
Results of the Long-Term Care Insurance Survey

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**Gorman Actuarial, LLC
210 Robert Road
Marlborough, MA 01752**

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Summary of Findings

Over the past decade insurance regulators have focused its attention on the pricing of Long-Term Care Insurance (LTCI) products. Insurance companies have been requesting premium rate increases to ensure future claims are paid and consumers are expecting predictable LTCI premiums. Regulators are constantly faced with balancing the goals of insurance companies and consumers. Like insurance regulators across the country, the Massachusetts Division of Insurance (the Division) has been receiving an increasing number of rate increase filings. In response, Massachusetts Insurance Commissioner Burnes contracted with Gorman Actuarial (GA) to survey 30 other state insurance regulators' processes to identify tools used in reviewing rate filings. GA found significant variation in the ways states address long-term care rate filings.

Administrative Processes

Although the 30 state regulators canvassed may have differing rate review laws, each state follows relatively similar administrative processes to review filings. Approximately 85% of states surveyed use actuaries to review filings and half involve the commissioner in rate increase decisions. Approximately one-third of the regulators contact other states to compare notes on a filing. Almost a half of the state regulators negotiate the level of approved rates with companies.

Rate Review Criteria

States differ in how they approach filings. Variations in rate filing review can be influenced by many factors such as, state size, insurance department resources, department policy and consideration of decisions of other states. States that are more likely to deny or limit the level of rate increase that is approved refer to the following reasons when denying or reducing requested rate increases:

- **Seven of the states' regulators have formal rate increase limits (two of these are outlined by bulletin or regulation).** Many also follow what other states approve, and limit the rate increase approved so that they are not cross subsidizing other states.
- **A number of the states' regulators do not want consumers to pay for incorrect assumptions the companies made when first setting rates.** Some believe that long-term care insurance companies should absorb the risks involved when pricing a new product and a few regulators have not allowed rate increases to be based on changes to initial lapse, investment or other actuarial assumptions.
- **Some of the states' regulators put more weight on a plan's current actual claims rather than on projected future claims.** They indicated that they will not approve rate increases if a product is currently more profitable than expected when setting rates in initial filings.
- **Many states consider the number of policies affected.** If the number is small and has relatively little impact to an insurance company's bottom line, they are more inclined to deny the rate increase.
- **Many states would disapprove a requested increase if it is filed "too soon" since the last approved rate increase of a policy.**

NAIC Rate Stabilization Provisions

Many states have made changes to incorporate the NAIC's Calendar Year (CY) 2000 rate stabilization provisions in the Long-Term Care Model Regulation. Although the provisions may be helpful, many states indicated that the NAIC changes do not help with policies issued prior to CY 2000. Some indicated that states may need more resources to review rates under the new provisions. Even with standardized NAIC guidelines and rate stabilization provisions, GA still observed variations in rate filing review processes.

1. Introduction

Long-term care insurance covers the cost of services provided to chronically ill individuals who are no longer able to perform certain Activities of Daily Living.¹ Coverage may include services provided in nursing homes, assisted living residences or other facilities, as well as community service programs provided while the insured continues to live in his/her home.

History

In the 1980s, Congress enacted and subsequently repealed legislation that would have established a long-term care benefit under Medicare. When it became clear that Medicare would not cover long-term care benefits for chronic conditions, the insurance industry developed products to cover the risk of needing long-term care services. The National Association of Insurance Commissioners (NAIC) assisted states to regulate these new products by developing model acts and regulations to establish consistent product and rate review standards. The NAIC has modified its model act and regulations a number of times to respond to federal law changes and emerging issues in the market for long-term care insurance.

The vast majority of long-term care insurance products are individually underwritten and guaranteed renewable insurance products², but individuals may also obtain coverage through employer-sponsored plans and group association plans. Plans most commonly pay a fixed dollar of benefits per day (e.g., \$150 per day) for a certain period of time (e.g., two years) following an initial waiting period called an elimination period (e.g., six months) for benefits specifically identified in the policy³.

When developing rates for long-term care insurance products, company actuaries calculate the revenue needed from all projected policyholders to pay the future cost of providing covered services. Actuaries make assumptions about how many people may die (mortality assumptions), may drop the coverage before they need services (lapse or persistency assumptions), and how many will retain a policy and need services (morbidity assumptions), while also considering how changing interest rates affect the ability to build reserves.

NAIC Rate Stabilization Provisions

Prior to CY 2000, most states promulgated regulations based on the NAIC's original model regulation for long-term care insurance, including a requirement that minimum loss ratios⁴ be at least equal to 60%. When making their original filings, insurance companies developed premiums that satisfied the noted loss ratio based on their projections for receiving future premiums and paying future claims.

During the 1990s, a number of insurance companies submitted significant rate increase filings to certain states' regulators based on their projected need to fund increased future claims costs. The rate increase filings created a difficult balancing act for state regulators who need to ensure that insurance companies

¹ This is defined in the Federal Long-Term Care Insurance Program as, "eating, dressing, bathing, using the bathroom ("toileting"), moving back and forth from a bed to a chair ("transferring") and remaining continent." See <http://www.ltcfeds.com/assets/glossary.html>.

² In states that have enacted the NAIC's model acts and regulation for long-term care insurance, there may be life insurance products that would qualify as long-term care policies. These policies differ from traditional long-term care products because there is a death benefit and there may be a cash value to the policy.

³ According to 211 CMR 65.00, long-term care insurance policies may cover stays in nursing homes, assisted living facilities, hospices or other such facilities, and home health care, chore care, personal care, emergency medical notification, and related services provided in the community.

⁴ Loss ratio equals projected claims payments divided by projected premium revenue collected.

have sufficient funds to make future payments and to protect policyholders who may be on fixed incomes and may not be able to afford rate increases.

In CY 2000, the NAIC revised its model regulation for long-term care insurance to include several rate stabilization provisions. Of special note, the model shifts the rate review process from a loss ratio analysis to an emphasis on the **actuarial certification** submitted at the time of the initial rate filing. As noted in the model regulation⁵, the actuarial certification must include:

- A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience. [*The assumption is that if initial rates are priced appropriately, there will be less need for future rate increases and greater rate stability.*]
- Statements that certify that policy design and coverage have been reviewed and considered.
- Statements that certify that underwriting and claims adjudication processes have been reviewed and considered.
- Description of the basis for contract reserves including a statement that the assumptions used contain reasonable margins for adverse experience.
- Statements certifying that the net valuation premium does not increase and the difference between gross and net valuation premium for renewal years is sufficient to cover expected renewal expenses.
- Statements certifying that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer, or a comparison of the rate schedules with an explanation of differences.

In addition to the actuarial certification, the CY 2000 revisions include a **new loss ratio requirement** for insurers requesting a rate increase,⁶ making a distinction between “exceptional rate increases” and other increases. As identified in the model regulation, “exceptional rate increases” are due to statutory/regulatory changes or unexpected increases in utilization affecting the majority of insurers with similar products. The model regulation would require rate increase filings to demonstrate that accumulated claims plus discounted claims are more than the sum of the following:

- 58% of the accumulated and discounted original premium;
- 70% of the accumulated and discounted exceptional increase premium; and
- 85% of the accumulated and discounted premium from non-exceptional rate increase. [*This would require 85% of premium dollars to be returned in claims payments.*]

According to CY 2000 revisions, once a rate increase is granted to an insurer, the regulator would **monitor the experience** for three years to see that rates are not increased unnecessarily. Insurers would be required to submit annual filings to be reviewed for three years following a rate increase. Upon review of actual experience to what was projected, a regulator could require an insurer to implement a premium or benefit adjustment.

Massachusetts Rate Reviews

Massachusetts has never passed the NAIC model law for long-term care insurance and regulates the market under the statutory authority granted for the review of individual accident and sickness product pursuant to M.G.L. c. 175, § 108.⁷ Under the related regulation, 211 CMR 65.00, individual long-term

⁵ NAIC Long-Term Care Insurance Model Regulation, section 19.

⁶ NAIC Long-Term Care Insurance Model Regulation, section 20.

⁷ M.G.L. c. 175, §108.8.A. indicates that “the commissioner may, within thirty days after the filing of a copy or form of such a [accident and sickness] policy, disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy...[i]n the notice to the insurer

care insurance products are to satisfy a projected loss ratio of 60% over the lifetime of the policy and may be disapproved if “the benefits provided therein are unreasonable in relation to the premium charged.” Absent any change to existing laws, Massachusetts does not have the authority to change its regulation to include the NAIC rate stabilization provisions.

The Massachusetts Division of Insurance has employed external actuarial consultants since CY 2002 to review individual accident and sickness insurance rate filings, including long-term care insurance rate increase filings, according to the standards defined in Massachusetts’ regulations. The independent consultants review whether the companies have submitted appropriate tables and actuarial support and make a determination as to whether the companies have submitted a filing that meets certain actuarial standards of practice. Such reports are then sent to the Massachusetts Division of Insurance.

When the Division’s external actuaries have found a long-term care rate increase request of over 20% to be actuarially supportable, the Division has asked companies to spread this increase over a number of years so that no more than 20% of that increase is implemented in any one year. The Division has also instructed companies how to communicate the multi-year rate increases to policyholders and to advise them of their right to reduce their benefits in order to have a reduced policy premium.

Differences in Rate Review Standards

Individual states review rate filings in different ways notwithstanding the NAIC models. California, for example, maintains a website⁸ that documents how other states have addressed individual insurance company rate submissions. In many cases, insurance companies have filed the same rate increase filings nationally and some states have tended to approve the requested rates and others have tended to disapprove or reduce the amounts filed.

In July 2008, the Government Accountability Office (“GAO”) issued a report entitled “Long-Term Care Insurance: Oversight of Rate Setting and Claims Settlement Practices (GAO-08-712).” The GAO commented that “consumers may face more risk of a rate increase depending on when they purchased their policy, from which company their policy was purchased, and which state is reviewing a proposed rate increase on their policy.”⁹

Massachusetts Insurance Commissioner Burnes contracted with Gorman Actuarial (GA) to gain a better understanding of the rate-setting criteria that other states employ, with an eye toward taking a fresh look at Massachusetts’ own practices and criteria in examining insurance companies’ requests to raise long-term care rates in the wake of the GAO report.

that a filing is disapproved] the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty days after request in writing by the insurer.”

⁸ Available at <http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/ltc-rate-history-guide/rate-history-inactive-long-term-care.cfm>

⁹ See GAO Report, July, 2008, at page 5 available at <http://www.gao.gov/new.items/d081016t.pdf>.

2. Survey Process

GA developed two survey instruments, one written and one oral, to conduct surveys of other state regulators. The written survey included questions that were geared more towards the administrative process of rate filing review. The oral survey was designed to understand the technical criteria used in evaluating requested rate increases for long-term care insurance. The written and oral survey instruments can be found in Appendix A and Appendix B, respectively.

GA chose thirty states to participate in the survey (see Table 1). This sample represents various population sizes as well as various regions across the nation. GA distributed both survey instruments to each of the 30 states and then scheduled phone interviews with 28 of the 30 states for the oral survey portion. Delaware and Oregon chose not to participate in the oral survey.

New England	South	Midwest	West
Connecticut	Delaware	Illinois	Arizona
Maine	District of Columbia	Iowa	California
New Hampshire	Florida	Kansas	Nevada
New Jersey	Georgia	Michigan	Oregon
New York	Maryland	Minnesota	Utah
Pennsylvania	Texas	Nebraska	Washington
Vermont	Virginia	North Dakota	
	West Virginia	Ohio	
		Wisconsin	

Table 1 – Participating States

The written survey (see Appendix A) was distributed electronically and in hardcopy form to the appropriate insurance department personnel in each of the 30 states. GA received completed surveys either electronically or via hardcopy from all of the states. The responses were combined into an electronic database to aggregate the information provided. The responses typically fell into distinct categories. Some questions prompted unique responses from which some common information can be gleaned.

The phone interviews were scheduled with individuals of varying backgrounds. For the most part, GA spoke with actuaries, rating analysts or other individuals responsible for the review of rate filings. Occasionally, Insurance Department lawyers participated on the calls. GA used the oral survey instrument as a guide to assist with the informal discussion that took place during the phone interview. Once each interview was complete, GA documented and summarized information. Results shown are aggregated with state information obscured, for purposes of confidentiality.

3. Written Survey: Administrative Processes

This section highlights some of the high-level observations of the regulators' administrative processes according to what was recorded in the written surveys. Detailed responses are found in Appendix C:

NAIC Act/Regulations

- 21 of the 30 states have enacted the current NAIC Long-Term Care Model Act and 22 states have promulgated the current NAIC Long-Term Care Model Regulation;
- 19 of the 30 states have enacted both the NAIC Long-Term Care Model Act and Regulation;
- 2 of the 30 states enacted the NAIC Long-Term Care Model Act but not the Regulation (1 is in the process of promulgating the Regulation); and
- 3 of the 30 states have not enacted the NAIC Long-Term Care Model Act but have promulgated the Regulation (2 of the 3 have similar regulations that cover the Act).

Although there are 6 states that have not adopted the NAIC Long-Term Care Model Act or Regulation,¹⁰ two of these states have laws that are similar to the Act or Regulation.

Approval Authority¹¹

State regulators' authority to review a long-term care insurance filing is governed by that regulator's state laws. The following identifies the regulators' type of statutory authority to review long-term care filings:

- 9 out of 30 states have the authority to both approve and disapprove filings;
- 9 out of 30 states have the authority to approve filings only; and
- 12 out of 30 states have the authority to disapprove filings only¹²

Companies' Right to Deem Filings

Many states have different laws regarding when a filing is approved or deemed approved. Among the 30 surveyed states, these are the deeming standards:

- 1 state has a "file and use" policy;
- 18 states have periods, following which the company may deem a filing approved;¹³
- 10 states have no deemer period; and
- 1 state declined to answer.

Of the states with deemer periods, virtually all allow the state to disapprove a filing after an increase has gone into effect, although a small number (4) can do so only if the company is believed to be in violation of a law/regulation.

¹⁰ Massachusetts has not enacted the NAIC's model acts or regulations for long-term care insurance.

¹¹ The summary of states' authority to approve and/or disapprove filings is based on responses to question 3 in the Statutory/Regulatory Provisions section of the written survey, and is based on the following definitions:

- ❖ Authority to approve filings only (meaning no change occurs until your agency formally approves it)
- ❖ Authority to disapprove filings (meaning that agency may disapprove filing, but filing may become effective if not disapproved)

¹² Under Massachusetts law, M.G.L. c. 175, § 108, the Division of Insurance only has the authority to disapprove individual accident and sickness filings.

¹³ Under Massachusetts law, M.G.L. c. 175, § 108, companies may deem filings to be approved if the Division does not respond within 30 days of the company's filing.

Timing of Reviews

The regulators indicated that their internal processes provide for the review of rate filings within a reasonable period of time but there may be delays because of either: (1) the quality and/or complexity of a filing or (2) the time that it takes a company to respond to requests for additional information. The regulators reported the following:

- The average length of time to complete a rate request review is 44 days, but can vary between 10 and 150 days;
- The minimum length of time to complete a rate request review varied from 1 to 43 days; and
- The maximum length of time to complete a rate request review varied from 30 to 438 days.

Administrative Processes When Reviewing Rate Filings

The state regulators indicated that it was important to have dedicated staff reviewing the filing. They also indicated that it was helpful to use standard checklists/review processes to ensure that the reviews comply with relevant laws, regulations, and rules, as well as the standards of actuarial practice. Among the other administrative processes, the states indicated the following:

Involving Regulator Staff

- 25 of the 30 states regularly use an actuary, 1 state does occasionally, and 4 states do not
- Only 2 of the 30 states' commissioners review all long-term care insurance rate increases
- 12 of the 30 states' commissioners review a long-term care rate increase only if the requested rate increase is above a certain threshold

Using Information from Other States

- 11 of the 30 consider acts of other states; 16 do not; 2 use sometimes
- 8 of the 30 consider acts of companies' domiciliary state; 19 do not; 2 use sometimes
- 9 of the 30 contact other states to compare notes or opinions; 17 do not; 2 do sometimes

Contacting Insurance Companies and Keeping Records

- 16 of the 30 contact the company prior to making a decision; 10 do not; 3 do sometimes
- 13 of the 30 negotiate rate increases with the company; 13 do not; 3 do sometimes
- 16 of the 30 catalogue long-term care insurance rate increases; 14 states do not
- 10 of the 30 may request that the company extends the allowed increase over time; 15 do not; 3 do sometimes

Administrative Hearings

In 26 of the 30 surveyed states, an insurance company has the right to administrative hearings when long-term care rate increase filings are disapproved; 4 states indicated that the company did not have this right. Among the states that do have administrative hearings, one state actually requires hearings to be held on all disapproved filings, not only rate increases, and another state requires hearings only when a rate request was previously approved.

4. Oral Survey Observations: Review Standards

As described in Section 2, the oral survey was designed to be an informal discussion with state regulators regarding their rate increase approval process for long-term care insurance. The findings are grouped into four broad categories of interest:

- NAIC LTCI Model Regulation
- State's Approval/Disapproval Record
- Rate Filing Review Process
- Criteria Used to Review Requested Rate Increases

Since the discussions with state regulators were structured as informal interviews, the statistics that support our observations may not be entirely accurate. For example, when it is reported that eight states have mentioned reviewing the actions of other states, this does not mean that *only* eight states review the actions of other states. There may be more than eight states that perform this exercise, but only eight states *mentioned* this review in our oral interview.

4.1. NAIC LTCI Model Regulation

As shown in Table 2, when asked if a state had adopted the rate stabilization provisions in the NAIC model regulation for long-term care insurance, 68% of our sample stated that they had adopted the new rate stabilization provisions. Three states are in the process of adopting the Act in CY 2009, and two have adopted it with some modifications. Four states have not adopted the rate stabilization provisions at this time.¹⁴

<i>Number of States that adopted Rate Stabilization</i>	19
<i>Number of States in process of adopting</i>	3
<i>Number of States that adopted Rate Stabilization with modifications</i>	2
<i>Number of States Not Adopting</i>	4
<i>Total</i>	28

Table 2 – Adoption of Rate Stabilization Provisions in NAIC Model Regulation

Of the four states who have not adopted the rate stabilization provisions in the NAIC model regulation, two indicated that they learned from speaking with other states that have adopted the changes, that while the initial rates were higher, insurance companies still continued to request high rate increases for newer policies. They are not convinced that the CY 2000 rate stabilization provisions will be effective. The other two states indicated that they were not considering adopting the new Model Act.

Table 3 illustrates when states surveyed adopted the rate stabilization provisions. Many states commented that it is too premature to understand the true impact of the rate stabilization provisions in the NAIC regulation. Most states had very little experience with rate increase filings for policies post rate stabilization. One state that adopted the Model Act in CY 2002 had seen about a dozen rate increase filings. Five states mentioned that they had seen a handful of rate increase filings and the

¹⁴ Note that these results differ slightly from the information received and captured in the written survey. Additional detail is located in Appendix D.

remaining states had seen either one or zero rate increase filings. Due to the lack of experience with rate increase filings for policies post rate stabilization, the discussions regarding the rate filing review process were focused on the older policies, which were issued before rate stabilization.

<i>Year Adopted</i>	<i>Number of States</i>
<i>2002</i>	<i>5</i>
<i>2003</i>	<i>8</i>
<i>2004</i>	<i>2</i>
<i>2005</i>	<i>4</i>
<i>2006</i>	<i>0</i>
<i>2007</i>	<i>1</i>
<i>2008</i>	<i>1</i>
<i>2009</i>	<i>3</i>
<i>Total</i>	<i>24</i>

Table 3 – Years that States Adopted Rate Stabilization Provisions in NAIC Model Regulation

Most of the states that have adopted the new model regulation have different requirements for policies that were issued prior to the adoption of the regulation. The minimum loss ratio requirement for these older policies for the vast majority of states is 60%. Four states stated that they have no real authority to disapprove rates and three of the four would generally approve requested rate increases if supported by an actuarial memorandum. One state modified its current regulation for older policies and implemented a similar loss ratio requirement as the new model regulation. Another issued a separate bulletin to address the rate increase filings for the older policies. A couple of states intend to apply the new model regulations to these older policies on a predetermined date.

State regulators must have a thorough understanding of when policies were issued. Due to the timing issues and the use of two different regulations, rate increase filing reviews can be quite complex. For example, if a rate increase filing is submitted for a policy that was issued prior to the adoption of the new model regulation, in most states, the old regulation would apply. Some insurance companies have sold policies after the adoption of the new regulation from a policy form issued prior to the adoption of the regulation. The result is a separation of pools in which the old regulation applies to older policies and the new regulation applies to the newer policies, all from the same policy form. In these instances, regulators have either combined the pool and reviewed projections under both regulations or separated the pools and reviewed the projections for each pool under the respective regulation.

Many states believe that the actuarial certification requirement under the new regulation will prove to be a useful tool in stabilizing long-term care insurance rates. Since an insurance company’s actuary must certify that initial rates are adequate under moderately adverse experience, states believe that the initial rates will be priced more conservatively and insurance companies will be less likely to request future increases. States also feel that the new regulation provides more authority than what was previously available. Many states noted that with the new rate stabilization provisions, they are able to complete a more thorough review of the initial rate filings and, when necessary, better able to receive additional data. In addition, states indicated that they can monitor the experience of a policy following a rate approval.

There is still very little experience with rate increase filings for policies post rate stabilization. However, discussions with states that did have some experience led to feedback on some of the shortcomings of the rate stabilization provisions. Some states are still experiencing high rate increase requests even for policies that were issued after the introduction of the rate stabilization provisions.

Some of these requests range from 75 - 100%. It appears that the initial actuarial certification alone may not stabilize future rates. States have speculated that there is still a marketing influence on the setting of initial rates.

Since the NAIC’s rate stabilization provisions do not define the term “moderately adverse experience”, it is subject to interpretation, resulting in a wide range of assumptions. As mentioned earlier, the new regulation is not applicable to older policies for which insurance companies have typically requested rate increases. Some states mentioned that the new regulation limits their negotiating ability. For example, if an insurance company is requesting a 50% rate increase which is supported by an actuarial certification it is difficult for a regulator to negotiate a lower increase for fear of the insurance company retracting its actuarial certification. A few states noted that the new regulation allows insurance companies to recoup past losses. Finally, a handful of states have mentioned that they do not have the resources to carry out the experience monitoring function allowed in the new regulation.

4.2. State’s Approval/Disapproval Record

GA asked a series of questions concerning a state’s approval record of requested rate increases for long-term care insurance. GA asked, “in general, what percent of rate increase filings are approved, what percent are modified, and what percent are denied?” The responses were somewhat subjective; some of the states would not answer the question and some of the states only answered a portion of the question. As indicated in Table 4, three states mentioned that they disapproved at least 70 - 80% of the rate increase filings. Most states negotiated with companies to modify a requested rate increase. Only two states noted that the majority of filings are approved.

<i>Number of States</i>	
<i>Disapproved 70-80%</i>	<i>3</i>
<i>Modified >50%</i>	<i>9</i>
<i>Modified <40%</i>	<i>8</i>
<i>Majority Approved</i>	<i>2</i>
<i>No disapproval authority</i>	<i>2</i>

Table 4 – Approval Record

GA also asked “What was the highest rate increase approved?” Not all of the states answered this question. This question also does not capture the cumulative effect of annual rate increases. For example, if the highest increase a state approves in a given year is 15%, the cumulative increase can be significantly higher. As indicated in Table 5, eight states indicated that the highest increase approved was 50% for a particular policy (and 12 of the 24 states approved a 50% or greater increase). One state recollected approving a 500% rate increase. But, in this situation, the state also requested that the insurance company give the policyholder the option to terminate the policy with a return of premium with 5% interest. As shown, premium increases can be significant and diverse across states.

<i>Highest Increase Approved</i>	<i>Number of States</i>
<i>10%</i>	<i>1</i>
<i>15%</i>	<i>1</i>
<i>20%</i>	<i>2</i>
<i>20-30%</i>	<i>4</i>
<i>30-50%</i>	<i>4</i>
<i>50%</i>	<i>8</i>
<i>75%</i>	<i>1</i>
<i>100%</i>	<i>2</i>
<i>500%</i>	<i>1</i>

Table 5 – Highest Increase Approved

Some of the states have allowed insurance companies to spread larger rate increases over a two to three year period. For example, if a 75% rate increase is required, a state may allow approximately 20% to be applied in each year of a three-year period with the goal of tempering shock lapses. Twelve states indicated that they have adopted this approach in the past.

Eight states indicated that they will not allow an insurance company to spread an increase over a period longer than 12 months. Instead, they have approved a lower rate increase than requested, and encouraged the insurance company to file for another rate increase the following year and reviewed the additional year of experience before approving further increases. The eight remaining states indicated that they would not allow an increase to be spread over time. One state’s regulations do not permit the regulator to approve increases for more than 12 months into the future.

4.3. Rate Filing Review Process

GA asked a series of questions related to the rate increase filing review process. All the states agreed that long-term care insurance rate increase filings were mostly due to incorrect lapse assumptions when policy rates were originally filed. Since fewer than expected numbers have lapsed policies, the number of expected policyholders in the insured pool is much higher than originally expected. Some states noted that, to a lesser extent, interest rate risk and morbidity impacted requests for rate increases.

GA asked states to explain the information examined when reviewing a rate increase filing. Below are our observations based on the responses received during the oral interview.

Most states request an actuarial memorandum that should include projections, underlying assumptions of the rate increase, and the basis of the assumptions. The states indicated that the memorandum should include an explanation of how the new assumptions have changed from the assumptions used in the initial rate filing, as well as the following:

- Six states expect to see projections with and without the requested rate increase;
- One state expects to see projections by age bracket;
- One state expects to see projections with/without the interest rate;
- Six states require reviewing durational loss ratios by calendar year;
- About half the states reviewed the lapse assumptions and underlying support; and
- One state requests the original data used to develop the lapse assumptions in the initial rate filing. (If this data does not support the original lapse assumptions, this state may deny the requested rate increase.)

A majority of states emphasized reviewing historical experience in determining whether to allow the rate increase.

- Twelve states review national and state-specific information;
- Four states review actual to expected claims costs;
- Eight states review historical rate increases;
- Eight states review other states' rate actions and premium levels for the same policy;
- Very few states focus on reserve estimates, expense assumptions, and types of underwriting used in the individual policy;
- One state reviews commission schedules due to limitations within their regulations;
- A few states want to understand the insurance companies' definition of moderately adverse experience and would like to see supporting documentation;
- A few states request the initial rate filing to be submitted with the rate increase filing;
- About a third of the states use a checklist to request data; the checklist may be within a state's regulations, within SERFF instructions or within the agency guidelines; and
- One state reviews claims experience for all similar policy forms in that state.

If a state needs to request additional data, the amount of time provided to the insurance company varies from state to state. Five states do not have a required time limit, and seven states allow only two weeks.

GA also asked how a state determines which assumptions are appropriate. Most replied that based on their experience they have a general understanding of the range of each assumption. Four states mentioned that they reviewed Society of Actuaries (SOA) experience studies and long-term care publications to get an understanding of appropriate assumptions. One state is developing a database of assumptions based on submitted rate filings.

Most states do not use external resources to assist them in their rate filing reviews. Five states indicated that they occasionally will refer to the NAIC Guidance Manual for Rating. A few states have mentioned the Actuarial Standards of Practice or the Practice Notes as a possible resource.

Most states do not conduct their own premium calculations, stating they do not have the time, resources, or the software necessary to do this. Two states request each insurance company's analysis and review the calculations to ensure they are correct. Five states do some high level analysis to develop premiums. Some of these states recalculate projections using the most current premium, or using the original lapse and/or investment assumptions.

4.4. Criteria Used to Review Requested Rate Increases

This section describes our observations from the oral survey pertaining to the various criteria used by states to assist them in evaluating the requested rate increases. GA grouped the data into broad categories and identified the number of states that mentioned the use of each of these criteria during the interview process.

Setting Rate Increase Limits

Seven states of the thirty have "formal" annual rate increase limits, either in a regulation or in some other defined policy within the agency. Among these states, increases are limited in the following ways:

- 10% (1 state) as identified in a bulletin;
- 15% (2 states);
- 15% and on exception 20% annual increase, as written in a regulation (1 state);

- 25% (1 state);
- 35% or greater than \$75 in monthly premium (1 state); and
- 50% (1 state).

In certain states with regulations stating annual rate increase limits, the regulators noted that insurance companies have annually received the maximum allowable increase. The cumulative impact has been to permit 50-75% cumulative increases over a 3 to 4 year period.

In addition to the formal limits, another seven of the thirty sampled states have informal annual limits. These states have indicated that if the increase is “too high,” “around 30%,” “or around 50%,” they would not allow the increase. Four states have said they would scrutinize the filing more closely if the increase were “high” (25% and above).

Among the rest, ten states indicated they have no rate increase limits and four did not respond.

Examining Possible Cross-Subsidization

Since long-term care insurance is a relatively new product, most insurance companies develop premium rates using national data due to the low credibility of state-specific experience. When a state’s rates are based on national experience and projections, it is possible that these rates may be higher than necessary if those states’ long-term care claims are lower than those of other states. This may lead to cross-subsidization if states with lower costs on average are subsidizing states with higher costs on average.

Cross subsidization can also exist when certain states disapprove a rate increase or approve a portion of an actuarially supported rate increase; those states which approve the actuarially supported increase may be subsidizing those who do not. A number of states indicated that they look closely at other states’ rate review actions with the goal of eliminating some or all of this cross subsidization.

For example, eight states, representing a mix of large and small states primarily in the West and Midwest, review other states’ long-term care rate review actions to assist them in evaluating a requested rate increase. Some states also review the policy’s premium levels in other states. If the premium levels or increase levels are lower in other parts of the nation, some of these states will not approve a companies’ rate increase request. One state specifically requests all of the rate increases and premiums approved in other states for the same product; then that state calculates a national average rate increase and uses this average as its rate increase limit. Other states indicated that it was cumbersome and difficult to obtain this type of information and use other methods.

Pooling of Data Across All Long-Term Care Policies

Many insurance companies offer more than one long-term care insurance product in a state. When sending in rate increase filings, however, they are based on the experience of only one policy which limits the actuarial credibility of data associated with that one policy. One way to address this concern is to pool data of like policies when analyzing any filed rate increase.

GA’s survey found that two states request that data for all “like policies” that have been offered in the state be pooled together when developing projections so that the regulator has information on the insurance companies’ profitability within their state. The pooling of policies can also decrease volatility in rate increases, especially for closed blocks of business. The laws in one large Southeast state also require that an insurance company pool its data for all similar polices of affiliated insurance companies.

Examining State-Specific Data and the Credibility of the Data

Almost all the states review state-specific experience and compare this data to national experience. Two states require insurance companies to adjust national projections using state-specific information. For example, an insurance company will be expected to adjust the national premium to reflect state-specific rate actions. Also, national claims costs must be adjusted to reflect a state-specific mix of business.

One of the larger states places greater emphasis on the credibility of data when reviewing rate increase filings. For example, if an insurance company requests a rate increase due to a change in lapse assumptions, the state will review the underlying data used to support the assumptions. If this data is not credible, the state will not approve the requested rate increase. Also, if the rate increase is supported by national data that is not credible, the requested rate increase will be adjusted by a credibility factor. For example, if the requested increase is 50%, and the state determines the national data to support the increase is only 50% credible, the state will approve no more than a 25% rate increase.

In examining the credibility of the data, states have established different criteria:

- Five states – mostly in the Mid-Atlantic and Southeast – obtain state-specific data and use their own formula to weight the credibility of state-specific and national data. They then use the new projections as the basis to review rate increases. When GA asked states to describe under what circumstances state-specific data was actuarially credible, there was much variation. Of those that responded, regulators indicated that state-specific data would be considered credible when the insurance company met the following thresholds:
 - \$1M of annual premium in the state;
 - \$80M in incurred claims in the state;
 - 500 covered lives in the state;
 - 1000 covered lives in the state;
 - 2000 covered lives in the state;
 - 1000 claims filed by state policyholders over the past 5 years;
 - 2000 claims filed by state policyholders; or
 - Other subjective criteria based on the data and experience of the company.
- Five states indicated that if state-specific data is inconsistent with national data, they would deny or modify the rate increase regardless of credibility.

Eliminating the Ability to Recover Past Losses

For older policies, many states continue to use a lifetime loss ratio requirement of around 60% that was in use prior to the development of the NAIC rate stabilization provisions. In the rate increase filing, insurance companies must submit projections that support this requirement. Since the lifetime loss ratio combines past experience with future projections, insurance companies may include information that attempts to recoup for past losses. Two states have indicated that they modify company calculations to replace historical premium with the most current premium in the submitted projections, thereby eliminating any attempt to recover for past losses. If the new projections show that the lifetime loss ratio is below the minimum, they will disapprove the rate increase.

Examining Actual-to-Expected Loss Ratios

A company's actual loss ratio equals paid claims divided by premiums collected. When developing long-term care insurance rates, companies calculate expected projected loss ratios which compare projected claims paid out for covered policyholders to projected premium revenue collected from those

policyholders. The question is whether the regulator should also examine the policy's current actual loss ratio in addition to examining the long-term projected loss ratio.

Six states stated that they scrutinize an insurance company's actual-to-expected loss ratios as of the time of the filing. These states examine actual submitted long-term care claims and premium revenues to the date of the filing and compare this to what was originally projected when setting the initial premium rates. Two states indicated that if the actual-to-expected ratio is less than 1.0, they will not allow the increase. If the ratio is greater than 1.0, the actual experience is worse than expected and perhaps initial premium rates are insufficient and some increase may be approved. For example, if the ratio is 1.09, a more moderate increase may be approved such as 10-15%. If the ratio is 1.5 or above, a higher increase may be approved.

While some companies use the actual-to-expected analysis, this method places greater emphasis on actual experience versus the insurance company's future projections. While historical experience may be positive, an insurance company may have new information which would suggest a future downturn and prompt a request for a rate increase. This expectation would be reflected in an insurance company's future projections. Using the actual-to-expected ratio does not necessarily consider an insurance company's change in expectations in the future.

Using a Loss Ratio Methodology

Four states have described using an informal loss ratio criterion to assist them in reviewing rate increase requests. Some of these criteria are outlined below.

- Criteria 1
 - If the current loss ratio is low (10-30%), the rate increase may not be approved. States have indicated that it is difficult to justify an increase to a policyholder when the insurance company is currently "profiting" from the policy.
- Criteria 2
 - If the current loss ratio is already greater than the minimum allowed, then the state may approve the requested increase. The thought here is that in these instances, the policy is already in a negative position and an increase is warranted.
- Criteria 3
 - If the projected loss ratio in the short term (10-12 years) approaches the minimum loss ratio requirement, the regulator may be inclined to approve the rate increase.
 - If the projected loss ratio in the long term (20 years) approaches the minimum loss ratio requirement, the regulator may not approve the increase. The thought here is that anything can happen in 20 years and the assumptions that are in place today may not be true in a 20 year time frame.

Holding Insurers Accountable for Original Assumptions

The topic of accountability came up many times in discussions with regulators. Many states agree that it is unfair to pass on all of insurance companies' pricing errors to the policyholders. The regulators believe that insurance companies entered into the market knowing all the risks involved and should be held accountable for their aggressive pricing strategies. Three states do not allow rate requests to reflect any changes to an insurance company's original lapse and investment assumptions. They believe the policyholder should not have to pay for the company's inaccurate rating assumptions.

Monitoring Insurer Solvency

Three states mentioned that they review the financial condition of an insurer to assist them in their rate filing review. Regulators are more likely to approve an increase of an insurance company that has weak financials or that primarily sells long-term care insurance.

Considering the Number of Policies Affected by the Change

Many states suggested that if the book of business is small, a significant rate increase may have very little impact on an insurer's bottom line and may "force" policyholders in these small books to exit the market. Due to these reasons, a state may deny the requested rate increase.

Considering the Age of the Policy

One state indicated that it considers the age of the policy when evaluating the rate increase filings. This state leans towards disapproving increases for older policies because policyholders are generally older and have invested a significant amount of money in premium payments. If these policyholders terminated their policies due to the high rate increases, they may not find a suitable replacement policy.

Taking into Account Date of Last Approved Increase

Many states disapprove a requested increase if it is filed too soon after the last approved rate increase of a policy. These states want to monitor and review developing experience from the last approved rate increase before approving another increase.

5. Conclusions of Survey

There is significant variation in how states conduct their reviews of long-term care insurance rate increase filings. One out of every four states in the survey has formal rate increase limits for long-term care insurance plans. Many are concerned with cross subsidization across states and consider this when reviewing rate increase requests. Some states confer with each other while other states do not. Since most rates are based on national experience, those states that remove cross-subsidies or implement rate increase limits raise the rate burden on those states that do not.

Many states do not focus on an insurance company's projections or changes in expectations; they focus instead on what has happened to date. Long-term care insurance policies' premiums are higher than claims in early years, but this changes as the policy matures. However, if an insurance company has been profitable on a policy to date, it makes it difficult for a state regulator to approve a substantial increase. Finally, there is a general consensus among states that long-term care insurance companies need to take responsibility for their actions and that the insurance companies should not pass on all of the loss to the policyholder. This philosophy has been implemented by a few states that have not allowed insurance companies to change their original lapse and investment income assumptions.

The rate stabilization provisions added in CY 2000 to the NAIC Long-Term Care Insurance Model Regulation were designed to assist with alleviating significant rate increases for long-term care insurance. Unfortunately, the provisions do not sufficiently assist with the rate increase requests for the older policies issued prior to CY 2000. Even those who have implemented the rate stabilization provision have indicated that significant rate increase requests are still being submitted for these newer policies. Finally, many states agree that it is too premature to tell if the new regulation will be effective. States do agree, however, that in order to implement the tools of the rate stabilization provisions, states need resources to utilize some of these new functions.

A few states have suggested that there needs to be stronger due diligence in reviewing the initial rate filing over and beyond what is suggested in NAIC models. Placing more emphasis on the initial rate filing may eliminate inadequate initial rates and stabilize rates for the future. Also, the pooling of data from similar policies may be an appropriate way to temper increases, especially for closed blocks of business. Unfortunately, this technique is used only by a small number of states. Finally, in order to ensure that long-term care insurance is viable in the future, it is prudent to review an insurance company's financials and its ability to absorb losses before making a decision on requested rate increases. Only a handful of states mentioned reviewing company financial reports.

6. Appendices

6.1. Appendix A – Written Survey Instrument

This appendix contains the written survey provided to the state commissioners.

Long-Term Care Insurance Survey

Written Section

Schedule A represents the first part of a Long Term Care Insurance (“LTCI”) Survey that Gorman Actuarial is conducting on behalf of the Massachusetts Insurance Commissioner.

In Schedule A we request that your office respond in writing to a series of questions about your review of long term care rate filings by January 6, 2009. There are 25 pages to this portion of the survey. Please answer the following questions to the best of your ability. As mentioned in the cover letter, all state-specific responses will be confidential and will be reported in an aggregated format only. Thank you in advance for your valued participation in this survey.

If you have any questions regarding this survey, please contact Gorman Actuarial at:

Phone: (508) 229-3525

Email: actuary@gormanactuarial.com

Electronic Submittal

Please use this document to store your responses electronically. Questions may require a written response and/or selection of a check box. All written responses must begin in the gray highlighted areas. Check boxes can be selected using the mouse. Please send completed surveys to:

actuary@gormanactuarial.com

Paper Submittal

Please submit your written responses in the enclosed pre-paid, self-addressed envelope.

Statutory/Regulatory Provisions

1. Has your state enacted the NAIC Long-Term Care Insurance Model Act?
 Yes No
 - a. If you have a related law that significantly differs from the model, please describe how your law differs from the NAIC model.
2. Has your state promulgated the NAIC Long-Term Care Insurance Model Regulation?
 Yes No
 - a. If you have a related regulation that differs significantly from the model, please describe how your regulation differs from the NAIC model.
3. Please indicate which of the following statutory standards apply to your review of a LTCI rate increase filing (check all that apply).
 - a. Authority to approve filings only (meaning no change occurs until your agency formally approves it)
 - b. Authority to disapprove filings (meaning that agency may disapprove filing, but filing may become effective if not disapproved)
4. When do you require a carrier to notify the Commissioner of a rate increase? How soon before a proposed effective date must the notification be sent?
5. Please explain whether the company may deem a filing approved if not disapproved within a certain number of days.
6. Please explain whether your agency may disapprove a filing even if it is beyond the deemer period or if the filing was previously approved by your agency.
7. Please explain whether your agency must call a hearing whenever you disapprove a filing.
8. If a filing has been disapproved, does the filing company have the right to call an administrative hearing at your agency?
 Yes No
 - a. How many days following notice of disapproval does a company have to call a hearing?

Volume

1. Does your agency maintain a catalogue of LTCI rate increases?
 Yes No
 - a. If you do, please briefly describe the information you capture when tracking LTCI rate increase requests.

- b. If you do, please provide a list similar to what is used in Massachusetts including the following for each filing: company, policy form identifier, rate increase request, and number of policies impacted by the request for each year beginning Calendar Year 2000. A sample of the Massachusetts list is shown in Exhibit A.

Please add attachment to either the Electronic or Paper Submittal

- c. If a list is not available, could you please provide the number of LTCI rate filings that have been submitted to your agency and the number of affected people?

Administrative Processes

1. Please describe the administrative process and review steps that you use to review LTCI rate filings.
2. Do you use an actuary to review the rate filings?
 Yes No
 - a. If so, is the actuary an internal or external consultant?
 Internal External
 - b. If not, have you ever considered using an actuary to review rate filings?
 Yes No
3. Which individuals are involved in reviewing rate filings submitted to your agency? Please include their titles, background, and/or other qualifications.
4. Does the Commissioner review each LTCI rate increase?
 Yes No
 - a. If not, which person(s) in your organization is (are) responsible to make the final decision on LTCI rate increases and what is (are) their titles, backgrounds and/or qualifications?
5. Does a LTCI rate filing involve Commissioner or senior staff level review only when the change is beyond a certain level (e.g., size of the increase or number of persons affected)?
 Yes No
 - a. If so, what are the threshold levels?
6. What has been the average length of time needed to complete a LTCI review from the date that the filing first comes in the door?
 - a. What has been the shortest time needed?
 - b. What has been the longest?

- c. Are there reasons why certain filings have taken longer than the average length of time?
7. What types of administrative tools does your agency use to ensure that each LTCI rate filing is reviewed consistently and that rate increases are approved or disapproved based on consistent criteria.
 8. If a carrier is in more than one state, do you consider the approval/disapproval decision of another state before making your final decision?
 - Yes No
 - a. Do you consider the decisions of a carrier's domiciliary state?
 - Yes No
 - b. Do you contact any other states for their opinions on any submitted filings to compare notes or develop questions/opinions?
 - Yes No

Communicating Findings

1. Does your agency contact the company prior to any formal letter to discuss a LTCI rate filing?
 - Yes No
 - a. If so, does your agency point out parts of the filing that do not appear to be correct to enable the company to correct them?
 - Yes No
 - b. Does your agency negotiate the amount of the rate increase?
 - Yes No
 - c. Does your agency request that the company extend any rate increase over a longer period of time?
 - Yes No
2. Do you send a letter to each filer to formally communicate whether a filing is approved or denied?
 - Yes No
 - a. If so, does your agency use a standard form letter?
 - Yes No
 - b. If so, does your agency identify the reasons that a filing has been approved or denied?
 - Yes No
 - c. If so, could you please submit a copy of this form letter along with this survey?

6.2. Appendix B – Oral Survey Instrument

This appendix contains the oral survey provided to the state commissioners.

Long-Term Care Insurance Survey

Oral Section

Schedule B represents the second part of a Long Term Care Insurance (“LTCI”) Survey that Gorman Actuarial is conducting on behalf of the Massachusetts Insurance Commissioner.

Schedule B includes questions that we intend to discuss during a call we will schedule with your agency. There are 3 pages to this portion of the survey. In order to facilitate the telephone call please review this Schedule prior to the phone interview. We anticipate the phone interview will take approximately 45 minutes. As mentioned in the cover letter, all state-specific responses will be confidential and will be reported in an aggregated format only. Thank you in advance for your valued participation in this survey.

If you have any questions regarding this survey, please contact Gorman Actuarial at:

Phone: (508) 229-3525

Email: actuary@gormanactuarial.com

Statutory/Regulatory Provisions

1. If you have adopted/promulgated the rate stabilization provisions in the model act/regulation, how have the rate stabilization provisions affected your review of rate increases?
 - a. Please identify any specific sections that you believe improved your ability to review submitted rate increase filings compared to what may have been in place before.
 - b. Do you have different requirements for policies issued before the adoption of the Model Act/Regulation vs. after?

Review of the Filing

1. In your opinion, what is the most common reason why companies are requesting rate increases?
2. What material do you generally receive to review LTCI rate increases submitted by a carrier?
3. Do you generally receive all the information you need when a carrier files for a rate increase?
 - a. If not, what information is critical to you?

- b. Has what you concentrated on changed over time?
 - c. Do you typically have to request follow up data, and if so what data?
 - d. How much time do you typically provide a carrier to submit follow up data?
4. Do carriers provide information in an initial rate filing that is necessary to have in order to review subsequent rate increase filings?
- a. Do you need to request additional data associated with an initial filing to assist in the review of a subsequent rate increase filing?
 - b. If yes, what additional information as backup to the initial filing do you request?
5. When reviewing rate increases, which assumptions do you feel are critical?
6. How do you evaluate the appropriateness of the assumptions?
7. Do you try to identify which assumptions in the initial filing are no longer appropriate (sources of adverse experience)?
8. If a company uses its own actual experience for its assumptions i.e.: morbidity, mortality, and lapse assumptions, when do you consider data credible?
- a. Does the data have to reflect a certain market size?
 - b. Do you ever require a carrier to use data that reflects their national experience? If yes, why?
 - c. Have you ever required a carrier to use data other than their own to develop specific assumptions?
9. Do you perform your own premium calculations?
- a. How do you develop your assumptions?
 - b. What type of model do you use to develop your own premium projections?
 - c. Do you perform your own sensitivity analysis on key assumptions?
 - d. How do you determine the range of assumptions to use when performing sensitivity analyses?
 - e. How do you define moderately adverse experience?
10. Do you use any published guidelines to assist you in the rate filing review?
11. What criteria do you use to ultimately accept, decline or modify submitted rate increases?
12. Have you ever denied requested rate increases for LTCI?

- a. What are the specific reasons that the rate increases were disapproved?
 - b. Do you have a limit to what you will approve?
13. Have you ever requested an increase be spread over time? Why?
14. Do you monitor the experience of policies where rate increases were approved?
- a. For how long?
 - b. What do you review?
 - c. What is the highest rate increase that was approved or permitted by your agency?
15. Have you ever prohibited marketing of products due to persistent practice of filing inadequate rates?
16. Have you ever determined that a policy is in a rate spiral?
- a. What did you do in this instance?

6.3. Appendix C – Written Survey Responses

This appendix contains the aggregated responses to the written survey.

Long-Term Care Insurance Survey

Statutory/Regulatory Provisions

1. Has your state enacted the NAIC Long-Term Care Insurance Model Act?
 - **21 states responded “Yes” and 9 responded “No”**

For those states that responded “No”, the responses are found in Appendix D.

- a. If you have a related law that significantly differs from the model, please describe how your law differs from the NAIC model.

Responses regarding differences between State’s regulations and the NAIC Act/Regulation are provided in Appendix D.

2. Has your state promulgated the NAIC Long-Term Care Insurance Model Regulation?
 - **22 states responded “Yes” and 8 responded “No”**

For those states that responded “No”, the responses are found in Appendix D.

- a. If you have a related regulation that differs significantly from the model, please describe how your regulation differs from the NAIC model.

Responses regarding differences between State’s regulations and the NAIC Act/Regulation are provided in Appendix D.

3. Please indicate which of the following statutory standards apply to your review of a LTCI rate increase filing (check all that apply).

- a. Authority to approve filings only (meaning no change occurs until your agency formally approves it)
- b. Authority to disapprove filings (meaning that agency may disapprove filing, but filing may become effective if not disapproved)

- **9 states responded “a” AND “b”**
- **9 states responded only “a”**
- **12 states responded only “b”**

4. When do you require a carrier to notify the Commissioner of a rate increase?
 - **Always (3)**
 - **Prior to implementation (5)**
 - **Filed before use (5)**
 - **30 days (6)**
 - **45 days (3)**
 - **60 days (6)**

- **90 days (2)**

How soon before a proposed effective date must the notification be sent?

- **No Answer (6)**
- **No Specified Time Frame (4)**
- **30 days (8)**
- **45 days (7)**
- **60 days (3)**
- **90 days (2)**

5. Please explain whether the company may deem a filing approved if not disapproved within a certain number of days.

- **19 states responded “Yes”, while 10 states responded “No”. Here is a further breakdown of all state responses:**

- **No (10)**
- **File and Use (1)**
- **Yes, 30 days (7)**
- **Yes, 45 days (3)**
- **Yes, 60 days (5)**
- **Yes, 90 days (1)**
- **Yes, but in practice this does not happen (2)**
- **Not answered (1)**

6. Please explain whether your agency may disapprove a filing even if it is beyond the deemer period or if the filing was previously approved by your agency.

- **19 states responded “Yes”**
- **7 states responded “Yes, if department believes a company may be in violation of insurance laws and regulations”**
- **4 states responded “Not Applicable” or “Not Answered”**

7. Please explain whether your agency must call a hearing whenever you disapprove a filing.

- **1 state responded “Yes”**
- **1 state responded “Yes, but in practice this does not happen”**
- **26 states responded “No”**
- **2 states responded “Only after a filing has been previously approved”**

8. If a filing has been disapproved, does the filing company have the right to call an administrative hearing at your agency?

- **25 states responded “Yes”**
- **4 states responded “No”**
- **1 state responded “Not Applicable” (Since they always require a hearing when a request has been disapproved)**

a. How many days following notice of disapproval does a company have to call a hearing?

- **Not Applicable (5)**
- **Not Defined (9)**
- **15 days (1)**
- **20 days (2)**
- **30 days (10)**

- 45 days (1)
- 60 days (1)
- 90 days (1)

Volume

1. Does your agency maintain a catalogue of LTCI rate increases?
 - 15 states responded “Yes” and 14 responded “No”
 - 1 state responded “Yes” and “No”; they don’t maintain a catalog per se, but are able to retrieve information from a database.
- a. If you do, please briefly describe the information you capture when tracking LTCI rate increase requests.

For the states that maintain a record of rate requests, Table 6 shows the data fields that are captured, and their prevalence:

Data Field	Prevalence
Carrier Name	100%
Identifier	100%
% Rate Increase Approved	94%
% Rate Increase Requested	59%
Date Approved	59%
Number of Policies	41%
Product Type	35%
Date Submitted	35%
Date to Policyholder	29%
NAIC Number	18%
Still Issued?	18%
Date Sold	12%
Sold in State?	12%
Sold in Other States?	12%
Expenses and Loss Ratio	12%
Amount of Premium	6%
Company Acquired From	6%
Date Acquired	6%
Approved or Not	6%
Rate Increase in State(Y/N)?	6%
Rate Increase out of State(Y/N)?	6%

Table 6 – Summary of Data Fields Captured for LTCI Rate Requests

- b. If you do, please provide a list similar to what is used in Massachusetts including the following for each filing: company, policy form identifier, rate increase request, and number of policies impacted by the request for each year beginning Calendar Year 2000. A sample of the Massachusetts list is shown in Exhibit A.

Please add attachment to either the Electronic or Paper Submittal

16 states provided LTCI rate increase summaries. Several states provide the information to the public via the World Wide Web.

- c. If a list is not available, could you please provide the number of LTCI rate filings that have been submitted to your agency and the number of affected people?

Six states responded to this question, and the responses are summarized in Table 7.

Summary of Responses
350 filings, 140,000 policyholders affected since 2000
236 filings since 2000; number affected not known
38 submitted; 30% rejected
Number of filings is tracked, number of people affected is not
Not known, but probably about 75 filings from 20-25 companies, affecting about 150,000 policies
53 LTCI Rate filings in 2007

Table 7 – Summary of Response to Question 1c in the Volume Section

Administrative Processes

1. Please describe the administrative process and review steps that you use to review LTCI rate filings.

The level of detail provided varied substantially by state. Some states provided a very cursory overview of the process while others provided great detail. All of the summarized responses, with redacted or obscured state identifying information (to the best of ability) are provided in Appendix E.

2. Do you use an actuary to review the rate filings?
 - **25 states responded “Yes”, 4 responded “No”, and 1 responded “Sometimes”**
 - a. If so, is the actuary an internal or external consultant?
 - **20 states responded “Internal” and 6 responded “External”**
 - b. If not, have you ever considered using an actuary to review rate filings?
 - **3 states responded “Yes” and 1 responded “No”**
3. Which individuals are involved in reviewing rate filings submitted to your agency? Please include their titles, background, and/or other qualifications.
 - **21 states responded that an Actuary was primarily responsible for the rate request review.**

Table 8 has a complete list of titles and the frequency of the responses.

Title of Reviewer	Number of Responses
Actuary	21
Actuarial Analyst	3
Director of Rates and Forms	2
Insurance Examiner	2
Actuary & Director of Rates and Forms	1
Actuarial Analyst & Attorney	1

Table 8 – Summary of Response to Question 3 in the Administrative Processes Section

4. Does the Commissioner review each LTCI rate increase?

- **2 states responded “Yes”, 26 responded “No”, 1 responded “Sometimes”, and 1 did not answer.**
- e. If not, which person(s) in your organization is (are) responsible to make the final decision on LTCI rate increases and what is (are) their titles, backgrounds and/or qualifications? **For the 27 states for which this question is applicable, 21 responded that the same person responsible for reviewing the rate request (as described in question 3 above) also makes the final decision. For the 6 states in which a different person makes the final decision, their titles are summarized in Table 9.**

Title of Reviewer	Title of Decision Maker
Actuarial Analyst	Director of Rates and Forms
Actuary	Director of Rates and Forms
Actuary	Insurance Examiner
Actuary	Actuary & Director of Rates and Forms & Assistant Commissioner
Actuary	Assistant Commissioner
Insurance Examiner	Actuary & Director of Rates and Forms

Table 9 – Summary of Response to Question 4a in the Administrative Processes Section

5. Does a LTCI rate filing involve Commissioner or senior staff level review only when the change is beyond a certain level (e.g., size of the increase or number of persons affected)?
- **12 states responded “Yes”**
- a. If so, what are the threshold levels?
For the 12 states that responded “Yes”, there was no consensus on a particular threshold. The responses are summarized in Table 10.

Threshold	Number of Responses
No Specific Threshold	5
10% or more	1
15% or more	1
20% or more	1
25% or more	1
30% or more	1
35% or more rate increase and/or dollar amount is \$75 or more per month	1
All Reviewed by Senior Staff	1

Table 10 – Summary of Response to Question 5a in the Administrative Processes Section

6. What has been the average length of time needed to complete a LTCI review from the date that the filing first comes in the door?
- **20 states responded to this question. In some cases the length of time is an estimate and in others it has been measured. Based on the 20 responses, the average, average length of time to complete a rate request review is 44 days**
 - **Varies from an average of 10 to 150 days**
 - **All responses shown in Figure 1**

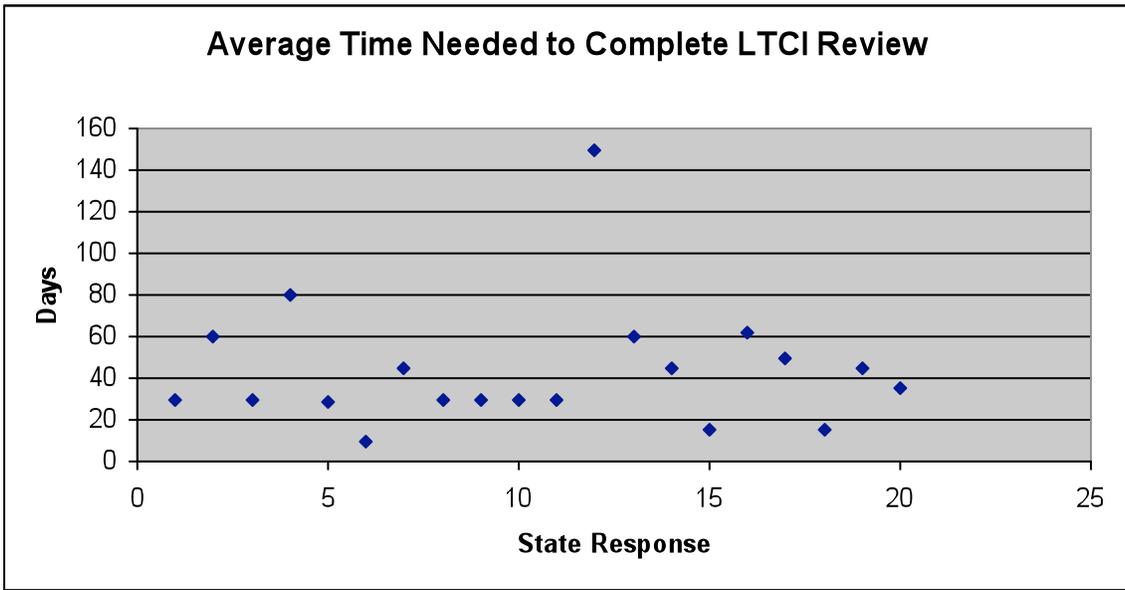


Figure 1 – Responses to Question 6 in the Administrative Processes Section

- a. What has been the shortest time needed?
 - **23 states responded to this question. In some cases the length of time is an estimate and in others it has been measured. Based on the 23 responses, the average, minimum length of time to complete a rate request review is 10 days**
 - Varies from an average of 1 to 43 days
 - All responses shown in Figure 2

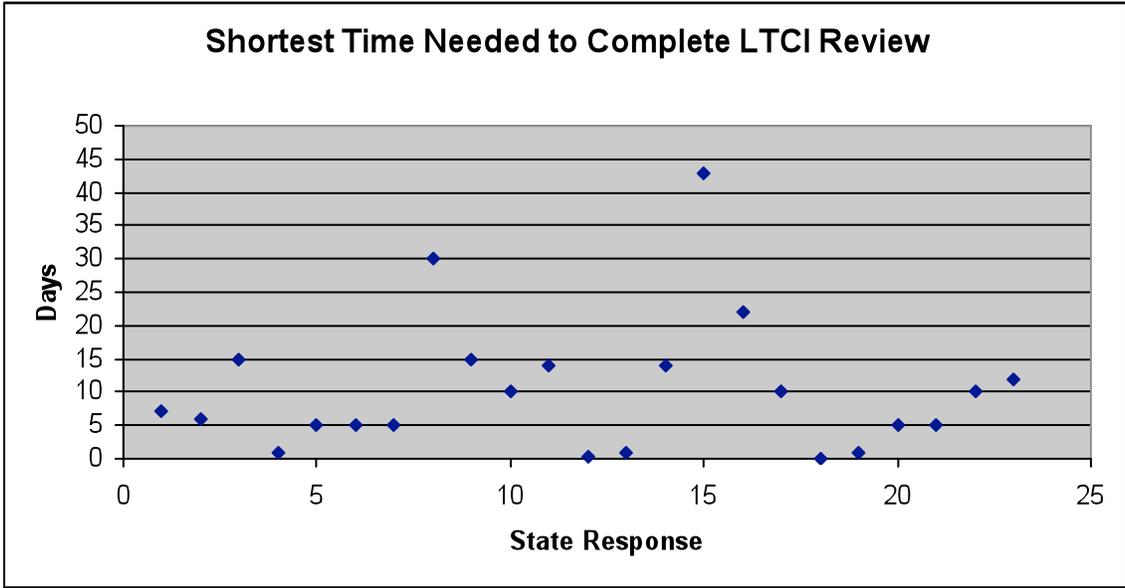


Figure 2 – Responses to Question 6a in the Administrative Processes Section

- b. What has been the longest?

- **23 states responded to this question. In some cases the length of time is an estimate and in others it has been measured. Based on the 23 responses, the average, maximum length of time to complete a rate request review is 171 days**
 - **Varies from an average of 30 to 438 days**
 - **All responses shown in Figure 3**

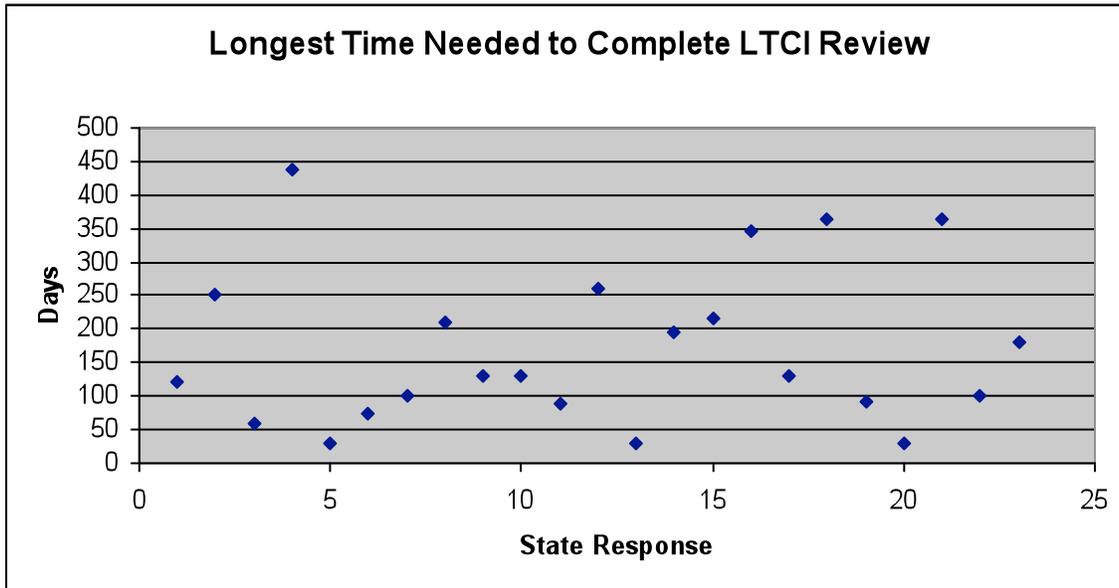


Figure 3 – Responses to Question 6b in the Administrative Processes Section

- c. Are there reasons why certain filings have taken longer than the average length of time?
 - **Typical reasons for delay in rate request review include:**
 - **Awaiting additional information / Slow response time**
 - **Large Increase Requested**
 - **Quality and/or complexity of filing**
 - **All responses are shown in Table 11**

Delay	Frequency of Response
Awaiting Additional Information	11
Large Increase Requested	9
Quality of Response	8
Slow Response Time	7
Higher Level Review	3
Workload	3
Complexity of Filing	3
Back and Forth	2
Disagree with assumptions/projections	2

Table 11 – Summary of Response to Question 6c in the Administrative Processes Section

Note that some states cited multiple reasons for delays, and therefore the total number of responses in Table 11 is greater than the number of participating states.

- 7. What types of administrative tools does your agency use to ensure that each LTCI rate filing is reviewed consistently and that rate increases are approved or disapproved based on consistent criteria.

- **Typical administrative tools used by states:**
 - **Consistent Staff**
 - **Consistent Review Process / Checklist**
 - **Consistent with Laws, Rules and/or Actuarial Standards**
- **All responses are shown in Table 12**

Administrative Tool	Frequency of Response
Consistent Staff	12
Consistent Review Process	8
Consistent with Law, Rules, Actuarial Standards	5
Checklist	4
Compare to Similar Filings	3
Actuarial judgement based on the filing	2
Adherence to statute	1
Compare assumed lapse rate to actual	1
NAIC Guidance Manual for Rating Aspects of the LTC Insurance Model Regulation	1
Transmittal Sheet	1
None	1
Random Audits	1

Table 12 – Summary of Response to Question 7 in the Administrative Processes Section

8. If a carrier is in more than one state, do you consider the approval/disapproval decision of another state before making your final decision?
- **11 states responded “Yes”, 16 responded “No”, 2 responded “Sometimes”, and 1 did not answer.**
- a. Do you consider the decisions of an insurance companies’ domiciliary state?
- **8 states responded “Yes”, 19 responded “No”, 2 responded “Sometimes”, and 1 did not answer.**
- b. Do you contact any other states for their opinions on any submitted filings to compare notes or develop questions/opinions?
- **9 states responded “Yes”, 17 responded “No”, 2 responded “Sometimes”, and 2 did not answer.**

Communicating Findings

1. Does your agency contact the company prior to any formal letter to discuss a LTCI rate filing?
- **16 states responded “Yes”, 10 responded “No”, 3 responded “Sometimes”, and 2 did not answer.**
- a. If so, does your agency point out parts of the filing that do not appear to be correct to enable the company to correct them?
- **Of the applicable states, 19 responded “Yes”, and 1 responded “No”.**
- b. Does your agency negotiate the amount of the rate increase?
- **13 states responded “Yes”, 13 responded “No”, 2 responded “Sometimes”, and 2 did not answer.**

- c. Does your agency request that the company extend any rate increase over a longer period of time?
- **10 states responded “Yes”, 15 responded “No”, 3 responded “Sometimes”, and 2 did not answer.**
2. Do you send a letter to each filer to formally communicate whether a filing is approved or denied?
- **22 states responded “Yes”, 5 responded “No”, 2 responded “Sometimes”, and 1 did not answer.**
- a. If so, does your agency use a standard form letter?
- **Of the applicable states, 8 responded “Yes”, and 16 responded “No”.**
- b. If so, does your agency identify the reasons that a filing has been approved or denied?
- **Of the applicable states, 17 states responded “Yes”, 5 responded “No”, 2 responded “Sometimes”.**
- c. If so, could you please submit a copy of this form letter along with this survey?
- **Of the applicable states, only 2 provided a copy of the form letter.**

6.4. Appendix D – Differences in Enacting NAIC LTCI Act

This appendix summarizes the responses provided to the first two questions of the written survey, when a state responded “No” as to whether they had enacted the NAIC Long-Term Care Insurance Model Act and Regulation.

Table 13 summarizes the responses provided in questions 1a and 2a when a state answered “No” to both question 1 and question 2 in the Statutory/Regulation Provisions section.

1a	2a
State has a related law that does not significantly differ from the NAIC Model Act	State has related rules that do not significantly differ from the NAIC Model Regulation.
State has a related law effective January 1, 2009. The principal difference from the NAIC model with regard to rates is a requirement for the commissioner to adopt rules establishing loss ratio standards.	State has a related regulation effective January 1, 2009. The principal difference from the NAIC model with regard to rates is the inclusion of loss ratio standards.
Portions of statutes may be based upon the NAIC Long Term Care Insurance Model Act, but the NAIC Long Term Care Insurance Model Act was not enacted verbatim and was not enacted in total.	Portions of State regulations may be based upon the NAIC Long Term Care Insurance Model Regulation, but the NAIC Long Term Care Insurance Model Regulation was not enacted verbatim and was not enacted in total. Long term care insurance regulations differ from the NAIC Models in some respects, for example benefit period and benefit dollar amounts.
State law requires specific loss ratios be met	
State has the old NAIC model in place with 60% Loss Ratio requirement	
There are many differences	

Table 13 – Summary of Responses Corresponding to “No” Response for Questions 1 and 2

Table 14 summarizes the responses provided in question 1a when a state answered “No” to question 1 and “Yes” to question 2 in the Statutory/Regulation Provisions section.

1a
State law defines long-term care insurance as coverage for both institutional and non-institutional care
State adopted Model Rules and Regulations which encompass most of the substantive provisions of LTC Model Act
The model Act was combined with the model regulation and, with a few modifications, was adopted as a regulation in 2008

Table 14 – Summary of Responses Corresponding to “No” Response for Question 1

Table 15 summarizes the responses provided in question 2a when a state answered “Yes” to question 1 and “No” to question 2 in the Statutory/Regulation Provisions section.

2a
In the regulatory process of promulgating the new rule. The draft rule is similar to the NAIC model, with some additional consumer protections.
No (No explanation provided)

Table 15 – Summary of Responses Corresponding to “No” Response for Question 2

6.5. Appendix E – Summary of State Administrative Processes

This appendix summarizes the responses provided to the first question in the Administrative Process section of the written survey. The level of detail provided varied substantially by state.

Administrative Process
<p><u>State #1</u> A completeness review is done to ensure that the filing contains:</p> <ol style="list-style-type: none">1. Certification of Qualified Actuary2. Actuarial Memorandum3. Complete rate history and dates filed4. Schedule of current and proposed rates5. State and Nationwide experience by issue year, including earned premium, losses paid and losses incurred6. A demonstration of how the rate revision was calculated. <p>When the filing is administratively complete, the closed block rate increase requests are passed on to the actuary for review</p>
<p><u>State #2</u> We send the rates to an outside consulting actuary</p>
<p><u>State #3</u> The Department reviews inception-to-date experience, on an actual-to-expected basis, for each policy form provided in the filing on a state-specific basis as well as nationwide. We also ask for the same level of detailed experience for all other policy forms sold in the State. We also review experience projections, but put much more weight on prior experience and specifically whether or not the company is meeting expected loss ratios under the original pricing assumptions</p>
<p><u>State #4</u> Actuarial review</p>
<p><u>State #5</u> All rate filings are required to be submitted via SERFF (since October 1, 2007) and are reviewed and processed by the appropriate department (actuarial). Issues or problems may rise to the Supervisory level for review and decision making. If unresolvable they may then rise to the Insurance Bureau level and/or possibly sent to Legal for input. If unresolvable they may rise to the Commissioners Office for a final decision.</p>

State #6

Rate change filings are submitted electronically through our Electronic Data Management System (EDMS). The filing is first checked for completeness, to be sure we have the information needed to conduct a proper review. If not, either the filing is returned to the company as "Incomplete" or additional information is requested.

The review consists of verifying the company's current assumptions, if different from those used in pricing and testing for compliance with the future and lifetime tests set forth in Rule X. Projections based on requirements of Rule Y. are used. Experience data is reviewed compared to expected experience. (A/E)

Correspondence may occur with company as filing progresses to resolve issues and answer questions. When review is complete, filing is subject to peer review, especially if more than 2000 lives are impacted or if any increase is greater than 10%. Final recommendation is then submitted to company. Request may be accepted or a counter offer may be made. If counter offer, company has 10 days to respond or filing will be closed as disapproved.

Note: we have not yet had a formal request for a rate increase on post Rate Stabilization business.

State #7

Receipt, Log-in tracking information, fee collection, Assignment to reviewer, review, preparation for presentation to Commissioner, Decision of Commissioner, Communication, Action on file, close file, update tracking and some data capture, mail copy to company for their records.

State #8

Rate filings are submitted to our Consumer forms approval area. They are then assigned to the {actuarial department} of the Division of Insurance. Within the {actuarial department} the filings are reviewed. Review consists of evaluation of the experience and projections and other actuarial data submitted to support the requested increase. Review criteria based on implementation date of rate stabilization provisions in the State: 1/1/2003.

If projections are found to be sound, and to demonstrate compliance with the applicable loss ratio standards, then filing is approved by {actuarial department}. Otherwise, the filing is not approved by the {actuarial department}. The Consumer forms approval area is notified of decision and generates either the approval or disapproval notice.

State #9

We consider the review of A&H rate increase proposals a two-step process, each with unique considerations and goals, but bound together by loss ratio requirements. Below is a quick summary of the process we use.

Step 1 main points:

- Analyze carrier experience, trends, and assumptions to determine if the rate increase proposal is actuarially justified. Various methods (which are technically sophisticated) are utilized to gauge the validity of the proposal
- If unable to confirm the proposal, a lower increase will be proposed. Thirty-five to forty percent of all A&H rate increase filings are negotiated to a lower amount.

Other considerations

§ What kind of justification did the carrier submit for the assumptions utilized?

§ Are the actual to expected factors greater than 1.0?

Step 1's overarching goal is to determine if the carrier's proposal is reasonable and justified. It involves a short term projection which is typically from the mid-point of the chosen experience period to the mid-point of the next rating period. It should be noted that while the model has developed over the years, the basic foundation of it has not changed. The simplest form of the model can really be boiled down to this formula:

$$\text{On-level loss ratio (for chosen experience period)} \cdot (1 + \text{trend})^x$$

Expected Pricing LR (for the next year)

====>>> where x=mid-point of the experience period to the mid-point of the proposed rating period in years, and on-level means that the premiums have been restated to the current rate level using the parallelogram method.

Step 2 main points:

- Confirm that the lifetime loss ratio calculation will satisfy the state's minimum loss ratio requirements; the proposed rates must be used in the projection
- Lifetime means accumulated value of all past experience plus the present value of future anticipated experience

Other Considerations

§ Did the carrier use reasonable assumptions in the projection of experience?

§ Did the carrier use interest in the projections?

The lifetime loss ratio calculation will normally involve long term projections such as 20-years, or much longer for business such as long term care insurance. The formula for the lifetime loss ratio calculation is shown below.

$$\frac{(\text{Accumulated [past] incurred claims} + \text{P.V. of [projected] incurred claims})}{\text{-----}}$$

$$(\text{Accumulated [past] earned premiums} + \text{P.V. of [projected] earned premiums})$$

Brief description from our LTC external consultant (INS): INS receives the rate filing via e-mail from the State Insurance Department. State Regulations pertaining to the rate filing are obtained from the State Insurance Department. The entire rate filing is reviewed by an INS actuary. The actuary also does a detailed review of the Actuarial Memorandum paying particular attention to pricing and projection assumptions, rate increase history, nationwide and state historical and projected experience exhibits, compliance with state regulations (minimum loss ratios, etc.), etc. At this point in the review process a request for additional information may be sent to the Company. After all information is reviewed INS performs an independent projection (which includes the proposed increase) to determine whether the lifetime loss ratio is in compliance with state regulations. The final step is INS' suggestion to approve, disapprove or approve a lower rate increase.

State #10

Companies file rate increases and they are reviewed by the Department within 30 days of receipt for compliance with state statutes and regulations. The company is then notified of the Department's determination.

State #11

Filings are accepted either electronically through SERFF (preferred) or on paper. They are reviewed for compliance with our statutory and regulatory requirements using a checklist and spreadsheet analysis. Any additional information requested or issues raised are handled through SERFF for electronic filings. For paper filings, they are generally handled by email or mail.

State #12

Filings are made with The Office of The Chief Actuary for final action

State #13

Review Steps:

- 1) Rates - Must be reasonable in relationship to the benefits being provided
- 2) Loss ratio - Must be at least 60%
- 3) Commission - Must be level for first 3 years if selling to individuals over 65
- 4) Spousal discount - Must be based on sound actuarial principles
- 5) Titling of policy - Must include both facility care and home health care. The home health care portion of coverage must be equal to at least half facility care benefits.
- 6) Lapse Rate - Should be in single digits.
- 7) For policies written on or after June 1, 2007, The following statement must be included:
"Initial premium rate is sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule is reasonably expected to be sustainable over the life of the policy or certificate with no future increases anticipated."
- 8) Although not statutorily required, determine how many State consumers will be affected by increase.

State #14

We check the filing for compliance with each section of the applicable law, and review the actuarial demonstrations for completeness, consistency, and reasonableness

State #15

The Actuary will review the filing. The cover letter is reviewed and then a close examination of the Actuarial Memorandum is closely reviewed. If there are questions about the filing the company would be contacted for additional information

State #16

The company files either electronically through SERFF or paper. Once the filing fees are received and recorded by our Accounting department the filing is assigned to the LTCI reviewer. The reviewer then ensures that all of the supporting material is received and reviews the filing in accordance with the Division's internal review procedures.

State #17

Review Assumptions

Review Policyholder Options - is there a nonforfeiture option?

Consider/Review Various Relativities

State #18

1. Logged in to our filing data base

2. Reviewed for completeness (e.g. actuarial memorandum)

3. Analyst reviews and makes recommendation to Health Bureau Chief or Managing Actuary

4. Health Bureau Chief or Managing Actuary takes final action.

State #19

Please see website under Insurer Information which contains check lists

State #20

Rate increase requests would be referred to the Actuary by the policy form analyst. The Actuary considers the level of rate increase requested; historical, projected future and projected lifetime loss ratios; assumptions used; and level and frequency of past rate increases. The Actuary will approve, disapprove or modify the rate increase requested, and the assigned policy analyst will communicate the decision to the requesting company

State #21

Steps we use to review LTC rate filings:

1. Does the filing comply with the regulation?

2. What are the changes in the assumptions?

2a. If the actuary had certified that the premiums were sufficient under moderately adverse experience, which assumptions are causing the problem?

3. What is the expected lifetime loss ratio, using an appropriate interest rate?

4. How do the durational loss ratios compare to those originally filed?

4a. For level premium policies the loss ratio in later years is expected to be greater than 65% and could be even higher than 100%. Can't give a rate increase just because the current calendar year loss ratio is greater than 100%.

4b. Need to make sure the company is not recouping past losses.

5. How do the premium rates in State compare to other states?

5a. If State's rates are higher than the national average, get the national experience on a State rate basis.

6. How many policies are in force? Credible experience? Trying to encourage lapse?

State #22

The filing is processed through intake, during which the support staff personnel make sure all of the required documents are present and necessary filing signatures are present. The support staff personnel assigns the LTC rate filing to one of two Life and Health Actuaries for the State Insurance Division. The actuary consults with the company the reason for the LTC rate change (normally a rate increase). The actuary makes a recommendation to the Insurance Administrator, who will make the final determination on whether to approve the rate filing.

State #23

See detailed docs for rate filing and rate increase review process.

State #24

The Rate and Form Analyst reviews the filing for accuracy, reasonableness, completeness and compliance with statute and rules. If questions arise the analyst will either resolve the questions with the insurer, or refer to the department actuary for review

State #25

Long-term care rate filings are reviewed by the Department Health Rate Analyst. The analyst reviews the filings to determine whether the insurer has demonstrated sufficient data to support a rate increase pursuant to State Regulations

State #26

All LTC rate filings are reviewed by an actuarial consultant. The information provided by the company must meet the requirements of Regulation X if an initial rate filing and Regulation Y if a rate increase filing. In addition, the company must also provide detailed support for all assumptions used.

State #27

The filings are assigned to an actuary for review.

State #28

Compare lapse rate assumed in rating to actual lapse rate
Compare durational losses actual to expected and review projected durational losses
Review type underwriting used (Medical application, phone interview, medical records, face-to-face when used and by age group)
Type benefits provided, including average elimination period
Number of policy holders covered
Marketing method used
Active block of business or closed block
Level of increase requested

State #29

Filing is reviewed by an insurance examiner to determine if it should be referred to the external actuarial consultant.

State #30

None provided

6.6. Appendix F – Massachusetts Long-Term Care Insurance Regulation (211 CMR 65.00)

211 CMR 65.00 LONG-TERM CARE INSURANCE

- 65.01: Purpose
- 65.02: Applicability
- 65.03: Authority
- 65.04: Definitions
- 65.05: Minimum Standards for Individual Policies
- 65.06: Mandatory Benefit Offers for Individual Policies
- 65.07: Form and Rate Filing Procedures for Individual Policies
- 65.08: Requirements for Agent Training and Marketing
- 65.09: Requirements for Disclosure
- 65.10: Protection Against Unintentional Lapse
- 65.11: Prohibition Against Post-Claims Underwriting
- 65.12: Severability
- 65.100: Policy Illustration Form
- 65.101: Outline of Coverage
- 65.102: Appendix A: Sample Definitions

65.01: Purpose

The purpose of 211 CMR 65.00 is to provide for full and fair disclosure of the provisions of long-term care insurance policies offered in Massachusetts and to promote the public interest by protecting applicants for long-term care insurance from unfair or deceptive sales and enrollment practices. 211 CMR 65.00 establishes minimum standards for individual long-term care insurance policies and minimum standards for disclosure, marketing and agent training for both individual long-term care insurance policies and group long-term care insurance policies that are not employment-based. 211 CMR 65.00 is intended to facilitate public understanding and comparison of long-term care policies, and to encourage flexibility and responsible innovation in the development of long-term care insurance.

65.02: Applicability

211 CMR 65.00, unless otherwise stated herein, applies to long-term care insurance policies or certificates issued in the Commonwealth of Massachusetts after January 1, 2000. The requirements contained in 211 CMR 65.00 are in addition to any other applicable statutory provisions or lawful regulations, including 211 CMR 40.00 and 211 CMR 42.00 where applicable. They do not in any way excuse any material noncompliance on the part of any agent or carrier marketing long-term care insurance regarding the provisions of any other law or statute. Unless otherwise stated, 211 CMR 65.00 does not apply to an employment-based group policy.

65.03: Authority

211 CMR 65.00 is issued under the authority of M.G.L. c. 118E, c. 175 § 108, c. 176 §26, and c. 176D.

65.04: Definitions

Activities of Daily Living (ADLs) means eating, toileting, transferring, bathing, dressing, and continence.

Agent means either (1) a person licensed under M.G.L. c. 175 §163 who solicits insurance on behalf of any carrier or transmits for a person other than himself/herself an application for or a policy of insurance to or from such carrier or offers or assumes to act in the negotiation of its continuance or renewal, (2) a person licensed under M.G.L. c. 175 §166 who acts or aids in any manner in negotiating policies of insurance or placing risks or effecting insurance, or in negotiating the continuance or renewal of such policies or contracts for a person other than himself/herself or (3) any other person legally authorized to represent a carrier in the marketing of long-term care insurance.

Alternate care benefits means benefits for services or other items not specified in the long-term care insurance policy, but to be covered as agreed to by the carrier, the insured, and the insured's caregiver. This includes, but is not limited to, payment for home modifications that allow the insured to continue living at home or a non-institutionalized setting and coverage of long-term care services that might not exist on the policy issue date.

Care management means those procedures employed by a carrier to approve covered services and to determine the appropriate level of care.

Carrier means a commercial insurance company licensed to issue accident and sickness policies under M.G.L. c.175 or a fraternal benefit society licensed under M.G.L. c.176.

Cold-lead advertising means making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that one of the purposes of the method of marketing is the solicitation of insurance and that contact will be made by a carrier or its agent.

Commissioner means the commissioner of insurance or his/her designee.

Convertible means a policy feature that gives the insured the right to switch to another policy offered or sponsored by the carrier.

Daily maximum benefit means the maximum daily amount that the long-term care insurance policy pays for specific services.

Deductible means the dollar amount of covered services that are to be paid solely by the insured before the long-term care insurance policy begins to pay benefits.

Division of Medical Assistance means the state agency responsible for administering programs of medical assistance in Massachusetts pursuant to M.G.L. c. 118E.

Elimination period means the number of days during which covered services must be received by an insured before the long-term care insurance policy begins to pay benefits.

Employment-based group policy means a certificate issued to an insured who is enrolled in a group policy issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Federally qualified means a policy that meets standards set forth in the federal Internal Revenue Code and related federal regulations in order to qualify for special tax treatment.

Group policy means the certificate issued to an insured who is enrolled through a group trust or association to which the carrier has issued a long-term care insurance policy. For the purposes of 211 CMR 65.00, this does not include employment-based group policies.

Guaranteed renewable means a policy feature that guarantees the insured's right to continue the policy in force by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, and cannot make any unilateral change in any provision of a guaranteed renewable policy without the agreement of the insured, but subject to the approval of the commissioner, a carrier may revise premium rates for guaranteed renewable policies on a class basis.

High-pressure tactics means employing any method of marketing that has the effect of or tends to induce or recommend the purchase of any insurance policy through force, fright, threat (whether explicit or implied) or undue pressure.

Home health care means those nursing, home health aide, rehabilitative therapy, and nutrition counseling services provided by a home health care agency.

Individual policy means a policy issued by a carrier directly to an insured.

Insured means the named policyholder or certificateholder under a long-term care insurance policy.

Lifetime maximum benefit period means the maximum number of days of benefits, as chosen by the insured, which the carrier will pay for covered benefits after the satisfaction of any elimination period or deductible.

Lifetime maximum dollar amount means the maximum dollar amount, as chosen by the insured, which the carrier will pay for covered benefits after the satisfaction of any elimination period or deductible.

MassHealth (Medicaid) means the program of medical assistance administered by the Massachusetts Division of Medical Assistance under Title XIX of the federal Social Security Act, 42 USCS §1396 *et seq.*, and M.G.L. c. 118E.

Medical necessity means:

- (1) in accordance with accepted standards of medical practice for the diagnosis and treatment of a condition;
- (2) delivered, when possible, in the least intensive setting required by the insured's condition; and
- (3) not solely for the convenience of the insured, the insured's family or the insured's health care provider.

Medicare means the federal health insurance program under Title XVIII of the federal Social Security Act, 42 USCS §1395 *et seq.*, as amended.

Mental or nervous condition means a condition as described in the standard nomenclature of the American Psychiatric Association.

Noncancelable means the policy feature that guarantees the insured's right to continue the policy in force at the same premium level by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, cannot make any unilateral change in any provision of coverage, and cannot revise premium rates for a noncancelable policy without the agreement of the insured.

Nonforfeiture benefit means a benefit to the insured in the event that the long-term care insurance policy lapses due to nonpayment of premium. Nonforfeiture benefits include, but are not limited to, return of premium and any partial paid-up benefits.

Policy means an individual long-term care insurance policy or a certificate of a group policy that is not employment-based, as well as the policy application, riders, amendments or other provisions that are attached to the policy to identify the contractual provisions of the insured's coverage.

Pre-existing condition means a medical condition for which an insured received diagnosis or treatment during the 24-month period prior to the effective date of coverage.

Twisting means knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or carriers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any policy or to take out a policy with another carrier.

65.05: Minimum Standards for Individual Policies

(a) Benefit Eligibility Standards

(1) Benefit Triggers.

(a) Individual policies that are not intended to be federally qualified may not include benefit eligibility standards that are more stringent than a requirement that the insured be unable to perform at least two Activities of Daily Living due to a loss of functional capacity or severe cognitive impairment.

(b) Individual policies that are intended to be federally qualified are required to meet the standards set forth in the federal Internal Revenue Code and related federal regulations.

(2) Prior Treatment Requirements. No individual policy may condition long-term care benefits on the insured's prior hospitalization or prior receipt of services from any long-term care provider.

(3) Medicare Eligibility. No individual policy may restrict or deny benefits because the insured is not eligible for Medicare.

(4) Improvement Requirement. No individual policy may condition receipt of covered benefits on a requirement that the insured be making a "steady improvement", have "recuperative potential" or have "returned to pre-morbid condition" or words of similar import.

(5) Medical Necessity. No individual policy may condition receipt of any services, except medical services provided by licensed medical professionals, on any standard of medical necessity. Any carrier using a medical necessity standard shall disclose that standard within the policy.

(6) Care Management. A carrier may establish a care management system to manage the benefits provided under the individual policy, and plan benefits may be disallowed if specific care management standards and procedures are not met. A carrier that intends to use a care management system must: (1) establish a needs assessment tool which measures functional ability, (2) file with the commissioner a description of its care management policy and procedures, as well as the mechanism by which the insured may appeal a care management decision, and file any and all updates to the management policy and procedures with the commissioner prior to implementation, (3) specify the care management procedures within the policy, as well as the way to appeal whenever benefits are disallowed for failure to meet care management standards, and notify the insured about any changes to care management procedures included in the policy prior to implementation, and (4) disclose applicable care management standards to insureds upon request.

(b) Benefit Requirements

(1) Elimination Periods and Deductibles.

(a) Individual policies may not include elimination periods of greater than 365 days, whether services are received within or away from the home.

(b) At a minimum, carriers shall count each day that the insured receives any service that would be applied against the lifetime maximum benefit amount or maximum benefit period toward the satisfaction of an individual policy's elimination period. Individual policies may not require that elimination periods be satisfied within a specified period of time or that days be consecutive.

(c) Individual policies may not apply more than one elimination period unless the insured has received no benefits for at least 180 consecutive days.

(d) Individual policies may offer deductibles in lieu of elimination periods, but not both.

(2) Individual Policy Benefits.

(a) Daily maximum benefit amounts for specific services must be clearly defined within the policy provisions. The daily maximum benefit may be limited by the carrier to the usual and customary cost of the service. If the service costs more than the maximum daily benefit and there is no law to the contrary, the insured is responsible for the amount over and above the daily maximum benefit.

(b) Lifetime maximum benefit periods may not cover fewer than 730 days beyond the policy's elimination period.

(c) Individual policies may include a lifetime maximum benefit amount in lieu of the lifetime maximum benefit period, provided that the lifetime maximum benefit amount may not be less than the product of 730 multiplied by the highest daily maximum benefit amount covered in the policy.

(3) Home Health Care and Community Care Benefits in Long-Term Care Insurance Policies A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits

(1) by requiring that the insured or claimant would need care in a skilled nursing facility if home health care Were not provided;

(2) by requiring that the insured or claimant first or simultaneously received nursing or therapeutic services, or both in a home, community, or institutional setting before home health care services are covered;

(3) by limiting eligible services to services provided by registered nurses or licensed practical nurses;

- (4) by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
 - (5) by excluding coverage for personal care services provided by a home health care aide;
 - (6) by requiring that the provisions of home health care services be at a level of certification or licensure greater than that required by the eligible services;
 - (7) by requiring that the insured or claimant have an acute condition before home health care services are covered;
 - (8) by limiting benefits to services provided by Medicare-certified agencies or providers;
 - (9) by excluding coverage for adult day care services.
- (a) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.
- (b) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
- (4) Minimum Benefits. Individual policies may not include any policy benefits that are so limited in scope that they are not likely to be of any substantial economic value to the insured.
- (5) Alternate Care Benefits. Individual policies must include a provision that enables the insured to use policy benefits after satisfying policy benefit triggers, elimination periods and deductibles to cover long-term care treatments or expenses not specifically identified in the policy's described benefits. The alternate care benefits must be made available to the insured subject to the agreement of the carrier, the insured and the insured's health care practitioner.
- (c) Limitations and Exclusions.
- (1) Pre-existing condition limitations.
 - (a) Pre-existing condition limitations must be specifically identified on the front of the policy and the outline of coverage.
 - (b) Pre-existing condition limitations may not apply for more than a six-month period from the effective date of the policy.
 - (2) No individual policy may exclude otherwise eligible persons from policy benefits due to the presence or history of mental or nervous conditions, Alzheimer's disease, alcoholism, or other chemical dependency.
 - (3) No individual policy may exclude otherwise eligible policy benefits because those benefits are also payable by a non-Medicare government agency or because the covered services are being received in a governmental facility.
 - (4) Other limitations. Individual policies may include other limitations or conditions subject to the approval of the commissioner, provided that they are clearly identified in a separate section of the policy. Such limitations may include, but are not limited to, illnesses, treatments or conditions arising out of the following circumstances:
 - (a) war or act of war (whether declared or undeclared);
 - (b) participation in a felony, riot or insurrection;
 - (c) service in the armed forces or units auxiliary thereto;
 - (d) attempted suicide or intentionally self-inflicted injury;
 - (e) services provided for alcohol or drug detoxification;
 - (f) aviation (this exclusion applies only to non-fare paying passengers);
 - (g) services for which benefits are payable under Medicare, any state or federal workers' compensation program, employer's liability or occupational disease law, or any motor vehicle no-fault law;
 - (h) services provided by members of the insured's immediate family; or
 - (i) services for which no amount is normally charged in the absence of insurance.
- (d) Continuation of Policy Benefits.
- (1) Renewal.
 - (a) Carriers may not refuse to renew any individual policy, except in cases when the carrier is under receivership, rehabilitation or liquidation proceedings pursuant to M.G.L. c. 175 or c. 176 § 33, administrative supervision pursuant to M.G.L. 175J or comparable statutory requirements of another jurisdiction. A carrier may discharge its obligation to renew existing individual policies only upon a finding that the carrier has obtained coverage for all existing insureds with equivalent benefits for value paid with another carrier.
 - (b) All individual policies shall be guaranteed renewable or noncancelable.
 - (2) Extension of Benefits.
 - (a) If an individual policy is terminated while an insured is confined to a nursing home, benefits shall continue until the earliest of the following occurs:
 - (1) the insured is discharged from the nursing home,
 - (2) the policy lifetime maximum benefit period has expired, or
 - (3) the insured has exhausted the lifetime maximum benefit amount for nursing home services.
 - (b) For the purposes of 211 CMR 65.05(d)(2), the insured shall be considered to be continuously confined to a nursing home while being transferred to another nursing home, receiving another level of nursing care in any nursing home or being transferred back to a nursing home from a temporary/acute hospitalization.
 - (c) 211 CMR 65.05(d)(2) does not apply if coverage under the individual policy terminates because of failure of the policyholder to pay the premium within the time set forth in the policy.

65.06: Mandatory Benefit Offers for Individual Policies

- (a) Inflation Adjustment Benefit.
 - (1) A carrier shall make available, at the time of application, an option to increase benefits in order to adjust for or mitigate against future inflation. The applicant must be informed regarding the cost of this benefit.

- (2) The initial option to purchase an inflation adjustment benefit must be offered to every applicant without additional underwriting.
- (3) The carrier must require the applicant to specifically reject this benefit on the application if he/she chooses not to include this benefit in the individual policy.
- (b) Nonforfeiture Benefit.
 - (1) A carrier shall make available, at the time of application, an option to purchase a nonforfeiture benefit. The applicant must be informed regarding the cost of this benefit.
 - (2) The initial option to purchase a nonforfeiture benefit must be offered to every applicant without additional underwriting.
 - (3) The carrier must require the applicant to specifically reject this coverage on the application if he/she chooses not to include this benefit in the individual policy.
- (c) Long-Term Care Insurance Benefits Qualifying the Insured for Exemptions from Certain Massachusetts MassHealth (Medicaid) Provisions.
 - (1) A carrier shall make available, at the time of application, at least one policy that satisfies the requirements of 130 CMR 515.014.
 - (2) A carrier may satisfy this requirement through the offer of an affiliated or nonaffiliated carrier's product(s), as long as the arrangement is subject to a written contract filed with and approved by the commissioner.
- (d) Home Health Care Benefit
 - (1) A carrier shall make available, at the time of application, at least one policy that covers home health care and community care benefits designed to help the insured remain at home.
 - (2) A carrier may satisfy this requirement through the offer of an affiliated or nonaffiliated carrier's product(s), as long as the arrangement is subject to a written contract filed with and approved by the commissioner.

65.07: Form and Rate Filing Procedures for Individual Policies

- (1) Carriers shall file all individual policy forms, including applications, disclosure statements and replacement forms, and associated rates pursuant to the provisions of 211 CMR 42.06.
- (2) Application forms must meet the requirements set forth in 211 CMR 42.08, 211 CMR 42.09(2), 211 CMR 42.99, M.G.L. c. 175I and any other applicable Massachusetts statute or regulation.
- (3) In the event that any provision of 211 CMR 42.00 is inconsistent with the provisions of 211 CMR 65.00, the provisions of 211 CMR 65.00 shall govern all matters concerning any policy form that is within the definition of long-term care insurance in 211 CMR 65.00.

65.08: Requirements for Agent Training and Marketing

- (a) Each carrier shall provide appropriate training to agents about its long-term care insurance products, maintain records regarding agents who have satisfactorily completed such training and file with the commissioner lists identifying those agents who have completed the carrier's long-term care insurance training program.
- (b) All long-term care insurance marketing and advertising shall conform to the provisions of 211 CMR 40.00. In addition, carriers shall establish auditable internal marketing procedures, methods for assuring compliance by agents, and prohibitions against twisting, high-pressure tactics and cold-lead advertising.
- (c) All agents or persons marketing a carrier's long-term care insurance shall clearly identify which plans being offered are individual products and which are group products. When marketing group products, the agent shall clearly identify the name of the group policyholder and any conditions that the eligible person must satisfy to join and remain a member of the group.
- (d) All agents marketing a carrier's long-term care insurance shall disclose to potential applicants the name of the carrier that the agent represents in the sale. The carrier's name must be disclosed on any and all printed sales or appropriate materials provided, distributed or shown to potential applicants and/or during presentations made to potential applicants in association with a sale, whether a part of a presentation or not.
- (e) All agents marketing a carrier's long-term care insurance policy must disclose the fact that the agent receives compensation in connection with the sale or replacement of all long-term care insurance.
- (f) All agents marketing a carrier's long-term care insurance shall not misrepresent their expertise, qualifications or training to potential clients and shall not comment on the legal or tax implications of purchasing long-term care insurance to the extent that they lack the training, qualification or license to provide such advice.
- (g) A carrier whose agent fails to comply with any provisions of 211 CMR 65.00, including, but not limited to, 211 CMR 65.08, will be deemed to have committed an unfair and deceptive act in the business of insurance subject to M.G.L. c. 176D.

65.09: Requirements for Disclosure

All individual and group policies of long-term care insurance must adequately disclose all policy provisions, including but not limited to the following provisions.

- (1) The first page of the policy must disclose the following:
 - (a) If the policy does not provide coverage for care in a nursing home, a notation of the fact shall be prominently attached to the first page of the policy in not less than 18-point type or in some other manner that distinguishes it from the print otherwise appearing in the policy.
 - (b) The following statement: "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."
 - (c) A section in boldface type highlighted on the first page of the policy shall either list all pre-existing condition exclusions or limitations or refer the individual to the section within the policy that lists all pre-existing condition exclusions or limitations.

- (d) A renewability section notice shall clearly identify whether the policy is noncancelable or guaranteed renewable, and whether it is being issued on other than an individual basis (policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the carrier for this purpose).
- (e) Qualification for Federal Income Tax Exemptions and Certain Massachusetts MassHealth (Medicaid) Exemptions.
- (1) All individual, group and employment-based group policies that are intended to qualify for certain federal income tax exemptions must comply with standards set forth in the federal Internal Revenue Code and related regulations.
 - (2) All individual, group and employment-based policies issued on or after March 15, 1999 that are intended to qualify for exemptions from certain Massachusetts MassHealth (Medicaid) provisions, including the financial eligibility exemption in M.G.L. c. 118E §25 and the liability exemption in M.G.L. c. 118E §33, must comply with the individual policy requirements of 211 CMR 65.05 and the minimum coverage requirements of 130 CMR 515.014. All such policies issued prior to March 15, 1999, need only comply with the minimum standards of 211 CMR 65.05, and the limitations and exclusions provisions of 211 CMR 65.06 that were effective from April 1, 1989 through May 27, 1999. The provisions of 211 CMR 65.09(1)(e)(2) shall apply regardless of whether the policy is issued within or outside the Commonwealth of Massachusetts.
 - (3) There shall be on the face of the policy or certificate, or on a sticker attached to the first page of the policy or certificate, a notice that includes the following in substantially the same language and format:

FEDERAL INCOME TAX EXEMPTIONS: This policy **(IS)(IS NOT)** intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy **(IS)(IS NOT)** intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read the Massachusetts Guide for the Financing of Long-Term Care for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT THE FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

(2) Policy Language.

- (a) All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits covered. No misleading policy names may be used (211 CMR 65.103 includes samples of acceptable language). The policy, riders and all amendments, as well as the application, outline of coverage and other required disclosure materials distributed to any potential applicant must be presented in no less than 12-point type and must satisfy the readability standards of M.G.L. c. 175 § 2B.
- (b) Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder or certificateholder.

(3) Separate Disclosure Forms.

- (a) No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless it contains an outline of coverage substantially similar to the one set forth in 211 CMR 65.100. The outline of coverage must be a document separate from the policy. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring. The carrier or its agent must deliver the outline of coverage at the time of initial presentation of a policy and must make it available at any time at the potential insured's request.
- (b) No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless the applicant receives a policy illustration in a form that is substantially similar to the one set forth in 211 CMR 65.101. The carrier or its agents must deliver the form at the first policy proposal or quote. In the case of direct response sales, the carrier must deliver the form at the time that the application or enrollment form is sent to the potential insured.
- (c) No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless the potential insured receives the Massachusetts Guide for the Financing of Long-Term Care, including any inserts regarding changes to state or federal laws, as prescribed by the commissioner, at the time of first face-to-face contact between the potential insured and the agent or in cases of direct response sales at the time that the application or enrollment form is sent to the potential insured.

(4) Special Disclosure Forms.

- (a) Other Than Requested. If the policy is issued on a basis other than that applied for, a disclosure statement properly describing the actual policy terms must be attached to the front of the policy or a sticker must be attached to the front of the policy in red print when it is delivered and must contain a statement substantially similar to the following: "NOTICE: Read this disclosure statement carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested, but it differs in the following respects: [list]."
- (b) Required Disclosure Regarding Suitability Standards. If the carrier uses a worksheet or other marketing to examine a potential applicant's financial situation, or uses any other marketing materials that purport to provide guidance as to whether the applicant is suitable for long-term care insurance and subsequently notifies the applicant that the carrier finds the applicant to be suitable for long-term care insurance, the carrier shall provide the following disclosure notice:
 "Although [the carrier] may have determined that you meet [its] internal standards of suitability, there are other considerations that might influence your decision about whether this product is appropriate for you. [The company] uses the following standards to determine suitability for its long-term care insurance policies:
 [list]"

Please note that you should not rely upon this statement alone in making this purchase. You may want to contact a financial advisor for additional information.”

- (c) Required Disclosure Regarding Changes to MassHealth (Medicaid) Eligibility and Recovery Exemptions Under 130 CMR 515.014. If the carrier issued a policy that met the standards of 130 CMR 515.014 and said standards are subsequently changed, the carrier shall notify all insureds whose policies will no longer satisfy the MassHealth (Medicaid) standards and shall offer all such insureds on a guaranteed issue basis the opportunity to purchase needed benefits to meet the MassHealth (Medicaid) policy criteria. The rates for any change in benefits shall be based upon the rate characteristics for the insured at the time of policy change.

(5) Required Disclosure for Medicare-Eligible Applicants.

Carriers shall provide the Guide to Health Insurance for People with Medicare and disclosure notice as required by 211 CMR 42.09(4).

65.10: Protection Against Unintentional Lapse

No individual or group long-term care insurance policy may be issued unless it complies with the following:

- (a) Notice of Nonpayment of Premiums Before Lapse or Termination. No individual or group long-term care insurance policy may be issued until the carrier has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. In the case of an applicant who elects not to designate an additional person, the waiver shall state: “Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice shall not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice.” The carrier shall notify the insured of the right to change this written designation, no less often than once every two years.
- (b) Lapse or termination for nonpayment of premium. No individual or group long-term care insurance policy shall lapse or be terminated for nonpayment of premium unless the carrier, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to 211 CMR 65.10(a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of ten days after the date of mailing.
- (c) Reinstatement. All individual or group long-term care insurance policies shall include a provision for reinstatement of coverage, in the event of lapse, if the carrier is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before expiration of the policy’s grace period. Reinstatement shall be available to the insured if requested within five months after termination, and shall allow for the collection of past due premium, where appropriate.

65.11: Prohibition Against Post Claims Underwriting

- (a) All applications and enrollment forms for individual and group long-term care insurance policies, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.
- (b) If an application or enrollment form contains a question that asks whether the applicant has had medication prescribed by a physician, then it must also ask the applicant to list the medication that has been prescribed and the reason that the medication was prescribed.
- (c) Except for policies that are guaranteed issue:
- (1) The following language shall be set out conspicuously near the applicant’s signature block on an application:
“Caution: If your answers on this application are incorrect or untrue, [carrier] has the right to deny benefits or rescind your policy.”
 - (2) The following language, or language substantially similar to the following, shall be set out conspicuously on the policy, as well as the outline of coverage, at the time of delivery:
“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]. If your answers were incorrect or untrue as of the date you signed the application, the carrier has the right to deny benefits or rescind your policy subject to the [Time Limit on Certain Defenses, Incontestable] section of 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 carrier at this address: [insert address]”
 - (3) A carrier may not deny any claims for services under a long-term care policy issued to an applicant age 80 or older unless the carrier obtained any one of the following prior to issuing the policy:
 - (a) a report of a physical examination;
 - (b) an assessment of functional capacity;
 - (c) an attending physician’s statement; or
 - (d) copies of medical records.
- (d) A carrier shall deliver a copy of the completed application or enrollment form to the insured no later than at the time of delivery of the policy unless the form was retained by the insured at the time of application.
- (e) Every carrier selling or issuing individual or group long-term care insurance policies in Massachusetts shall maintain a record of all individual policy or group certificate rescissions, both on a state and national basis, except those that the insured voluntarily effectuated, and shall furnish this information to the commissioner upon request.

65.12: Severability

If any section or portion of a section of 211 CMR 65.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 65.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

65.100: Policy Illustration Form

**[INSURANCE COMPANY NAME AND ADDRESS]
LONG-TERM CARE INSURANCE POLICY ILLUSTRATION FORM**

[Drafting Note: Sections I-VIII must be on the front of the Policy Illustration Form and the text following must be on the reverse side of the Policy Illustration Form. Text on the reverse page will provide detail regarding any of the footnoted sections.]

I. FEDERAL TAX/STATE MASSHEALTH (MEDICAID) EXEMPTIONS

This Individual/Group Policy is Intended to:	Yes/No
1. Qualify for Federal Income Tax Deductions/Exemptions under Federal Law*	
2. Qualify for MassHealth (Medicaid) Exemptions under Massachusetts Law*	

*These laws are subject to change at any time. These exemptions might not apply to this policy at a future date. Please read the Massachusetts Guide for Financing Long-Term Care for more information.

II. THIS POLICY COVERS THE FOLLOWING LONG-TERM CARE SERVICES

Type of Service	Daily Benefit ¹	Max Benefit (\$/Days) ¹	Type of Service	Daily Benefit ¹	Max Benefit (\$/Days) ¹
1. Nursing Home			5. Home Care		
2. Assisted Living			6. Adult Day Care		
3. Home Health Care			7. Respite Care		
4. Personal Care			8. Other		

III. BENEFIT LIMITS²

\$ _____ per day/month/year for _____ days/months/years OR \$ _____ per lifetime

IV. BENEFITS BEGIN AFTER:

_____ Days OR \$ _____ Deductible
--

V. EXCLUSIONS AND LIMITATIONS

Type	Yes/No ³
PREEXISTING CONDITIONS	
OTHER:	

VI. TO BE ELIGIBLE FOR BENEFITS

[Drafting Note: In Section VI, carriers must include all the following text and cross out terms that do not apply in the policy for which the proposal is being developed. For example, this section must include both the terms “hands-on help” and “standby help” and will cross out whichever does not apply.]

You must need supervision due to a cognitive impairment OR You must need hands-on help/standby help with ___ of the following Activities of Daily Living: eating, transferring, bathing, dressing, toileting, continence due to a loss of physical capacity or severe cognitive impairment.

VII. OTHER BENEFITS

Yes/No	Type	Terms	Premium
	Inflation Protection		\$
	Nonforfeiture Benefit		\$
	Other		\$

VIII. ANNUAL PREMIUM

Terms and Conditions ⁴	Total
	\$

IMPORTANT: This is a brief summary of proposed coverage and not a policy. If you choose to purchase a policy, please read and review your policy carefully to verify that the coverage you have purchased is the coverage you intended to purchase.

^{1,2,3,4} See reverse side for more information

ADDITIONAL INFORMATION

¹ These benefit amounts usually are not cumulative. For example, if your policy provides a total of 730 days of coverage and you use 100 days to pay for home health care services, you will have 630 days of coverage left to apply to other services such as nursing home care.

Further information about the benefits covered by this policy:

[To be completed by carrier.]

² Long-term care insurance usually does not cover the full cost of long-term care services. According to the most recent Massachusetts Guide to the Financing of Long-Term Care, the **average cost** of private nursing home care in Massachusetts was \$ _____ per day and the **average stay in a nursing home lasted** _____ days; the average cost of home health care services was \$ _____ per day.

Inflation is likely to have increased these average costs by the time you need long-term care services. Inflation protection coverage will help protect the value of your benefits:

[To be completed by carrier. INFLATION PROTECTION ILLUSTRATION demonstrating graphically how inflation and inflation protection option could affect policy benefits over 20-year period. If necessary, a separate page may be attached to the Policy Illustration Form that includes an illustration of the policy's inflation protection.]

³ Further information about the **exclusions or limitations** contained in this policy:

[To be completed by carrier.]

⁴ **Level premiums** are designed to stay the same for the life of the policy, although they can be changed for an entire class of policyholders. **Guaranteed premiums** can never be increased. Some premiums are subject to **discounts** (for example, spousal discounts or a first-year-only discount).

Prepared For: [Name]
Agent: [Name, Address, Phone]

Date:

65.101: Outline of Coverage

[CARRIER NAME]
[ADDRESS - CITY & STATE],[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE - OUTLINE OF COVERAGE

Policy Number:

[The following three paragraphs must be included in substantially similar language at the top of the policy.]

FEDERAL INCOME TAX EXEMPTIONS: This policy **(IS)(IS NOT)** intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy **(IS)(IS NOT)** intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read the Massachusetts Guide for the Financing of Long-Term Care for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT THE FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

1. This policy is [an individual policy of insurance/a group policy which was issued in (indicate jurisdiction in which group policy was issued)]. THIS IS A LIMITED POLICY. This policy may not cover all the expenses associated with your long-term care needs.

[Except for policies or certificates that 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]. If your answers are incorrect or untrue as of the date you signed the applications, the carrier 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 were incorrect, contact the carrier at this address: [insert address]

2. SUMMARY OF POLICY FEATURES

This policy:

1. is not a Medicare Supplement policy.
2. is guaranteed renewable/is noncancelable for your lifetime.
3. is/is not subject to automatic premium increases as you get older.
4. may be/is not subject to across the board premium increases for all policyholders in your class.
5. does/does not offer an option to purchase inflation protection after the policy is issued without any medical underwriting.
6. does/does not offer an option to purchase nonforfeiture protection after the policy is issued without any medical underwriting.
7. does/does not contain special age limitations for purchase.
8. covers/never covers services due to pre-existing conditions (existing health problems) for a period of __ months from policy issue
9. may/does not have an elimination period of __ days before benefits are payable by policy.
10. may/does not offer a waiver of premium after __ days of __ benefits.

3. PURPOSE OF OUTLINE OF COVERAGE. An outline of coverage provides a very brief description of the important features of the coverage. 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 actual contractual provisions. This means that your [policy/certificate] sets forth in detail the rights and obligations of both you and the carrier. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR [POLICY/CERTIFICATE] CAREFULLY!

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

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

(1) Policies and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS [POLICY/CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier 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.

OR

(1) Policies and certificates that are noncancelable must contain the following statement:] RENEWABILITY: THIS [POLICY/CERTIFICATE] IS NONCANCELABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own without your agreement, and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Carrier Name] may increase your premium at that time for those additional benefits.

OR

(1) Policies and certificates that are convertible from a group policy must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS CONVERTIBLE TO AN INDIVIDUAL POLICY.](For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy:]

- (a) [Describe waiver of premium provisions or state such provisions are not in the policy]
- (b) [State whether or not the carrier has a right to change premium, and if the right exists, describe clearly and concisely each circumstance under which premium may change, including that it is subject to the commissioner's approval.]

5. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE RETURNED AND PREMIUM REFUNDED.

- (a) [Provide a brief description of the right to return—the policy's "free look" provision, which must be a minimum of ten days from the date of policy delivery.]
- (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.]

6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the carrier.

- (a) [For agents] Neither [insert carrier name] nor its agents represent Medicare, the federal government, or any state government.
- (b) [For direct response] [insert carrier name] is not representing Medicare, the federal government or any state government.

7. 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, including, but not limited to care in a nursing home, other long-term care facility or program or in the home.

[Except for policies or certificates which have unlimited daily benefits and no coinsurance cost-sharing features, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

This [policy/certificate] 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.

8. BENEFITS PROVIDED BY THIS [POLICY/CERTIFICATE].

- (a) [Covered services, deductible(s), waiting periods, elimination periods and maximums.]
- (b) [Institutional benefits, by skill level.]
- (c) [Non-institutional benefits, by skill level.]

[A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import must include an explanation of such terms in this section of the outline of coverage.]

[Any benefit screening must be explained in this section. If these screens differ for different benefits, explanation of the screen 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. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

9. LIMITATIONS AND EXCLUSIONS

[Describe:

- (a) Pre-existing conditions
- (b) Non-eligible facilities/provider
- (c) Non-eligible levels of care (e.g. unlicensed providers, care by a family member, etc.)
- (d) Exclusions/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 (6) above.]

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

10. 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 specified amount or percentage;
- (d) If there is not 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) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

[Carriers must include the following information in or with the outline of coverage:

- (1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with the benefit levels of a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a 20-year period.
- (2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. A carrier may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.]
- (3) Whether or not the benefit was chosen by the policyholder.]

11. NONFORFEITURE BENEFITS. As an accident and sickness policy, this policy does not have a cash value associated with life insurance products. This policy does offer [for an additional charge (if applicable)] a nonforfeiture benefit that will continue until exhausted even if the policy lapses due to nonpayment of policy premiums. The following represents an example of how this benefit would apply to your policy: [As applicable, indicate the following:

[Carriers must include the following information in or with the outline of coverage:

- (1) A description of the benefits that would accrue at different periods of policy lapse
- (2) Whether or not the benefit was chosen by the policyholder.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

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

13. PREMIUM

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice of benefit options, indicate the portion of annual premium that corresponds to each benefit option; OR
- (c) Refer individual to schedule page of the policy. For reference during the presentation, individual may be referred to policy illustration form for premium.]

COMPLAINTS. If you have a complaint, call us at () ____ or your agent. If you are not satisfied, you may call or write the Massachusetts Division of Insurance.

65.102: Appendix A: Sample Definitions

The following represent sample definitions of terms used in long-term care insurance policies. Any marketing or sales practices will be considered to be in compliance with the law if policies use substantially the same definitions and comply with all other laws related to the marketing of insurance policies

Adult day care means dementia day care or social day care.

Adult day health means those nursing, educational, and rehabilitative services provided by an adult day health program.

Adult day health program means a program approved by the Massachusetts Division of Medical Assistance or by a program meeting the requirements of the state in which the adult day health services are provided.

Adult foster care means personal care and other related services provided in a family-like setting that are provided by programs approved by the Massachusetts Division of Medical Assistance or that meet the requirements of the state in which services are provided.

Assisted living facility means a facility that has been certified as an assisted living residence by the Massachusetts Executive Office of Elder Affairs or a facility meeting the requirements of the state in which services are provided.

Chore care means non-medical services that are provided in the insured's home and are designed to maintain the insured's home so that it remains habitable, including at a minimum: vacuuming (including the moving of furniture), washing floors and walls, defrosting freezers, cleaning ovens, cleaning attics and basements to remove fire and health hazards, changing storm windows, performing heavy yardwork, shoveling snow, and making minor home repairs (such as replacing windows, door/window locks, handrails and safety rails, making minor repairs to stairs or floors and weatherizing the home).

Class means the underwriting and rating classifications originally used at the time that the policy was issued.

Community care benefits means those services provided to the insured in a home or community setting by a community-based service provider, including, but not limited to, home health care, personal care, home care and respite care.

Custodial care means non-medical services provided by a nursing home or a home health care agency.

Dementia day care means services provided by a dementia day care program operating in accordance with standards issued by the Executive Office of Elder Affairs, including a structured, secure environment for individuals with cognitive disabilities to maximize the individual's functional capacity, to reduce agitation, disruptive behavior, and the need for psychoactive medication, and to enhance cognitive functioning.

Disability means the functional or cognitive inability to engage in the regular and customary activities of daily living without human assistance as measured by Activities of Daily Living (ADLs).

Elimination period means the number of days of covered services that are to be paid solely by the insured before the insurance policy begins to pay benefits.

Guaranteed renewable means the policy feature that guarantees the insured's right to continue the in-force insurance policy by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, and cannot make any unilateral change in any provision of a guaranteed renewable coverage without the agreement of the insured, but on a class basis, the carrier may revise premium rates for guaranteed renewable policies subject to the approval of the commissioner.

Home care means non-medical assistance with activities of daily living which are designed to maintain the insured's ability to live independently that are provided by a home care provider and include, but are not limited to shopping, planning menus, preparing meals, home delivered meals, laundry, and light house cleaning and maintenance, including vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen/bathroom and changing beds.

Home care provider means an entity that provides home care services and meets the provider requirements set forth by the Executive Office of Elder Affairs.

Home health care means those nursing, home health aide, rehabilitative therapy, and nutrition counseling services provided by a home health care agency.

Home health care agency means an agency certified by the Massachusetts Department of Public Health or an agency or program meeting the requirements of the state in which the home health care services are provided.

Hospice care means those palliative services provided by a hospice to a patient deemed to be terminally ill.

Hospice means an agency or program licensed by the Massachusetts Department of Public Health or an agency or program meeting the requirements of the state in which hospice services are provided.

Hospital means a facility licensed by the Massachusetts Department of Public Health or meeting the requirements of the state in which the facility is located.

Intermediate nursing care means routine nursing services with the periodic availability of skilled nursing and rehabilitative services that are provided by a nursing home, a home health care agency, or by an adult day health program.

Lifetime maximum benefit period means the maximum number of days of benefits, as chosen by the insured, which the carrier shall pay for covered benefits after the satisfaction of any elimination period or deductible.

Lifetime maximum dollar amount means the maximum dollar amount, as chosen by the insured, which the carrier shall pay for covered benefits after the satisfaction of any elimination period or deductible.

Medicaid means the program of medical assistance administered by the Massachusetts Division of Medical Assistance under Title XIX of the federal Social Security Act, 42 USCS §1396 *et seq.*, and M.G.L. c 118E.

Medical necessity means:

- (1) in accordance with accepted standards of medical practice for the diagnosis and treatment of a condition;
- (2) delivered, when possible, in the least intensive setting required by the insured's condition; and
- (3) not solely for the convenience of the insured or the insured's family or the insured's health care provider.

Medicare means the federal health insurance program under Title XVIII of the federal Social Security Act, 42 USCS §1395 *et seq.*, as amended.

Mental or nervous condition means a condition as described in the standard nomenclature of the American Psychiatric Association.

Noncancelable means the policy feature that guarantees the insured's right to continue the in-force insurance policy at the same premium level by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, cannot make any unilateral change in any provision of coverage, and cannot revise premium rates for a noncancelable policy without the agreement of the insured.

Nurse means all nurses, including, but not limited to, registered nurses (R.N.), licensed practical nurses (L.P.N.), or licensed vocational nurses (L.V.N.) meeting the appropriate licensing or registration requirements of the state in which the nurse provides services.

Nursing home means a facility which is primarily engaged in providing nursing care and related services on an inpatient basis under a license issued by the Department of Public Health or the appropriate licensing agency of the state in which it is located.

Personal care means services provided by a personal care attendant to assist in activities of daily living. Services that are provided by a personal care provider and include, but are not limited to, assistance with bathing, bedpan routines, foot care, dressing, and care of dentures; shaving and grooming; assistance with eating; and assistance with ambulating and transfers.

Personal care provider means an entity that provides personal care services and meets the provider requirements set forth by the Executive Office of Elder Affairs

Pre-existing condition means a medical condition for which an insured received diagnosis or treatment during the 24-month period prior to the effective date of coverage.

Respite care means services to temporarily relieve a caregiver of the daily stresses and demands of care for the insured. In addition to home care, personal care and home health care, respite care services may include but are not limited to short term placements in adult foster care, nursing facilities or rest homes.

Skilled nursing care means skilled nursing, rehabilitative and other related services provided by a nursing home or home health care agency.

Social day care means training, counseling, and social services as defined by standards issued by the Executive Office of Elder Affairs, including assistance with walking, grooming, and eating and planned recreational and social activities suited to the needs of the participants and designed to encourage physical and mental exercise and stimulate social interaction.

Usual and customary, reasonable and customary, or words of similar import must be defined and explained in the policy form and in the outline of coverage.