

4. Paid and incurred/earned loss ratios for each of the years recognized in (c)3 above, where the incurred/earned loss ratio should be calculated both without and with the change in active life reserves;

5. The assumptions used in the calculation of the loss ratio, including:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or anti-select morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, by policy duration by issue age and sex;

iv. The secular trend factors by policy duration by issue age and sex;

v. The interest rates by policy duration, which rates shall equal a carrier's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes). Alternatively, the Department will permit use of a six percent interest rate graded linearly to four percent over 10 years and four percent thereafter or a five percent level interest rate. The Commissioner shall review annually the alternate interest rate and adjust those rates based on corporate bond yields for Aaa and Baa bonds as reported in U.S. Financial Data which is published by the Research and Public Information Division of the Federal Reserve Bank of St. Louis. The Commissioner shall provide public notice of new alternate interest rates by publication in the New Jersey Register;

vi. Expenses by policy duration, including commission, override and bonus rates; other marketing expense rates; other maintenance expense rates; any new-market expense rates; other acquisition expense rates; and the explicit profit margin or risk charged on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable basis;

vii. The distribution of expected policies by policy and rider benefits by issue age and sex; and

viii. A summary statement of the underwriting standards (such as short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market (that is, the segment(s) of the general public, for example, middle income based on predetermined ZIP code selections) for the policy forms;

6. The specific formulas and methodology used in calculating gross premiums; and

7. A certification signed by an actuary who is a member of the American Academy of Actuaries stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and

fully disclose the basis of the calculation of the anticipated loss ratio.

11:4-34.18 Premium rate schedule increases

(a) This section applies to any individual long-term care policy issued in this State on or after January 18, 2006 and for which initial rates were filed pursuant to N.J.A.C. 11:4-34.8.

(b) A carrier shall request approval of a revised premium rate schedule, including an exceptional increase, from the Commissioner at least 60 days prior to sending the notice to be provided to the policyholders, and the carrier's request shall include:

1. Information required by N.J.A.C. 11:4-34.7 concerning disclosure of rating practices;

2. Certification by a qualified actuary that:

i. If the requested premium rate schedule increase is implemented and the underlying assumptions for the revised rate filing which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated; and

ii. The premium rate filing is in compliance with the provisions of N.J.A.C. 11:4-34.18;

3. An actuarial memorandum justifying the rate schedule change request that includes:

i. Lifetime projections of earned premiums and incurred claims (on a year-to-year basis), based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

ii. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger a contingent benefit upon lapse;

iii. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, a comparison of the pricing assumptions and current assumptions and what other actions taken by the carrier have been relied on by the actuary; and

iv. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

5. Sufficient information for review and approval of the premium rate schedule increase by the Commissioner.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits whose cost exceeds the assumed cost in the initial premium;

2. Premium rate schedule increases that are not exceptional shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

i. The accumulated value of the initial earned premium times 58 percent;

ii. Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

iii. The present value of future projected initial earned premiums times 58 percent; and

iv. Eighty-five percent of the present value of future projected premiums not in (c)2iii above on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in (c)2ii and iv above will also include seventy percent for exceptional rate increase amounts; and

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in N.J.A.C. 11:4-6.16.

(d) For each rate increase that is implemented, the carrier shall file for approval by the Commissioner updated projections, as defined in (b)3i above, annually for the next three years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that insure 250 or more persons where the policyholder has 5,000 or more eligible employees of a single employer or where the policyholder pays 20 percent or more of the total premium for the group in the calendar year prior to the year a rate increase is filed, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than 150 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in (b)3i above, shall be filed for approval by the Commissioner every five years following the end of the required period in (d) above.

(f) If the Commissioner has determined that the actual experience following a rate increase does not adequately

match the projected experiences and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in (c) above, the Commissioner may require the carrier to implement either of the following:

1. Premium rate schedule adjustments; or

2. Other measures to reduce the difference between the projected and actual experience.

(g) If 25 percent or more of the policies to which the increase is applicable are eligible for the contingent benefit upon lapse, the carrier shall file:

1. A plan, subject to Commissioner approval, for improved administration and/or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in (h) below; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to (c) above had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in (c)2i and iii above.

(h) If 25 percent or more of the policies to which a rate increase is applicable are eligible for contingent benefit upon lapse, the Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated.

(i) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evident in the actual results as presented in the updated projections provided by the carrier following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Commissioner may require the carrier to offer, without underwriting, to all in force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the carrier or its affiliates. If the carrier or its affiliates are no longer offering one or more reasonably comparable products, the Commissioner may take other steps, including requiring pooling of all of the carrier's long term care policies for rating purposes, or disapproving or reducing rate increase requests.

1. The offer shall:

i. Be subject to the approval of the Commissioner;

ii. Be based on actuarially sound principles, but not on attained age; and

iii. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by

6. All communications between either the assuming or ceding insurer with the policyholders, including letters, memoranda, identification cards, advertisements or other material;

7. Affirmative consent of the owner is not required, but if obtained, the consent form shall be part of the submission. The certificate of assumption form shall not include a provision indicating that consent of the policyholder is deemed or implied as the result of some positive or negative action;

8. A certification by the assuming insurer that it will adhere to all conditions and representations which were part of the original filing of the forms being assumed;

9. Certifications by the assuming and ceding insurers that any communications by a policyholder with the ceding insurer will have the same legal status as a communication which is sent directly to the assuming insurer. Additionally, the ceding insurer shall certify that it will maintain systems to forward all communications of this nature to the assuming insurer;

10. The certificate of assumption form shall include the following:

- i. An appropriate title, such as Certificate of Assumption;
- ii. The business address of both the ceding and assuming insurers;
- iii. Clear directions regarding the submission of payments and claims; and
- iv. The signature of an officer of the insurer, and a statement that the form is to be attached to and made part of the policy; and

11. If health insurance or credit insurance is being assumed, the assuming insurer shall agree that rate revisions will be based on the experience since the original issue date. It is the responsibility of the assuming insurer to obtain and maintain the necessary experience data.

11:4-40.9 File and use eligibility

(a) An insurer may deliver or issue for delivery in this State a form providing life, health or annuity benefits, and accompanying rates if applicable, without obtaining prior approval from the Commissioner pursuant to this subchapter provided the form is set forth in this section as a type eligible for file and use and is filed with the Commissioner pursuant to the procedures set forth at N.J.A.C. 11:4-40.10, or the form is specifically exempt from compliance with this subchapter.

(b) The following types of non-variable individual life insurance forms shall be eligible for file and use pursuant to this section:

1. Scheduled premium term policies without cash values, other than universal/flexible-factor forms, multiple-

life forms with survivorship benefits, limited death benefit forms, policies with re-entry options, single premium forms, field issued forms or funeral insurance;

2. Accidental death benefit;
3. Business exchange/substitute insured;
4. Cost of living benefit;
5. Option to purchase additional insurance;
6. Waiver of premium;
7. Spouse and/or child rider; and
8. Applications.

(c) The following types of non-variable individual annuity forms shall be eligible for file and use pursuant to this section:

1. Immediate annuities, other than structured settlement, field issued forms or funeral insurance;
2. Scheduled premium deferred annuities, other than structured settlement, field issued forms or funeral insurance;
3. Flexible premium deferred annuities, other than structured settlement, field issued forms or funeral insurance;
4. Waiver of premium; and
5. Applications.

(d) The following types of individual health insurance forms shall be eligible for file and use pursuant to this section:

1. Business buyout, keyperson and overhead expense disability income policies;
2. Medical expense conversion policies in which a portion of the premium is chargeable to or subsidized by the group policy from which conversion is made;
3. Benefit riders for use with the type of policies set forth at (d)1 and 2 above; and
4. Applications other than those used with medicare supplement and long-term care policies.

(e) The following types of non-variable group life insurance forms shall be eligible for file and use pursuant to this section:

1. Policies and certificate forms which provide life insurance benefits only, and which do not provide cash values or loan values other than funeral expense;
2. Retired lives reserve contracts;
3. Benefit riders for use with the type of policies set forth at (e)1 and 2 above; and
4. Applications and evidence of coverage forms.

(f) The following types of group health insurance forms shall be eligible for file and use pursuant to this section:

1. Policies, certificates and evidence of coverage which provide only temporary disability benefits pursuant to N.J.S.A. 34:15-1 et seq.;
2. Policies and certificates which provide only disability income benefits for loss due to both accident and sickness and which are sold exclusively to employer groups;
3. Benefit riders for use with the type of policies set forth at (f)1 and 2 above; and
4. Applications and evidence of coverage forms.

(g) In the month of September or October of each year, the Department shall conduct a hearing pursuant to P.L. 1995, c.73 for the purpose of determining the specific types of forms eligible for file and use pursuant to this section.

1. The hearing shall be preceded by a notice of hearing published in the New Jersey Register at least 30 days prior to the date of the hearing, which notice shall include information concerning the date by which, and the person to whom, written public comment may be made. Notice shall also be provided to persons who have previously requested receipt of such notice.

2. The notice published in the New Jersey Register and as otherwise provided pursuant to (g)1 above shall also request that persons who wish to testify at the hearing provide the Department with timely notice of this intention, including a brief summary of the subject matter of their testimony.

3. The notice shall indicate whether the hearing shall address the merits of maintaining all forms currently on the file and use eligibility list, or whether the hearing will consider only specific additions, deletions or clarifications regarding the list.

4. The hearing shall be conducted by a hearing officer designated by the Commissioner. The length of testimony permitted at the hearing and the receipt of questions from the floor will be within the discretion of the hearing officer.

5. A transcript of the hearing shall be made and a copy thereof shall be made available to any interested person upon request and payment of the appropriate fee.

6. The record of the hearing shall include the following:

- i. Timely-received written public comments;
- ii. The transcript of the hearing; and
- iii. Any other information which the hearing officer may deem relevant.

7. The record and transcript of the hearing shall be public records pursuant to N.J.S.A. 47:1A-1 et seq. except to

the extent that any information is submitted pursuant to a statute or rule providing for confidentiality.

8. Upon review of the file and use eligibility list hearing record, the Commissioner shall determine within 30 days whether any modifications should be made by rule to the current list.

9. If the Commissioner determines during the term of a duly promulgated file and use eligibility list that changed conditions require a modification of the list, the Commissioner may amend the list by rule following a hearing conducted pursuant to this subsection.

Public Notice: Hearing to determine forms eligible for filing and use.
See: 28 N.J.R. 4121(a).

Public Notice: Hearing to determine forms eligible for filing and use.
See: 30 N.J.R. 3108(b).

Public Notice: Hearing to determine forms eligible for filing and use.
See: 33 N.J.R. 3379(a).

Amended by R.2001 d.408, effective November 5, 2001.

See: 33 N.J.R. 2263(a), 33 N.J.R. 3747(a).

In (a), added “, or the form is specifically exempt from compliance with this subchapter”; deleted former (g); recodified former (h) as (g) and substituted “(g)1” for “(h)1”.

Public Notice: Notice of Public Hearing; Life/Health/Annuity Forms Certification Eligibility.

See: 34 N.J.R. 3544(b).

Public Notice: Life/Health/Annuity Forms certification eligibility.

See: 35 N.J.R. 4144(a).

Amended by R.2004 d.174, effective May 3, 2004.

See: 35 N.J.R. 4437(a), 36 N.J.R. 2197(a).

In (b), deleted former 8 and recodified former 9 as 8; in (c), deleted former 4 and recodified former 5 and 6 as 4 and 5.

Public Notice: Life/Health/Annuity Forms Certification Eligibility.

See: 36 N.J.R. 3940(a).

Public Notice: Notice of Public Hearing; Life/Health/Annuity Forms Certification Eligibility.

See: 27 N.J.R. 4320(a), 37 N.J.R. 3463(a), 38 N.J.R. 3928(a).

11:4-40.10 File and use procedures

(a) An insurer seeking to file and use a form specified at N.J.A.C. 11:4-40.9 to be eligible for file and use shall, in addition to the items set forth at N.J.A.C. 11:4-40.5(b), submit the following to the Department:

1. A certification memorandum signed and acknowledged by a responsible officer of the insurer, which shall include the following:

i. A statement that the certification is filed pursuant to P.L. 1995, c.73, section 17;

ii. A statement that the responsible officer signing the certification memorandum is authorized to execute the document;

iii. A statement that the responsible officer signing the certification memorandum is familiar with the insurer’s filing and all laws, regulations, bulletins and published guidelines applicable to the particular type of form, and that the form complies with all laws, regulations, bulletins and published guidelines applicable to the particular type of form;