

## Health Insurance Reserves Minimum Reserve Requirements

The following requirements apply to all individual and group health and accident and sickness insurance, excluding credit disability insurance.

### I. Definitions

1. "Annual claim cost" is the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a \$100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be \$12, while the gross premium for this benefit might be \$18. The additional \$6 would cover expenses and profit or contingencies.
2. "Claims liability" is that portion of claims incurred on or prior to the valuation date that results in liability of the company for the payment of benefits for medical services that have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability that have occurred on or prior to the valuation date, that the company has not paid as of the valuation date, but for which it is liable and will have to pay after the valuation date.
3. "Claims reported" is considered as a reported claim for annual statement purposes when a company has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date.
4. "Claim reserve" represents that portion of claims incurred on or prior to the valuation date that results in liability of the company for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date.
5. "Date of disablement" is the earliest date the insured is considered disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.
6. "Elimination period" is a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.
7. "Gross premium" is the amount of premium charged by the company. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.
8. "Group insurance" includes blanket insurance and franchise insurance and any other forms of group insurance.
9. "Level premium" is a premium calculated to remain unchanged throughout either the lifetime of the policy or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the company, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.
10. "Long-term care insurance" is any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization, to the extent they are otherwise authorized to issue life or health insurance, may issue long-term care insurance. Long-term care insurance does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
11. "Modal Premium" refers to the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is \$100 and if, instead, monthly premiums of \$9 are paid then the modal premium is \$9.
12. "Negative reserve" refers to a negative terminal reserve that may occur when the value of the benefits decrease with advancing age or duration. Normally the terminal reserve is a positive value.
13. "Preliminary Term Reserve Method" is a method of valuation whereby the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant

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## Health Insurance Reserves Minimum Reserve Requirements VM-25

valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all expected claims incurred after the end of the preliminary term period.

14. "Present value of amounts not yet due on claims" is the reserve for "claims reserve" (see definition) discounted at interest.
15. "Rating block" means a grouping of contracts determined by the valuation actuary based on common characteristics, such as a policy form or forms having similar benefit designs.
16. "Terminal reserve" is the reserve at the end of a contract year and is defined as the present value of expected incurred claims after that contract year minus the present value of future valuation net premiums.
17. "Unearned premium reserve" values that portion of the premium paid or due to the company which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of \$120 was paid on November 1, \$20 would be earned as of December 31 and the remaining \$100 would be unearned. The unearned premium reserve could be on a gross basis as in this example or on a valuation net premium basis.
18. "Valuation net modal premium" is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

### II. Claim Reserves

1. A company shall hold claim reserves for all incurred but unpaid claims on all health insurance policies, which is measured as the present value of future benefits or amounts not yet due as of the valuation date that are expected to arise under claims which have been incurred as of the valuation date and shall hold appropriate claim expense reserves for the estimated expense of settlement of all incurred but unpaid claims.
2. A company shall test all claim reserves for prior valuation years for adequacy and reasonableness using claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.
3. The maximum interest rate for claim reserves disability income insurance is as specified in Exhibit 1.
4. The minimum morbidity assumptions for disability income insurance are as specified in Exhibit 1, except that at the option of the company:
  - a. For individual disability income claims incurred on or after [enter operative date of valuation manual], assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the company's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.
  - b. For group disability income claims incurred on or after [enter operative date of valuation manual]:
    - i. Assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the company's experience, if experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities;
    - ii. Assumptions regarding claim termination rates for the period two (2) or more years but less than five (5) years from date of disablement may be based on the company's experience on business if the experience is credible and for which the company maintains underwriting and claim administration control.
  - c. With respect to (a) and (b) above, for experience to be considered credible for purposes of these requirements, the company should be able to provide claim termination patterns over no more than six (6) years reflecting at least 5,000 claims terminations during the third through fifth claims durations on reasonably similar applicable policy forms. Prior to the adoption by a company of either (a) or (b)(ii), a plan of modification to the reserve basis must be prepared and must include:
    - i. An analysis of the credibility of the experience;
    - ii. A description of how all of the company's experience is proposed to be used in setting reserves;
    - iii. A description and quantification of the margins to be included; and
    - iv. A summary of the financial impact that the proposed plan of modification would have had on the company's last filed annual statement.
5. For disability income contracts with an elimination period, the duration of disablement must be measured as dating from the time that benefits would have begun had there been no elimination period.

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## Health Insurance Reserves Minimum Reserve Requirements VM-25

6. The maximum interest rate for claim reserves for insurance other than disability income is as specified in Exhibit 1.
7. The morbidity assumptions or assumptions for other contingencies for insurance other than disability income must be based on the company's experience, if such experience is credible, or upon other assumptions designed to place a sound value on the liabilities.
8. A generally accepted actuarial reserving method or other reasonable method or a combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, must be determined in the aggregate.
9. For claims, liabilities and claim reserves to reflect "sound values" and/or reasonable margins, valuation tables based on credible experience should be adjusted regularly to maintain reasonable margins.
10. Claim reserves for survivor income benefits contained in group long-term disability contracts must be established based on the design of the survivor income benefits including the minimum period of disability before the spouse of a disabled person becomes eligible for a survivor income benefit and the amount of the benefit. A company may approximate the sum of the reserves for the basic disability benefit and the reserve for the survivor income benefit by computing the reserve for the basic disability at an interest rate less than the maximum interest rate if
  - a. the company performs rigorous testing of the approximation; and
  - b. testing indicates that basic disability reserves calculated at a 3.5% valuation interest rate adequately approximate the sum of basic disability reserves and survivor income benefits assuming:
    - i. a 12-month disability requirement;
    - ii. a maximum survivor income benefit duration of 24 months;
    - iii. a survivor income benefit of .667 of the disability income; and
    - iv. a valuation interest rate of 5.5%.

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### III. Premium Reserves

1. Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.
2. If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums must be carried as an offsetting liability.
3. The gross premiums paid in advance for a period of coverage commencing after the valuation date must be held as a separate liability.
4. The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:
  - a. The valuation net modal premium on the contract reserve basis applying to the contract; or
  - b. The gross modal premium for the contract if no contract reserve applies.
5. In no event may the sum of the unearned premium and contract reserves for all contracts of the company subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve must never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.
6. The company may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Such approximations or estimates must be tested periodically to determine their continuing adequacy and reliability.

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<#>Single premium credit disability insurance individual policies and group certificates are excluded from unearned premium reserve requirements of this section.¶

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### IV. Contract Reserves

1. Contract reserves are required for all unmatured contractual obligations of a company arising out of the provisions of an individual or group health insurance contract consistent with unearned premium reserve and claim reserves held for their respective obligations. Unless otherwise specified below, contract reserves are required for individual and group contracts with constant or level premiums, and all individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums

for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any pre-funding. If the premium is also intended to recover costs for any prior years, the actuary should also disclose the reasons for and magnitude of such recovery. The values specified in this paragraph must be determined on the basis specified in Sections IV.6 - IV.12 below.

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2. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any pre-funding. If the premium is also intended to recover costs for any prior years, the actuary should also disclose the reasons for and magnitude of such recovery. The values specified in this paragraph must be determined on the basis specified in this subsection.

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3. If premium rates are determined for a block such that each year's premium is intended to cover that year's cost, the rating block approach above results in no contract reserves, unless required by Section VI. If premium rates for a block are designed to prefund future years' costs, contract reserves are required.

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4. Contracts not requiring a contract reserve are contracts that cannot be continued after one year from issue and contracts already in force on January 1, 2001 for which no contract reserve was required by the company's domiciliary state.

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5. The contract reserve is in addition to claim reserves and premium reserves.

6. The methods and procedures for determining contract reserves must be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

7. The total contract reserve established shall incorporate provisions for moderately adverse deviations.

8. The minimum morbidity assumptions are as specified in Exhibit 1 subject to the following:

a. Contracts for which morbidity assumptions are not specified in Exhibit 1 must be valued using morbidity tables established for reserve purposes by a qualified actuary and the morbidity tables must contain a pattern of incurred claims cost that reflects the underlying morbidity and must not be constructed for the primary purpose of minimizing reserves.

b. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. If the gross premiums for a policy form do not vary by age, the valuation net premiums will nonetheless vary based on age at issue for each contract, since at issue the present value of valuation net premiums for a contract must equal the present value of tabular claim costs.

c. If the morbidity assumptions specified in Exhibit 1 are on an aggregate basis, the morbidity assumptions specified in Exhibit 1 may be adjusted to reflect the effect of company underwriting by policy duration. The adjustments must be appropriate to the company's underwriting.

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<#>In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. This provision is not intended to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and can be evaluated and quantified.¶

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d. Effective [enter operative date of valuation manual], when determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience subject to paragraph 7 above, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and that is able to be evaluated and quantified.

e. Business in force prior to [enter operative date of valuation manual] may be permitted to retain the original reserve basis, which may not meet the provisions of (d) above.

9. The maximum interest rate is specified in Exhibit 1.

10. Termination rates are the specified mortality tables in Exhibit 1, except as follows:

## Health Insurance Reserves Minimum Reserve Requirements VM-25

- a. Under contracts for which premium rates are not guaranteed, and where the effects of company underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of eighty percent of the total termination rate used in the calculation of the gross premiums or eight percent.

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11. For long-term care individual policies or group certificates issued on or after [enter operative date of valuation manual], the contract reserve shall be established on the basis of:

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<#>For long-term care individual policies or group certificates issued within the period January 1, 2001 to December 31, 2006, the contract reserve may be established on a basis of separate mortality as specified in Exhibit 1, and terminations other than mortality that do not exceed.¶

- a. Mortality (as specified in Exhibit 1); and
- b. Terminations other than mortality, where the terminations are not to exceed:
- i. For policy year one, the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and six percent (6%);
- ii. For policy years two (2) through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%);
- iii. For policy years five (5) and later, the lesser of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums and two percent (2%), except certificates under policies issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of a labor organization where the 2% shall be three percent (3%).

i. For policy year one, the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and eight percent (6%);¶

ii. For policy years two (2) through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%); and¶

iii. For policy years five (5) and later, the lower of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums, and three percent (3%) for employer group insurance or 2% for all other.¶

12. The reserve method is applied only in relation to the date of issue of a contract and is

- a. For insurance other than long-term care and return of premium or other deferred cash benefits, the two-year full preliminary term method in which the terminal reserve is zero at the end of the first and second contract anniversaries;
- b. For long-term care insurance, is the one-year full preliminary term method in which the terminal reserve is zero at the end of the first contract anniversary;
- c. For return of premium or other deferred cash benefits, the one year preliminary term method if the benefits are provided at any time before the twentieth anniversary or the two year preliminary term method if the benefits are only provided on or after the twentieth anniversary.

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13. Reserve adjustments introduced after issue, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons must be applied immediately as of the effective date of adoption of the adjusted basis.

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14. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

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15. For long term care insurance the contract reserve on a policy basis must not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications. For purposes of this paragraph, nonforfeiture benefits include contingent benefits upon lapse of a long term care insurance contract only during the period of time that the benefit may be exercised.

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16. If the contract reserves are not less in the aggregate than the reserve determined using the above specified methods and assumptions, the company, in determining a sound value of its liabilities under the contracts, may:

- a. In place of the above specified assumptions, use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency; or
- b. In place of the above specified methods, use other methods including, but not limited to the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

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## Health Insurance Reserves Minimum Reserve Requirements VM-25

c. Use approximations such as: those involving age groupings, groupings of several years of issue, groupings of average amounts of indemnity, or groupings of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

17. The company shall conduct an appropriate annual review of prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The company shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate subject, however, to the minimum standards in Sections IV.6 - IV.12 above.

18. In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

### V. Reinsurance

Increases to, or credits against, reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the company's liabilities.

### VI. Health Insurance Reserve Adequacy and Additional Reserves

1. Adequacy of a company's health insurance reserves is to be determined on the basis of the aggregate of claim reserves, premium reserves and contract reserves. However, appropriate reserves must be determined for each of these three categories of reserves separately.

2. When a company determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, the company shall hold such increased reserves and the increased reserves are the minimum reserves for that company.

3. With respect to any block of contracts, or with respect to a company's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

4. A gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the company's health business as a whole. In the event inadequacy is found to exist, the company shall recognize the loss immediately and restore the reserves to adequacy. A company shall hold adequate reserves (inclusive of claim, premium and contract reserves, if any) with respect to all contracts, regardless of whether contract reserves are required for such contracts pursuant to the valuation manual.

5. Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement pursuant to the valuation manual.

6. A company shall hold reserves for experience rated contracts such that

- The method used to estimate the reserves is reasonable based on the company's procedures and is consistent among reporting periods; and
- The assumptions used are consistent with the assumptions made in determining other reserves.

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## Exhibit 1

### Morbidity

I. Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

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1. For Disability Income Benefits Due to Accident or Sickness:

a. Contract Reserves:

- i. The 1985 Commissioners Individual Disability Tables A (85CIDA); or
- ii. The 1985 Commissioners Individual Disability Tables B (85CIDB).

Each company shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard.

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b. Claim Reserves:

- i. For claims incurred on or after January 1, 2002:

The 1985 Commissioners Individual Disability Table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

Duration	Adjustment Factor	Adjusted Termination Rates*
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448
17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

## Health Insurance Reserves Minimum Reserve Requirements VM-25

\*The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (*Transactions of the Society of Actuaries* (TSA) XXXVII, pp. 457-463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

\*\*Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pp. 462-463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (The 1985 Commissioners Individual Disability Table C).

ii. For claims incurred prior to January 1, 2002:

Each company may elect which of the following to use as the minimum standard for claims incurred prior to January 1, 2002:

- a. The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred, or
- b. The standard as defined in Item (i), applied to all open claims.

Once a company elects to calculate reserves for all open claims on the standard defined in a, all future valuations must be on that standard.

2. For Hospital Benefits, Surgical Benefits and Maternity Benefits (scheduled benefits or fixed time period benefits only):

- a. Contract Reserves:  
The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.
- b. Claim Reserves: No specific standard.

3. Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

- a. Contract Reserves: The 1985 NAIC Cancer Claim Cost Tables.
- b. Claim Reserves: No specific standard.

4. Accidental Death Benefits.

- a. Contract Reserves: The 1959 Accidental Death Benefits Table.
- b. Claim Reserves: Actual amount incurred.

5. Other Individual Benefits.

- a. Contract Reserves: For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.
- b. Claim Reserves: For all benefits other than disability, claim reserves are to be determined as provided in the standards.

## II. Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

1. Disability Income Benefits Due to Accident or Sickness.

- a. Contract Reserves: The 1987 Commissioners Group Disability Income Table (87CGDT).
- b. Claim Reserves: The 1987 Commissioners Group Disability Income Table (87CGDT);

2. Other Group Benefits.

- a. Contract Reserves: For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.
- b. Claim Reserves: For all benefits other than disability, claim reserves are to be determined as provided in the standards.

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Single Premium Credit Disability. ¶  
Contract Reserves:¶  
For contracts issued on or after January 1, 2002:¶  
For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).¶  
For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in Item (i).¶  
¶  
For contracts issued prior to January 1, 2002, each insurer may elect either i or ii below to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard in ii., all future valuations must be on that basis.¶  
The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or¶  
The standard as defined in a., applied to all contracts.

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<#>Single Premium Credit Disability¶  
<#>Contract Reserves for contracts issued on or after January 1, 2002:¶  
<#>For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).¶  
¶  
<#>For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in item (i).¶  
¶  
<#>For contracts issued prior to January 1, 2002, each insurer may elect either i. or ii. below to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in i., all future valuations¶ ... [12]

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### III. Interest

1. For contract reserves the maximum interest rate is the maximum rate allowed by the Standard Valuation Law in the valuation of whole life insurance issued on the same date as the health insurance contract.
2. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.
3. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

### IV. Mortality

1. For long-term care insurance individual policies or group certificates issued on or after enter operative date of valuation manual, the mortality basis used shall be the 1994 Group Annuity Mortality Static Table.
2. Other mortality tables adopted by the NAIC and promulgated by the commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the commissioner. The request for approval shall include the proposed mortality table and the reason that the standard specified in 1 above is inappropriate.

#### Exhibit 2

#### Reserves for Waiver of Premium (Supplementary explanatory material)

Determination of waiver of premium reserves involves several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in-force contracts. Therefore, contract reserves based on these tables are NOT reserves on "active lives", but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables. Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

1. Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.
2. Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.
3. Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

If a company is, instead, valuing reserves on an active life table, or if a specific valuation table is not being used but the company's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any company using such a true "active life" basis should carefully consider whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

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**Deleted:** Unless 3 or 4 below applies, the mortality basis used for all policies except long-term care individual policies and group certificates issued before January 1, 2001 shall be according to a table (but without use of selection factors) allowed by law for the valuation of whole life insurance issued on the same date as the health insurance contract. ¶

**Deleted:** For long-term care insurance individual policies or group certificates issued from January 1, 2001 through December 31, 2006 the mortality basis used shall be the 1983 Group Annuity Mortality Table without projection

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<#>For single premium credit insurance using the 85 CIDA table, no separate mortality shall be assumed.¶

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with duration from date of disablement of less than two years, a company may use its own morbidity experience, if such experience is credible; or may use other morbidity assumptions, if such assumptions are expected to place a sound value on the liabilities.		
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For group disability income claims incurred prior to		
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through December 31, 2006		
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with a duration from date of disablement of more than two (2) years but less than five (5) years, reserves may be based on the		
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company's experience if such experience is considered credible and for which the		
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company maintains underwriting and claim administration control.		
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#### Single Premium Credit Disability

Contract Reserves for contracts issued on or after January 1, 2002:

For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).

For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in item (i).

For contracts issued prior to January 1, 2002, each insurer may elect either i. or ii. below to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in i., all future valuations must be on that basis.

The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or

The standard as defined in a., applied to all contracts.