

**TITLE 365. INSURANCE DEPARTMENT  
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

**RULEMAKING ACTION:**

Proposed PERMANENT Rules

**RULES:**

Subchapter 1.	General Provisions
Part 1.	General Provisions
365:10-1-14.	Notice of Withdrawal or Discontinuance of Writing [NEW]
Subchapter 5.	Minimum Standards; Contract Guidelines
Part 1.	Minimum Standards and Benefits for Accident and Health Insurance
365:10-5-9.	Disclosure of Reasonable Charge Determination [NEW]
Part 5.	Long-Term Care Insurance
365:10-5-45.1	Reporting requirements [AMENDED]
365:10-5-55.	Availability of New Services or Providers [AMENDED]
Part 17.	Actuarial Opinion and Memorandum Regulation
365:10-5-177.	Description of actuarial memorandum including an asset adequacy analysis [AMENDED]
Subchapter 15.	Utilization Review Regulations
365:10-15-2.	Private review agents [AMENDED]
Subchapter 17.	Valuation of Life Insurance Policies Regulation (Including the Introduction and Use of New Select Mortality Factors)
365:10-17-4.	General calculation requirements for basic reserves and premium deficiency reserves [AMENDED]
Subchapter 25.	Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities
365:10-25-4.	2001 CSO Preferred Class Structure Table [AMENDED]
365:10-25-5.	Conditions [AMENDED]
Appendix CC.	Long-Term Care Insurance Claims Denial Reporting Form [AMENDED]

**AUTHORITY:**

Insurance Commissioner, 36 O.S. §§ 307.1, 311, 1466, 4427, 4502(B)(9)(d)(2), 6516(A)(6), 6555, and 6571.

**ANALYSIS:**

The new Section 365:10-1-14 provides notice requirements for an insurer who desires to withdraw from writing insurance in Oklahoma.

The new Section 365:10-5-9 provides disclosure requirements for contracts or certificates of insurance which base payment for health care services, procedures or supplies on a determination of average area charges for those services, procedures or supplies. The new section also defines “average area charge” and provides requirements for the disclosure.

The amendment to Section 365:10-5-45.1 adds the definitions of “claim”, “denied” and “report” to the existing language as a result of the adoption of these amendments by the National Association of Insurance Commissioners.

The amendment to Section 365:10-5-55 changes the effective date of the section to July 14, 2009 in order to update the reference to the effective date.

The amendment to Section 365:10-5-177 clarifies a requirement of the regulatory asset adequacy issues summary.

The amendment to Section 365:10-15-2 updates the statutory reference for health maintenance organizations to reflect the relevant health maintenance organization sections of law within Title 36 of the Oklahoma Statutes.

The amendment to Section 365:10-17-4 deletes requirements for which certain select mortality factors are subject; specifically that the percentage not be less than twenty percent (20%) and that the percentage not decrease in any successive policy years. The amendment also adds the requirement of disclosure by the actuary if the percentage is less than one hundred percent (100%) at any duration for any policy. The actuary shall disclose the impact of the insufficiency of assets to support payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods.

The amendment to Section 365:10-25-4 allows for the substitution of the 2001 CSO Preferred Class Structure Mortality Table and 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies with the consent of the Commissioner subject to the conditions set forth in 365:10-25-5. Section 365:10-25-5 is amended to prohibit the use of the 2001 CSO Preferred Class Structure Table for the valuation of policies issued prior to January 1, 2007 if particular frequencies of modes of payment of the reinsurance premium exist.

The amendment to Appendix CC adds the manner of reporting long-term care denials to the instruction sections section of the appendix. The amendment specifies what is not included in the definition of a “denied” claim and adds a field to the form regarding the total number of In-force Policies as of the end of the year. These amendments are the result of adoptions by the National Association of Insurance Commissioners.

## **SUBCHAPTER 1. GENERAL PROVISIONS**

### **PART 1. GENERAL PROVISIONS**

#### **365:10-1-14. Notice of Withdrawal or Discontinuance of Writing**

(a) Any insurer desiring to withdraw from the state or discontinue the writing of a particular type or class of insurance in this state shall give one hundred eighty (180) days notice in writing to the Rate and Form Filing Compliance Division of the Insurance Department and shall state in writing its reasons for such action. The insurer shall also provide the following information:

- (1) The number of policyholders affected;
- (2) The number of insurance agents affected;
- (3) The date the insurer will cease writing new business;
- (4) The date the insurer will start non-renewing insurance policies;

- (5) Whether the insurer has made arrangements with another insurer to cover the renewals;
- (6) The lines of insurance on which the insurer plans to concentrate; and
- (7) Whether the insurer anticipates re-entering the market.
- (b) The provision of information required by subsection (a) of this section by an insurer electing to nonrenew all of its health benefit plans issued in this state that are subject to the Health Insurance Portability and Accountability Act, Public Law 104-194, shall constitute compliance with the obligations of the insurer to report to the Insurance Commissioner pursuant to 36 O.S. § 4502(B)(9)(d)(2).
- (c) The provision of information required in this section by a small employer carrier electing to nonrenew all of its health benefit plans issued to small employers in this state shall constitute compliance with the obligations of the small employer carrier to report to the Insurance Commissioner pursuant to 36 O.S. § 6516(A)(6).

**SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES**  
**PART 1. MINIMUM STANDARDS AND BENEFITS FOR ACCIDENT AND HEALTH INSURANCE**

**365:10-5-9. Disclosure of Reasonable Charge Determination**

- (a) Any contract or certificate of insurance issued by an insurance company, not-for-profit hospital service and medical indemnity plan, health insurance service organization or preferred provider organization which bases its payment for health care services, procedures, or supplies on a determination of average area charges for health care services, procedures, or supplies shall disclose that information to the contract purchaser and certificate holder at the time that the policy or certificate is delivered.
- (b) “Average area charge” means any determination of a charge for health care services, procedures, or supplies on a basis other than the billed rate or contracted rate of the health care provider. For example, “average area charge” includes, but is not limited to, the terms “customary and reasonable,” “usually and customary,” “usual, customary, and reasonable,” or other similar terms.
- (c) The disclosure shall be located on the first page or in a separate document affixed to the front page of the contract or certificate. The disclosure shall:
- (1) Be appropriately captioned and printed in font size at least two (2) points larger than the other text of the policy.
  - (2) Reference the applicable section of the contract or certificate that specifies how average area charges are determined and provide an example of how this determination will affect the payment for services, procedures, or supplies of a health care provider. This example shall provide an explanation of the liability for charges of the insured that exceed the average area charge.

(3) Advise the insured of the provisions of 36 O.S. § 6571 and provide a point of contact for health care providers to request the information used to determine the average area charge.

(4) Include language advising the insured that noncompliance with 36 O.S. § 6571 should be reported to the Oklahoma Insurance Department.

## **PART 5. LONG-TERM CARE INSURANCE**

### **365:10-5-45.1. Reporting requirements**

(a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by (a) of this section.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(f) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. An insurer shall use the form in Appendix CC to comply with this provision.

(g) For purposes of this section, ~~"policy" shall mean:~~

(1) "Policy" means only long-term care insurance and "report";

(2) Subject to paragraph 3 of this subsection, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(3) "Denied" means the insurer refused to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) "Report" means on a statewide basis.

(h) Reports required under this section shall be filed with the commissioner.

### **365:10-5-55. Availability of New Services or Providers**

(a) An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided

within twelve (12) months of the date of the new policy series is made available for sale in this state.

(b) Notwithstanding Subsection (a) of this section, notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the commissioner.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this Subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to O.A.C. 365:10-5-45 and 365:10-5-48.5, and the reporting requirements of O.A.C. 365:10-5-45.1(a)-(e).

(f) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection (a) of this section shall be made to the offering entity. However, if the policy is issued to a group defined at Section 4424(4)(a) of Title 36, the notification shall be made to each certificateholder.

(g) Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or

providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(h) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(i) This section shall become effective on or after July 14, ~~2008~~ 2009.

## **PART 17. ACTUARIAL OPINION AND MEMORANDUM REGULATION**

### **365:10-5-177. Description of actuarial memorandum including an asset adequacy analysis**

(a) **General.**

(1) In accordance with Section 4061 of the Oklahoma Insurance Code, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the Commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the Insurance Department or subject to automatic filing with the Commissioner.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Rule 365:10-5-173(b) of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the Commissioner requests a memorandum and no such memorandum exists or if the Commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the Commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the Commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the Commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three (3) years.

(5) In accordance with Section 4061 of the Oklahoma Insurance Code, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which

are specified in Subsection (c). The regulatory asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(b) **Details of the memorandum documenting asset adequacy analysis.** When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Rule 365:10-5-173(d) of this regulation and any additional standards under this regulation. It shall specify:

- (1) For reserves:
  - (A) Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;
  - (B) Source of liability in force;
  - (C) Reserve method and basis;
  - (D) Investment reserves;
  - (E) Reinsurance arrangements
  - (F) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;
  - (G) Documentation of assumptions to test reserves for the following (The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.):
    - (i) Lapse rates (both base and excess);
    - (ii) Interest crediting rate strategy;
    - (iii) Mortality;
    - (iv) Policyholder dividend strategy;
    - (v) Competitor or market interest rate;
    - (vi) Annuitization rates;
    - (vii) Commissions and expenses; and
    - (viii) Morbidity.
- (2) For assets:
  - (A) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;
  - (B) Investment and disinvestment assumptions;
  - (C) Source of asset data;
  - (D) Asset valuation bases;

- (E) Documentation of assumptions made for (The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.):
  - (i) Default costs;
  - (ii) Bond call function;
  - (iii) Mortgage prepayment function;
  - (iv) Determining market value for assets sold due to disinvestment strategy; and
  - (v) Determining yield on assets acquired through the investment strategy.
- (3) Analysis basis:
  - (A) Methodology;
  - (B) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;
  - (C) Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);
  - (D) Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and
  - (E) Effect of federal income taxes, reinsurance and other relevant factors.
- (4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;
- (5) Summary of results; and
- (6) Conclusions.
- (c) **Details of the regulatory asset adequacy issues summary.**
  - (1) The regulatory asset adequacy issues summary shall include:
    - (A) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

- (B) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;
  - (C) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;
  - (D) Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;
  - (E) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and
  - (F) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.
- (2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.
- (d) **Conformity to standards of practice.** The memorandum shall include the statement: 'Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum.'
- (e) **Use of assets supporting the interest maintenance reserve and the asset valuation reserve.**
- (1) An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.
  - (2) The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.
- (f) **Documentation.** The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

## SUBCHAPTER 15. UTILIZATION REVIEW REGULATIONS

### 365:10-15-2. Private review agents

(a) The following persons or entities shall be considered "private review agent(s)" for purposes of the Hospital and Medical Services Utilization Review Act, ~~Okla. Stat. tit. 36, § 6551, et seq.~~ Sections 6551 through 6581 of Title 36 of the Oklahoma Statutes:

(1) Any person or entity who performs utilization review on behalf of an employer in this state. The term "employer" means any person or entity who employs any person in this state. No person or entity who performs utilization review on behalf of an employer in this state shall be exempt from the provisions of the Hospital and Medical Services Utilization Review Act on the basis that the employer is self-insured or participates in an ERISA exempt employee welfare benefit plan or multiple employer welfare arrangement;

(2) Any person or entity who performs utilization review on behalf of a health maintenance organization which has been issued a license pursuant to ~~Okla. Stat. tit. 63, § 2501 et seq.~~ Sections 6901 through 6936 of Title 36 of the Oklahoma Statutes. However, any such person or entity performing utilization review on behalf of a health maintenance organization so licensed shall be exempt from the provisions of the Hospital and Medical Services Utilization Review Act if, prior to performing utilization review, such person or entity has obtained written documentation from the health maintenance organization that:

(A) the health maintenance organization is federally regulated; and

(B) the health maintenance organization has filed with the Commissioner of Health a plan of utilization review which is carried out by health care professionals and which has established complaint and appellate procedures for claims;

(3) Any person or entity who performs utilization review on behalf a third party providing or administering hospital and medical benefits to citizens of this state, including but not limited to a health insurer, not-for-profit hospital service or medical plan, health insurance service organization, preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state;

(b) Any licensed physician or other licensed health care professional who, pursuant to contract, agreement, or through the receipt or promise of any valid consideration, is consulted during the course of utilization review by a person or entity who is licensed to perform utilization review shall not be considered a private review agent.

(c) A private review agent whose provides utilization review services exclusively pursuant to a contract with the federal or state government concerning patients eligible for hospital and medical services under the Social Security Act is exempt from the certification required for private review agents in the Hospital and Medical Services Utilization Review Act.

(d) A private review agent who conducts in-house utilization review services solely for hospitals, home health agencies, preferred provider organizations, or other managed care entities, clinics, private offices or any other health facility or entity must be certified if the private review

agent's review results in the approval or denial of payment for hospital and medical services on a particular case. If such private review agent's in-house utilization review is only of a general nature and does not result in the approval or denial of payment for such services on a case by case basis, no certification is required.

(e) A private review agent who conducts "outside" utilization review services for an insurance company, not-for-profit hospital service or indemnity plan, or a not-for-profit medical or indemnity plan, shall be certified in compliance with the Hospital and Medical Services Utilization Review Act.

(f) Individual employees of a certified private review agent need not be separately certified.

#### **SUBCHAPTER 17. VALUATION OF LIFE INSURANCE POLICIES REGULATION (INCLUDING THE INTRODUCTION AND USE OF NEW SELECT MORTALITY FACTORS)**

##### **365:10-17-4. General calculation requirements for basic reserves and premium deficiency reserves**

(a) At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner for this purpose). If select mortality factors are elected, they may be:

- (1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;
- (2) The select mortality factors in the Appendix BB of this chapter; or
- (3) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner for the purpose of calculating basic reserves.

(b) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner). If select mortality factors are elected, they may be:

- (1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;
- (2) The select mortality factors in the Appendix BB of this chapter of this regulation;
- (3) For durations in the first segment, X percent of the select mortality factors in the Appendix BB of this chapter, subject to the following:

- (A) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;
- (B) ~~X shall not be less than twenty percent (20%);~~
- ~~(C) X shall not decrease in any successive policy years;~~
- ~~(D)~~ X is such that, when using the valuation interest rate used for basic reserves, unit (i) is greater than or equal to unit (ii);
- (i) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;
- (ii) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;
- ~~(E)~~ (C) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;
- ~~(F)~~ (D) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Section 365:10-17-3(b)(3);
- ~~(G)~~ (E) The appointed actuary may decrease X at any valuation date as long as X ~~does not decrease in any successive policy years and as long as it~~ continues to meet all the requirements of Section 365:10-17-3(b)(3); and
- ~~(H)~~ (F) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.
- ~~(I)~~ (G) If X is less than 100 percent at any duration for any policy, the following requirements shall be met:
- (i) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Section 365:10-5-176; and
- (ii) The appointed actuary shall disclose, in the Regulatory Asset Adequacy Issues Summary, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods; and
- (iii) The appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of Subsection B(3). This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

- (4) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner for the purpose of calculating deficiency reserves.
- (c) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.
- (d) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.
- (e) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.
- (f) The Insurance Commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Section 365:10-5-176.

## **SUBCHAPTER 25. REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES**

### **365:10-25-4. 2001 CSO Preferred Class Structure Table**

At the election of the company, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this regulation, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. For policies issued on or after July 14, 2003, and prior to January 1, 2007, these tables may be substituted with the consent of the Commissioner and subject to the conditions of Rule 365:10-25-5. In determining such consent, the Commissioner may rely on the consent of the Commissioner of the company's state of domicile. No such election shall be made until the company demonstrates at least 20% of the business to be valued on this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred

Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this rule, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of the NAIC model regulation, "Recognition of the 2001 CSO Mortality Table For Use In Determining Minimum Reserve Liabilities And Nonforfeiture Benefits Model Regulation."

**365:10-25-5. Conditions**

(a) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

(c) Unless exempted by the commissioner, every authorized insurer using the 2001 CSO Preferred Class Structure Table shall annually file with the commissioner, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of this regulation. The form of the reports

shall be established by the commissioner or the commissioner may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the commissioner.

(d) The use of the 2001 CSO Preferred Class Structure Table for the valuation of policies issued prior to January 1, 2007 shall not be permitted in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following:

(1) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds, by more than the amount specified in this paragraph as Y, the gross reserve calculated before reinsurance. Y is the amount of the gross reinsurance premium that

(A) provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year and the next reinsurance premium due date, and

(B) would be refunded to the ceding entity upon the termination of the policy.

(2) In cases where the mode of payment of the reinsurance program is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this paragraph as Z. Z is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(e) For purposes of subsection (d) of this section, both the reserve credit and the gross reserve before reinsurance (i) for the mean reserve method shall be defined as the mean reserve minus the deferred premium asset, and (ii) for the mid-terminal reserve method shall include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the 2001 CSO Preferred Class Structure Table.

**APPENDIX CC. LONG-TERM CARE INSURANCE CLAIMS DENIAL  
REPORTING FORM**

**For the State of \_\_\_\_\_  
For the Reporting Year of \_\_\_\_\_**

Company Name: \_\_\_\_\_ Due: June 30 annually  
Company Address: \_\_\_\_\_

Company NAIC Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Line of Business: Individual                      Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. Indicate the manner of reporting by checking one of the options below:

- Per Claimant – counts each individual who makes one or a series of claim requests.
- Per Transaction – counts each claim payment request.

“Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. “Denied” does not include a request for payment that is in excess of the applicable contractual limits.

In-force Data

	<b>State Data</b>	<b>Nationwide Data<sup>1</sup></b>
<u>Total Number of In-force Policies [Certificates] as of December 31<sup>st</sup></u>		

Claims and Denial Data

		<b>State Data</b>	<b>Nationwide Data<sup>1</sup></b>
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		

<sup>1</sup> The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	Long-Term Care Services Not Covered under the Policy <sup>2</sup>		
9	Provider/Facility Not Qualified under the Policy <sup>3</sup>		
10	Benefit Eligibility Criteria Not Met <sup>4</sup>		
11	Other		

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<sup>2</sup> Example—home health care claim filed under a nursing home only policy.

<sup>3</sup> Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

<sup>4</sup> Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.