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Ohio Administrative Code

Rule 3901-3-13 Health insurance reserves.

Effective: February 14, 2022

(A) Purpose

The purpose of this rule is to establish the minimum reserve standards for all individual and group health insurance coverages, including single premium credit disability insurance. All other credit insurance is not subject to this rule.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 and division (Q) of section 3903.723 of the Revised Code.

(C) Scope

(1) These standards establish a minimum reserve standard for all individual and group health insurance coverages, including single premium credit disability insurance. When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

(2) With respect to any block of contracts, or with respect to an insurer'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.

(3) Such 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 insurer's health

business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

(4) 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 under these standards.

(5) This rule sets forth minimum standards for three categories of health insurance reserves: claim reserves, premium reserves and contract reserves. Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of these categories separately.

(D) Definitions

(1) "Annual claim cost" means 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 one hundred dollar 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 thirty-five, in a certain occupation might be twelve dollars, while the gross premium for this benefit might be eighteen dollars. The additional six dollars would cover expenses and profit or contingencies.

(2) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(3) "Claims reported" means a claim that has been incurred on or prior to the valuation date and the insurer has been informed of it on or before the valuation date. This claim is considered a reported claim for annual statement purposes.

(4) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer 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. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

(5) "Claims unreported" means a claim that has been incurred on or prior to the valuation date but the insurer has not been informed of it on or before the valuation date. This claim is considered an unreported claim for annual statement purposes.

(6) "Date of disablement" means the earliest date the insured is considered as being 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.

(7) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(8) "Gross premium" means the amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

(9) "Group insurance" means blanket insurance and franchise insurance and any other forms of group insurance.

(10) "Group long-term disability income insurance" means any group insurance policy or rider advertised, marketed, offered or designed to provide group disability income coverage with a maximum benefit duration longer than two years that is based on a group pricing structure. The term

"group long-term disability income insurance" does not include voluntary group disability income insurance coverage that is priced on an individual risk structure and generally sold in the workplace.

(11) "Level premium" means 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 insurer, 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.

(12) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve 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. Long-term care insurance may be issued by 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. Long-term care insurance shall 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.

(13) "Modal premium" means 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 one hundred dollars and if, instead, monthly premiums of nine dollars are paid then the modal premium is nine dollars.

(14) "Negative reserve" means the terminal reserve where the values of the benefits are decreasing with advancing age or duration such that it results in a negative value, called a negative reserve. Normally the terminal reserve is a positive value.

(15) "Preliminary term reserve method" means the method of valuation where 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 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 claims expected to be incurred following the end of the preliminary term period.

(16) "Present value of amounts not yet due on claims" means the reserve for "claims unaccrued" which may be discounted at interest.

(17) "Rating block" means a grouping of contracts determined by the valuation actuary based on common characteristics filed with the superintendent, such as a policy form or forms having similar benefit designs.

(18) "Reserve" means all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date, (on these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves); or

(b) Claims which are expected to be incurred after the valuation date, (any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.)

(19) "Terminal reserve" means the reserve at the end of the contract year which is equal to the

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present value of benefits expected to be incurred after the contract year minus the present value of future valuation net premiums.

(20) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of one hundred twenty dollars was paid on November first, twenty dollars would be earned as of December thirty-first and the remaining one hundred dollars would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(21) "Valuation manual" means the manual produced by the "National Association of Insurance Commissioners" (NAIC) and updated annually that contains the minimum reserve and related requirements for life, accident and health insurance.

(22) "Valuation net modal premium" means 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.

(23) "Worksite franchise disability insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide individual disability coverage that is sold at the worksite through employer-sponsored enrollment and complies with section 3923.11 of the Revised Code. Worksite franchise disability insurance does not include coverage for business overhead expense, disability buyout, or key person policies.

(24) "Worksite individual disability insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide personal disability coverage that is sold to an individual at the worksite, and is not associated with employer-sponsored enrollment. Worksite individual disability insurance does not include business overhead expense, disability buyout, or key person policies.

(E) Claim reserves

(1) General

(a) Claim reserves are required for all incurred but unpaid claims on all health insurance policies. For contracts with an elimination period, the duration of disablement shall be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(b) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(c) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(d) For claim reserves on policies that require contract reserves, the claim incurral date is to be considered the "issue date" for determining the table and interest rate to be used for claim reserves.

(e) The maximum interest rate for claim reserves is specified in paragraph (I) of this rule.

(f) With respect to claim reserves for policies issued prior to January 1, 2017, the operative date of the valuation manual, the requirements for claim reserves on claims incurred after that date shall be as described in the valuation manual based on the incurred date of the claim.

(2) Minimum morbidity standards for individual disability income claim reserves

(a) For claims incurred prior to January 1, 2005, each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(ii) The standards as defined in paragraph (E)(2)(b) or (E)(2)(c) of this rule, applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in either paragraph (E)(2)(b) or (E)(2)(c) of this rule, all future valuations must be on that basis.

(b) For claims incurred on or after January 1, 2005 and prior to the effective date for the company as determined in paragraph (E)(2)(e) of this rule, the minimum standards with respect to morbidity are those specified in paragraph (I) of this rule, except that, at the option of the insurer, assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(c) For claims incurred on or after January 1, 2020, the minimum standards are those specified in paragraph (I) of this rule, including (as derived in accordance with actuarial guideline L, as included in the 2019 version of the NAIC accounting practices and procedures manual):

(i) The use of the insurer's own experience; and

(ii) An adjustment to include the insurer's own experience measurement margin; and

(iii) The application of a credibility factor.

(d) In determining the minimum reserves in accordance with paragraph (E)(2)(c) of this rule, the provisions in paragraphs (E)(2)(c)(i) to (E)(2)(c)(iii) of this rule are not required if:

(i) The insurer meets the own experience measurement exemption provided in actuarial guideline L as included in the 2019 version of the NAIC accounting practices and procedures manual; or

(ii) For worksite franchise disability insurance policies with benefit periods of up to two years, at the option of the insurer, disabled life reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(e) An insurer may begin to use the minimum reserve standards in paragraph (E)(2)(c) of this rule at a date earlier than the effective date of this rule.

(f) An insurer may apply the new standards in paragraph (E)(2)(c) of this rule to all open claims regardless of incurred date. Once an insurer elects to calculate reserves for all open claims based on

paragraph (E)(2)(c) of this rule, all future valuations must be on that basis.

(3) Minimum morbidity standards for group disability income claim reserves

(a) For claims incurred prior to January 1, 2005, each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred; or

(ii) The standards as defined in paragraph (E)(3)(b) of this rule, applied to all open group long-term disability income insurance claims; or

(iii) The standards as defined in paragraph (E)(3)(c) of this rule, applied to all open group disability income insurance claims.

Once an insurer elects to calculate reserves for all open claims on a more recent standard, then all future valuations must be on that basis.

(b) For group long-term disability income insurance claims incurred on or after January 1, 2005, but before the effective date in paragraph (E)(3)(c) of this rule, and group disability income insurance claims incurred on or after January 1, 2005, that are not group long-term disability income, the minimum standards with respect to morbidity are those specified in paragraph (I) of this rule, except that, at the option of the insurer:

(i) Assumptions regarding claim termination rates for the period less than two years from the date of disablement may be based on the insurer's experience, if the experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(ii) Assumptions regarding claim termination rates for the period two or more years but less than five years from the date of disablement may, with the approval of the superintendent, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(A) An analysis of the credibility of the experience;

(B) A description of how all of the insurer's experience is proposed to be used in setting reserves;

(C) A description and quantification of the margins to be included;

(D) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(E) A copy of the approval of the proposed plan of modification by the insurance regulatory agency of the insurer's state of domicile; and

(F) Any other information deemed necessary by the superintendent.

(iii) Each insurer may elect which of the following to use as the minimum morbidity standard for group long-term disability income insurance claim reserves:

(A) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(B) The standards as defined in paragraph (E)(3)(c) of this rule, applied to all open claims.

Once an insurer elects to calculate reserves for all open claims on a more recent standard, then all future valuations must be on that basis.

(c) For group long-term disability income insurance claims incurred on or after January 1, 2020, the minimum standards with respect to morbidity shall be based on the 2012 GLTD termination table in accordance with actuarial guideline XLVII, as included in the 2019 version of the NAIC accounting practices and procedures manual with considerations of:

(i) The use of the insurer's own experience; and

(ii) An adjustment to include the insurer's own experience measurement margin; and

(iii) The application of a credibility factor.

(d) An insurer may begin to use the minimum reserve standards in paragraph (E)(3)(c) of this rule at a date earlier than the effective date of this rule. An insurer may apply the standards in paragraph (E)(3)(c) of this rule to all open claims incurred prior to the effective date of paragraph (E)(3)(c) of this rule for the insurer. Once an insurer elects to calculate reserves for all open claims based on paragraph (E)(3)(c) of this rule, all future valuations must be on that basis.

(4) Minimum morbidity or other contingency standard for other health insurance claim reserves

The reserve must be based on the insurer's experience, if the experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(5) Claim reserve methods generally

A generally accepted actuarial reserving method or other reasonable method, based on information and data describing the proposed method, or a combination of methods may be used to estimate all claim liabilities if approved by the superintendent prior to the statement date. 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, shall be determined in the aggregate.

(F) Premium reserves

(1) General

(a) Unearned premium reserves are required for all contracts, except individual and group single premium credit disability insurance, with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums

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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 shall be carried as an offsetting liability.

(c) The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(2) Minimum standards for unearned premium reserves

(a) 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:

(i) The valuation net modal premium on the contract reserve basis applying to the contract; or

(ii) The gross modal premium for the contract if no contract reserve applies.

(b) In no event may the sum of the unearned premium and contract reserves for all contracts of the insurer 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 shall 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.

(3) Premium reserve methods generally

The insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Such approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

(G) Contract reserves

(1) General

(a) Contract reserves are required, unless otherwise specified in paragraph (G)(1)(b) of this rule for:

(i) All individual and group contracts with which level premiums are used; or

(ii) 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 prefunding. 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 paragraph (G)(1)(a)(ii) of this rule shall be determined on the basis specified in paragraph (G)(2) of this rule.

(b) Contracts not requiring a contract reserve are:

(i) Contracts which cannot be continued after one year from issue; or

(ii) Contracts already in force on the effective date of this rule for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves.

(d) The methods and procedures for contract reserves should 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.

(e) The contract reserves for single premium credit disability insurance shall never be less than the expected claims for the period beyond the valuation date.

(f) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

(2) Minimum standards for contract reserves

(a) Basis

(i) Morbidity or other contingency. Minimum standards with respect to morbidity are those set forth in paragraph (I) of this rule. 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.

Contracts for which tabular morbidity standards are not specified in paragraph (I) of this rule shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the superintendent. The morbidity tables shall contain a pattern for incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

(A) 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. 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.

(B) Business in force as of the effective date of paragraph (G)(2)(a)(iii)(c) of this rule may be permitted to retain the original reserve basis which may not meet the provisions of paragraph (G)(2)(a)(i)(a) of this rule, subject to the acceptability of the superintendent.

(ii) Interest. The maximum interest rate is specified in paragraph (I) of this rule.

(iii) Termination rates. Termination rates used in the computation of reserves shall be on the basis of

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a mortality table as specified in paragraph (I) of this rule except as noted in paragraphs (G)(2)(a)(iii)(a), (G)(2)(a)(iii)(b), and (G)(2)(a)(iii)(c) of this rule.

(A) Under contracts for which premium rates are not guaranteed, and where the effects of insurer 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:

(i) Eighty per cent of the total termination rate used in the calculation of the gross premiums, or

(ii) Eight per cent.

(B) For long-term care individual policies or group certificates issued after December 31, 2003, the contract reserve may be established on a basis of separate:

(i) Mortality (as specified in paragraph (I) of this rule); and

(ii) Terminations other than mortality, where the terminations are not to exceed:

(i) For policy years one through four, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and eight per cent;

(ii) For policy years five and later, the lesser of one hundred per cent of the voluntary lapse rate used in the calculation of gross premiums and four per cent.

(C) For long-term care individual policies or group certificates issued on or after January 1, 2011, the contract reserve may be established on a basis of separate:

(i) Mortality (as specified in paragraph (I) of this rule); and

(ii) Terminations other than mortality, where the terminations are not to exceed;

(i) For policy year one, the lesser of eighty per cent of the voluntary lapse rate used in the calculation

of gross premiums and six per cent;

(ii) For policy year two through four, the lesser of eighty per cent of the voluntary lapse rate used in the calculation of gross premiums and four per cent;

(iii) For policy year five and later, the lesser of one hundred per cent of the voluntary lapse rate used in the calculation of gross premiums and two per cent, except for group long-term care insurance as defined in section 3923.41 of the Revised Code where the two per cent shall be three per cent.

(D) Where a morbidity standard specified in paragraph (I) of this rule is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the superintendent.

(b) Reserve method

(i) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(ii) For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(iii) For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(A) For individual policies and group certificates issued on or before December 31, 1996, reserves calculated on the two-year full preliminary term method;

(B) For individual policies and group certificates issued on or after January 1, 1997, reserves calculated on the one-year full preliminary term method.

(iv) For return of premium or other deferred cash benefits, the minimum reserve is the reserve

calculated as follows:

(A) On the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary;

(B) On the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

(c) Negative reserves. 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.

(d) Nonforfeiture benefits for long-term care insurance. The contract reserve on a policy basis shall 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.

(3) Alternative valuation methods and assumptions generally

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, 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.

(4) Tests for adequacy and reasonableness of contract reserves

Annually, an appropriate review shall be made of the insurer's 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 insurer 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 of paragraph (G)(2) of this rule.

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, or is otherwise restricted by law, 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.

(H) 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 insurer's liabilities.

(I) Specific standards for morbidity, interest and mortality

(1) Morbidity

(a) Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

(i) Disability income insurance benefits due to accident or sickness.

(A) Contract reserves:

(i) Contracts issued on or after January 1, 1965 and prior to January 1, 1992:

The 1964 commissioners disability table (64CDT).

(ii) Contracts issued on or after January 1, 1992 and prior to January 1, 2020:

(i) The 1985 commissioners individual disability tables A (85CIDA); or

(ii) The 1985 commissioners individual disability tables B (85CIDB).

(iii) Contracts issued during 1987 to 1991:

(i) Optional use of either the 1964 table or the 1985 tables; and

(ii) Each insurer 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. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(iv) Contracts issued on or after January 1, 2020:

(i) The 2013 IDI valuation table with modifiers as described in actuarial guideline L as included in the 2019 version of the NAIC accounting practices and procedures manual; and

(ii) An insurer may begin to use the 2013 IDI valuation table with modifiers at a date earlier than the effective date of this rule.

(v) Once an insurer begins to use the 2013 IDI valuation table the insurer may elect to apply that morbidity standard for all policies issued subject to other valuation tables. This may be done if the following conditions are met:

(i) The insurer must apply the morbidity standard to all in-force policies and incurred claims;

(ii) The insurer elects or has elected to apply the 2013 IDI valuation table to all claims incurred regardless of incurred date;

(iii) The insurer maintains adequate policy records on policies issued prior to 2020 that allow the insurer to apply the 2013 IDI valuation table appropriately; and

(iv) Once an insurer elects to calculate reserves for all in-force policies based on the current morbidity standard, all future valuations must be on that basis.

(B) Claim reserves:

(i) For claims incurred prior to January 1, 2004:

Each insurer may elect which of the following to use as the minimum standard for claims incurred prior to January 1, 2004:

(i) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred; or

(ii) The standard as defined in paragraph (I)(1)(a)(i)(b)(ii) or (I)(1)(a)(i)(b)(iii) of this rule, applied to all open non-worksite claims provided the insurer maintains adequate claim records to allow the insurer to apply the standard defined in paragraph (I)(1)(a)(i)(b)(ii) or (I)(1)(a)(i)(b)(iii) of this rule appropriately; and

(iii) Once an insurer elects to calculate reserves for all open claims on the standard defined in paragraph (I)(1)(a)(i)(b)(ii) or (I)(1)(a)(i)(b)(iii) of this rule, all future valuations must be on that basis. This option, with respect to paragraph (I)(1)(a)(i)(b)(iii) of this rule, may be selected only if the insurer maintains adequate claim records for all claims incurred to use the 2013 IDI valuation table appropriately.

(ii) For claims incurred on or after January 1, 2004 and prior to January 1, 2020:

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	**

*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, pages 457 to 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, pages 462 to 463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (the 1985 commissioners individual disability table C).

(iii) For claims incurred on or after January 1, 2020, the 2013 IDI valuation table with modifiers and adjustments for company experience as prescribed in actuarial guideline L, as included in the 2019 version of the NAIC accounting practices and procedures manual, except for worksite disability insurance policies with benefit periods of twenty-four months or less.

For worksite franchise disability insurance policies with benefit periods of twenty-four months or less, claim reserves may be calculated using claim run-out analysis or claim triangles, or other methods that place a sound value on the reserves that are appropriate for the business and risks involved.

(ii) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(A) Contract reserves:

(i) Contracts issued on or after January 1, 1955, and prior to January 1, 1982:

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The 1956 intercompany hospital-surgical tables.

(ii) Contracts issued on or after January 1, 1982:

The 1974 medical expense tables, table A, TSA XXX, page 63. Refer to the paper (in the same volume, page 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:

Standards are based on paragraphs (E)(4) and (E)(5) of this rule.

(iii) Cancer expense benefits:

(A) Contract reserves:

(i) Contract issued on or after January 1, 1986 and prior to January 1, 2019:

The 1985 NAIC cancer claim cost tables (1985 CCCT).

(ii) Contracts issued on or after January 1, 2019:

(i) For first occurrence and hospitalization benefits:

The 2016 NAIC cancer claim cost valuation tables (2016 CCCVT);

(ii) For all other benefits:

Assumptions based on company experience, relevant industry experience, and actuarial judgement. Such assumptions should be appropriate for valuation which considers a margin for adverse experience.

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(B) Claim reserves:

No specific standard. See paragraph (I)(1)(a)(vi) of this rule.

(iv) Accidental death benefits.

(A) Contract reserves:

Contracts issued on or after January 1, 1965:

The 1959 accidental death benefits table.

(B) Claim reserves:

Actual amount incurred.

(v) Single premium credit disability.

(A) Contract reserves:

(i) For contracts issued prior to January 1, 2004, each insurer may elect either paragraph (I)(1)(a)(v)(a)(i)(A) or (I)(1)(a)(v)(a)(i)(B) of this rule to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in paragraph (I)(1)(a)(v)(a)(i) of this rule, all future valuations must be on that basis.

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

(ii) The standard as defined in paragraph (I)(1)(a)(v)(a)(ii) of this rule, applied to all contracts.

(ii) For contracts issued on or after January 1, 2004:

(i) 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 per cent.

(ii) For plans having a thirty day and greater elimination period, the 85CIDA for a fourteen day elimination period with claim incidence rates increased by twelve per cent.

(B) Claim reserves:

Claim reserves are to be determined as provided in (paragraphs (E)(4) and (E)(5) of this rule.

(vi) Other individual contract 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 income insurance, claim reserves are to be determined as provided in the standards.

(b) Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(i) Disability income insurance benefits due to accident or sickness, where this rule references this paragraph (I)(1)(b)(i) of this rule, paragraphs (I)(1)(b)(i)(a) and (I)(1)(b)(i)(b) of this rule apply; otherwise actuarial guideline XLVII, as included in the 2019 version of the NAIC accounting practices and procedures manual.

(A) Contract reserves:

(i) Contracts issued prior to January 1, 1992:

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The same basis, if any, as that employed by the insurer as of January 1, 1992.

(ii) Contracts issued on or after January 1, 1992:

The 1987 commissioners group disability income table (87CGDT).

(B) Claim reserves:

(i) For claims incurred on or after January 1, 1992:

The 1987 commissioners group disability income table (87CGDT).

(ii) For claims incurred prior to January 1, 1992:

Use of the 87CGDT is optional.

(ii) Single premium credit disability

(A) Contract reserves:

(i) For contracts issued prior to January 1, 2004, each insurer may elect either paragraph (I)(1)(b)(ii)(a)(i)(A) or (I)(1)(b)(ii)(a)(i)(B) of this rule to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in paragraph (I)(1)(b)(ii)(a)(ii) of this rule, all future valuations must be on that basis.

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

(ii) The standard as defined in paragraph (I)(1)(b)(ii)(a)(ii) of this rule, applied to all contracts.

(ii) For contracts issued on or after January 1, 2004:

(i) 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 per cent.

(ii) For plans having a thirty day and greater elimination period, the 85CIDA for a fourteen day elimination period with the adjustment in paragraph (I)(1)(b)(ii)(a)(i)(A) of this rule.

(B) Claim reserves:

Claim reserves are to be determined as provided in paragraphs (E)(4) and (E)(5) of this rule.

(iii) Other group contract 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 income insurance, claim reserves are to be determined as provided in the standards.

(2) Interest

(a) For 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 health insurance contract.

(b) 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.

(c) 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.

(3) Mortality

(a) Except as provided in paragraphs (I)(3)(b) and (I)(3)(c) of this rule, the mortality basis used for all policies, except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued prior to January 1, 2004 shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after January 1, 2004, the mortality basis used shall be the 1983 group annuity mortality table without projection. For long-term care insurance individual policies or group certificates issued on or after January 1, 2011, the mortality basis used shall be the 1994 group annuity mortality static table.

(b) Other mortality tables adopted by the NAIC and promulgated by the superintendent may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the superintendent. The request for such approval must include the proposed mortality table and the reason that the standard specified in paragraph (I)(3)(a) of this rule is inappropriate.

(c) For single premium credit insurance using the 85CIDA table, no separate mortality shall be assumed.

(J) Reserves for waiver of premium

(1) Waiver of premium reserves involve 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. Hence, 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.

(2) Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

(a) Claim reserves should include reserves for premiums expected to be waived, valuing as a

minimum the valuation net premium being waived;

(b) Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived; and

(c) 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.

(3) If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer'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 insurer using such a true active life basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

(K) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms, and provisions shall continue in full force and effect.