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GENERAL ASSEMBLY OF NORTH CAROLINA
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H **D**

HOUSE DRH30107-MH-56 (02/22)

Short Title:	Long-Term Care Insurance Changes.-AB	(Public)
Sponsors:	Representative Dockham.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT UNREASONABLE PREMIUM RATE INCREASES FOR LONG-TERM CARE INSURANCE.

The General Assembly of North Carolina enacts:

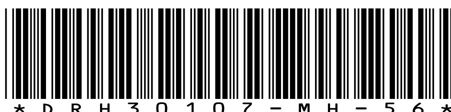
SECTION 1. G.S. 58-51-95 reads as rewritten:

"**§ 58-51-95. Approval by Commissioner of forms, classification and rates; hearing; exceptions.**

(a) No policy of insurance against loss or expense from the sickness, or from the bodily injury or death by accident of the insured shall be issued or delivered to any person in this State nor shall any application, rider or endorsement be used in connection therewith until a copy of the form thereof and of the classification of risks and the premium rates, or, in the case of cooperatives or assessment companies the estimated cost pertaining thereto, have been filed with the Commissioner. The types of policies to which this section applies are listed in subsection (j) of this section.

…

(f) An insurer may revise rates chargeable on policies subject to this section, other than noncancellable policies, with the approval of the Commissioner if the Commissioner finds that the revised rates are not excessive, not inadequate, and not unfairly discriminatory; and exhibit a reasonable relationship to the benefits provided by the policies. The approved rates shall be guaranteed by the insurer, as to the policyholders affected by the rates, for a period of not less than 12 months; or as an alternative to the insurer giving the guarantee, the approved rates may be applicable to all policyholders at one time if the insurer chooses to apply for that relief with respect to those policies no more frequently than once in any 12-month period. The rates shall be applicable to all policies of the same type; provided that no rate revision may become effective for any policy unless the insurer has given the policyholder written notice of the rate revision 45 days before the effective date of the ~~revision.~~ revision, including an explanation to the insured, approved by the Commissioner, of why the insurer requested the increase. The policyholder must then pay the revised rate in order to continue the policy in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submission of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet these standards. In adopting the rules under this subsection, the Commissioner may require identification of the types of rating methodologies used by filers and may also address issue age or attained age rating, or both; policy reserves used in rating; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries.



(f1) For long-term care policy forms, rate revision requests must satisfy all of the following:

(1) The rate revision shall not have the effect of transferring the lapse risk or mortality risk to the policyholders.

(2) The maximum rate increase that may be implemented in any calendar year for any policyholder is an increase of ten percent (10%) of the current policy premium rate in effect prior to the increase.

(3) The cumulative effect of all approved rate increases for a long-term care policy form shall not exceed one hundred percent (100%) of the original rate in effect when the policy form was initially approved.

(4) If the insurer determines that additional rate increases in excess of ten percent (10%) are required, and if a rate increase is approved by the Commissioner, then the insurer shall clearly state in a notification letter to the affected policyholders the insurer's current estimate of the amount of additional rate increase needed in addition to the approved amount that the insurer anticipates will be requested in future years.

(5) The notification letter required by subdivision (4) of this subsection shall be submitted to the Commissioner for approval prior to being sent to the policyholders.

(f2) For rate revisions intended to apply to long-term care policies issued prior to February 1, 2003, the following requirements apply:

(1) The anticipated lifetime loss ratio must be at least sixty percent (60%) for individual long-term care policies and at least seventy-five percent (75%) for group long-term care policies in order for the proposed revised rate schedule to be found reasonable by the Commissioner.

(2) The Commissioner shall deem excessive an insurer's proposed revised rate schedule for a policy form if it exceeds the rate schedule that, if it had been in place from inception of the policy form, would have generated an anticipated lifetime loss ratio equal to the greater of (i) the minimum required lifetime loss ratio in effect when the form was approved for sale or (ii) the insurer's originally anticipated lifetime loss ratio based on the original pricing assumptions.

(f3) For rate revisions intended to apply to long-term care policies issued after January 31, 2003, the Commissioner shall deem excessive an insurer's proposed revised rate schedule for a policy form if it exceeds the rate schedule that, if it had been in place from inception of the policy form, would have generated an anticipated lifetime loss ratio equal to the greater of seventy-five percent (75%) or the insurer's originally anticipated lifetime loss ratio based on the original pricing assumptions.

(f4) For purposes of subdivision (f2)(2) and subsection (f3) of this section, the calculation of the anticipated lifetime loss ratio shall be based on the insurer's actual historical incurred claims, and the currently anticipated future incurred claim experience for the form, without inclusion of active life reserves. The interest rate to be used in calculating the anticipated lifetime loss ratios referenced in subsections (f2) and (f3) of this section shall be the average maximum valuation rate of interest permitted by this State to be used to calculate policy reserves, as reported in the NAIC Annual Statement of the insurer for the affected policies.

(f5) For rate revisions intended to apply to long-term care policies, a proposed rate schedule shall be deemed to be excessive if it is in excess of the rate schedule applicable to similar forms currently available for sale from the insurer or any affiliate of the insurer, after taking into account differences in benefits and underwriting.

(f6) The Commissioner may waive the requirements of subsections (f1), (f3), and (f5) and subdivision (f2)(2) of this section if the Commissioner finds that the solvency of the insurer is threatened.

(f7) For rate revisions applicable to long-term care policies issued after January 1, 2014, if the nonforfeiture offer required to be made under G.S. 58-55-31 is rejected, a contingent nonforfeiture benefit on lapse shall be triggered whenever (i) an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium based on the insured's issue age, as set forth in the following table, and (ii) the policy or certificate lapses within 120 days of the due date of the increased premium:

Triggers for Contingent Nonforfeiture Benefit

Issue Age	Percent Increase Over Initial Premium
Under 55	100%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(f8) The contingent nonforfeiture benefit required by subsection (f7) of this section shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The contingent nonforfeiture benefits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate. The same benefits will be payable for a qualifying claim at the amounts and

frequency in effect at the time of lapse but not increased thereafter, but the lifetime maximum dollars or days of benefits shall be determined as follows, subject to the limitation that all benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status:

(1) The standard nonforfeiture credit shall be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration.

(2) The minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse.

(g) For policies subject to this section, an individual health insurer shall not increase an individual's renewal premium for continued health insurance coverage under the terms of the individual's health insurance policy based on any health status-related factors in relation to the individual or a dependent of the individual, including:

(1) Health status.
(2) Medical condition (including physical and mental illnesses).
(3) Claims experience.
(4) Duration from issue.
(5) Receipt of health care.
(6) Medical history.
(7) Genetic information.

(h) Every policy that is subject to this section and that provides individual accident and health insurance benefits to a resident of this State shall return to policyholders benefits that are reasonable in relation to the premium charged. The Commissioner may adopt rules or utilize existing rules to establish minimum standards for loss ratios of policies on the basis of incurred claims experience and earned premiums in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. Every insurer providing policies in this State subject to this section shall not less than annually file for approval its rates, rating schedules, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this State as adopted by the Commissioner. For long-term care policies issued prior to February 1, 2003, the annual filing shall be submitted before October 1 of each year. All filings of rates and rating schedules shall comply with the standards adopted by the Commissioner. The filing shall include a certification by an individual who is either a Fellow or an Associate of the Society of Actuaries or a Member of the American Academy of Actuaries that the rates are not excessive, not inadequate, and not unfairly discriminatory; and that the rates exhibit a reasonable relationship to the benefits provided by the policy. If the current rates are limited by subsection (f1), (f3), (f5) or subdivision (f2)(2) of this section, the actuary may modify the certification statement as necessary to reflect such limits. Nothing in this subsection shall require an insurer to provide certification with respect to a previous rate period, or to require an insurer to reduce properly filed and approved rates before the end of a rate period. This subsection does not apply to any long-term care policy issued in this State on or after February 1, 2003, and noncancellable accident and health insurance.

…."

SECTION 2. This act becomes effective July 1, 2013, and applies to rate revisions submitted to the Commissioner on or after that date.