue date, then sufficient information is required to justify not applying the decrease to earlier issues.
- (b) For premium rate schedules where premiums are initially based on issue age and where premiums are scheduled to change during the premium-paying period according to a specified pattern due to attained age or duration since issue, the company shall certify that scheduled premium changes do not occur more than five (5) years from the most recent prior change, or issue date of the policy if no prior change has occurred and provide the following:
 - (i) A sample description of the manner in which scheduled premium rates will be explained to the applicant which need not show every scheduled premium rate; and
 - (ii) A sample of the manner in which the policy will show each premium rate change in the schedule and the period for which the resulting premium is applicable.

Drafting Note: These requirements apply where premiums are determined by applying a percentage rate to the base policy cost of insurance rates and where either the base policy cost of insurance rates or the percentages applied change with attained age or duration since issue.

(2) ACTUARIAL SUBMISSION REQUIREMENTS

- (a) In addition to the requirements of the actuarial certification of § 2B. 1, for noncancellable and guaranteed renewable dollar-for-dollar long-term care insurance coverages, the company may certify that the basis for future rate increases on the base policy will not include adverse experience for dollar-for-dollar long-term care insurance. This certification would then exempt the company from future filings under §4. Additional Submission Requirements for Premium Rate Schedule Increase Filings, whenever rates are increased on the base policy.

B. ACTUARIAL SUBMISSION REQUIREMENTS FOR RATE SCHEDULE INCREASE FILINGS

- (1) In addition to the requirements of the actuarial certification of § 4C (1) include:
- (a) A statement that the dollar-for-dollar long-term care insurance design and coverage provided have been reviewed and taken into consideration;
- (b) A statement that the underwriting and claims adjudication processes applicable to dollar-for-dollar long-term care insurance have been reviewed and taken into consideration; and
- (c) If the rate premium schedule increase submitted applies to a premium rate schedules where premiums are initially based on issue age and where premiums are scheduled to change during the premium-paying period according to a specified pattern due to attained age or duration since issue, a statement that the premium rate schedule following the rate increase continues to comply with the requirements for a rate schedule as set forth in § 6.A(1)(b).
- (2) An actuarial memorandum prepared, dated and signed by a member of the Academy of Actuaries who provided the information shall be provided and shall comply with the Actuarial Standards of Practice (in particular ASOP No. 18) and providing at least the following information with respect to the form as approved for use in Interstate Insurance Product Regulation Commission states:
- (a) Disclosure of the analysis performed to determine why a premium rate schedule increase is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary in providing the certification in § 6.B(1), above. The disclosure should describe the

sources and levels of margins incorporated into the premiums after the rate schedule increase that are the basis for the statement in § 6B.(1)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states must be clearly described. Deviations in margins are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating premium schedules; and

- (b) A statement that the rate schedule after the premium rate schedule increase is not greater than the premium rate schedule for new business approved for use by the Interstate Insurance Product Regulation Commission except for differences attributable to benefits and premium paying pattern, unless sufficient information to demonstrate such differences are justified is provided.

Drafting Note: The requirements of § 6.B(1) do not contain a loss ratio demonstration to support the reasonableness of premiums in relation to the premiums for dollar-for-dollar long-term care insurance benefits.