DFS Methodology for Review and Analysis of Long Term Care (LTC) Rate Applications

Background. Long term care (LTC) insurance provides insurance coverage to help people pay their expenses related to nursing home and home care services. Like most types of insurance, LTC insurers charge policyholders premiums that go towards paying for those benefits.

DFS provides information about LTC insurance, benefits, premiums, market developments, legislation, and more in its biennial report, "Long Term Care Health Insurance Plans," available on the DFS website.

DFS also recently issued a report, "Long Term Care Insurance: Looking Back and Thinking Ahead," initiated by Superintendent Adrienne A. Harris, analyzing the LTC insurance market. As stated in the report, the LTC market nationwide is in crisis due to historical mispricing, which has led to ever-increasing premium rates and insurers leaving the market.

The report identifies several issues that contributed to today's nationwide crisis. Insurers' ability to initially price LTC policies accurately was hindered by a lack of historical claims data and because claims were often made decades after the original premiums were established. Furthermore, when LTC insurers first sought approval to significantly increase premium rates from regulators, including the New York State Insurance Department (the predecessor to DFS), regulators were reluctant to take action that could have increased rates or diminished benefits for policyholders who had purchased coverage as part of their long term care planning.

DFS Oversight. LTC insurance can be sold by either health insurers, life insurers, or property insurers. DFS oversees the following aspects of LTC insurance:

- Solvency: DFS keeps close track of LTC insurers' financial condition to make sure insurers remain solvent, *i.e.*, have enough money to pay claims. This is one of DFS's most important consumer protection responsibilities because, without it, policyholders would be unable to get the benefits that they have investing in, sometimes for decades.

- Policies: DFS reviews all LTC policies to make sure that they include the minimum required benefits.

- Premium rates: DFS reviews premium rates of new LTC products before they go on the market, as well as any LTC rate increases.

These factors are intertwined in that premium rates must reflect the benefits that are being offered, and must be enough to ensure that the LTC insurer remains solvent.

Rate Increase Applications and DFS Review. Adjustments to LTC premium rates must be approved by DFS. DFS's actuarial analysis and decision-making is governed by the Insurance Law, which requires LTC rates to be "reasonably related to the benefits provided" and "self-supporting" so that they are sufficient to cover anticipated claims (see Insurance Law Section 1117).

Insurers submit rate adjustment applications to DFS, which must include, in general, company financial information and the underlying actuarial data used to calculate the requested premium change.

- *Company Financial Information:*
    - Key information from the financial statements for the last three (3) to five (5) years, including reserves, assets and liabilities, investment income, and other factors impacting solvency.
    - Past and future claims experience, by calendar years, on earned premiums, incurred claims, and number of lives.
    - Actuarial reserves held at the latest valuation date.
    - Allowance for an expense provision.

- *Actuarial Data:* For each policy included in the rate application, the insurer must provide data supporting its assumptions regarding:
    - Morbidity: The probability of the policyholder going on claim and remaining on claim.
    - Mortality: The probability of the policyholder dying.
    - Lapse: The probability of a policyholder voluntarily giving up the policy.
    - Interest rate: The value used to calculate present values and in effect the portion of the company's investment earnings credited to the policyholder.

More specifically, LTC insurers are required to submit the following information in their rate applications to DFS:

- *Actuarial Memorandum:* This must describe each element in the rate application certified by an actuary who is a Member of the Society of Actuaries and meets the "Qualification Standard of Actuarial Opinion" as adopted by the American Academy of Actuaries. (11 NYCRR 52.40(a)).

- *Justification of Proposed Rate Increases*: See 11 NYCRR 52.25(e), 11 NYCRR 52.40(d)(2), 11 NYCRR 52.40(e), 11 NYCRR 52.45(h). Specifically, this must include the following:
    - Full description of proposed changes including:
        - Type of changes
        - Purpose and underlying rationale
        - Scope of applicability
        - Limitations and exclusions
    - First and last year of issue in New York and date of original form approval.
    - Actual and expected loss ratios by duration and in the aggregate for existing business.
    - Expected loss ratios by duration and in the aggregate for future issues only.
    - Detailed actuarial justification of the proposed changes.
        - If rates are not changing:
            - Demonstrate impact on loss ratios and/or product profitability.
            - Describe handling of existing business.
        - If rates are being revised:
            - History of previous New York rate revisions.

- Complete New York experience since inception. If New York experience is not credible, also provide nationwide experience and history of previous non-New York rate revisions as well.
- Include yearly and in total collected premiums, paid claims, change in claim reserves, change in active life reserves, earned premiums, incurred claims, cash loss ratio, and incurred loss ratio.
- Describe the basis for active life and claim reserves.
- If nationwide experience is used where New York experience is not credible, adjust premium items above to current New York rate schedule.
- Derivation of the proposed rate revision in detail, including demonstrations that:
    - The expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosure loss ratio, and
    - The expected future loss ratio is at least as large as the applicable minimum loss ratio, per 11 NYCRR 52.45(h).
- A statement that the rates, when approved, will be applied to all policies delivered or issued for delivery in New York State, regardless of place of current residence.

- *Actuarial Certification:* See 11 NYCRR 52.40(a), 11 NYCRR 52.45(f). This must certify the following:
    - The filing is in compliance with all applicable law and regulations of the State of New York.
    - The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans."
    - The expected loss ratio meets the minimum requirements of the State of New York. The minimum loss ratio for issue ages 65 and over for all individual policies shall be 65 percent, and for issue ages 64 and below for all such policies shall be 60 percent (11 NYCRR 52.45(h)).
    - The benefits are reasonable and in relation to the premiums charged.
    - The rates are not unfairly discriminatory.
    - The expected loss ratios for issue ages 64 and under, 65 and over, all ages combined.

The full checklist for insurers' rate applications can be found on the Department's Health Insurers: Accident and Health Product Checklists and Outlines webpage.

DFS will independently review all data submitted by insurers to confirm it is accurate, that the insurer's assumptions are reasonable, that the proposed rates comply with New York's minimum loss ratio requirements in 11 NYCRR 52.45(h), that the premiums are non-discriminatory, that the insurer's actuarial analysis complies with actuarial standards of practice, that the proposed rate change is actuarially justified, that the proposed rates changes are reasonably related to the benefits provided and are self-supporting, and that the proposed rate application complies with Insurance Law Section 1117.

Non-actuarial Considerations. DFS also considers other information that may not be included in the rate applications, including the following:

- The impact on policyholders.
- Phase-in of approved rates over a number of years.
- Possible benefit reductions that may be available policyholders to help mitigate premium increases.
- Waiting periods between rate increase requests.
- The history of rate increases for the insurer.
- Contributions for corporate affiliates.
- Comments submitted by consumers during the public comment period.

DFS also carefully reviews insurers' notices to policyholders to make sure they are accurate and understandable, so policyholders know the amounts of the rate changes and their options, and to make sure that the notices comply with applicable statutes and regulations.

Additional LTC information and resources can be found on the Department's LTC webpage.