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Section 2. Claim Reserves
Section 3. Premium Reserve
Section 4. Contract Reserves

(6) With respect to claim reserves for policies issued before 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.

Drafting Note: The historical application of new requirements for claim reserves has been the incurred date of the claim. The 2009 changes

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

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

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

(v) A copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(vi) Any other information deemed necessary by the commissioner.

(c) Each insurer may elect which of the following to use as the minimum morbidity standard for group long-term disability income 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 Section 2C(3), 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.

(3) For group long-term disability income claims incurred on or after January 1, 2017, the minimum standards with respect to morbidity shall be based on the 2012 GLTD termination table or subsequent table with considerations of:

(a) The insurer's own experience computed in accordance with Actuarial Guideline XLVII, ,

(121-2.5)

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(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.

(2) However, 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. The reserve shall never be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for elsewhere.

Drafting Note: States should be aware that while single premium credit disability insurance is excluded from unearned premium reserve requirements, there may be requirements elsewhere in statutory accounting to test reserves against the premium refund net liability.

C.

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

- 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%);

- 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

- 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 for group insurance as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act, i.e., employer groups] where the 2% shall be three percent (3%).

(iv) Where a morbidity standard specified in Appendix A is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of

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(ii) 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.

(3) 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

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Section 5. Reinsurance

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded,

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APPENDIX A. SPECIFIC STANDARDS FOR MORBIDITY, INTEREST AND MORTALITY

I. MORBIDITY

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

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued on or after January 1, 1965, and prior to January 1, [YEAR 1]:

The 1964 Commissioners Disability Table (64 CDT).

Contracts issued on or after January 1, [YEAR 1] and before January 1, 2020:

The 1985 Commissioners Individual Disability Tables A (85CIDA); or

The 1985 Commissioners Individual Disability Tables B (85CIDB).

Contracts issued during [YEAR 1 or YEARS]:

Optional use of either the 1964 Table or the 1985 Tables.

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.

Contracts issued on or after January 1, 2020:

The 2013 IDI Valuation Table with modifiers as described in Actuarial Guideline L.

An insurer may begin to use the 2013 IDI Valuation Table with modifiers at a date earlier than January 1, 2020, but not prior to January 1, 2017.

Within three years of 2020, or the earlier date 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 inforce 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;

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Contracts issued on or after January 1, 1982:

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. See (6).

(3) Cancer Expense Benefits.

(a) Contract Reserves:

(i) Contracts issued on or after January 1, 1986 and before January 1, 2019:

The 1985 NAIC Cancer Claim Cost Tables (1985 CCCT).

(ii)

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The same basis, if any, as that employed by the insurer as of January 1, [SAME YEAR];

Contracts issued on or after January 1, [YEAR]:

The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim Reserves:

For claims incurred on or after January 1, [YEAR]:

The 1987 Commissioners Group Disability Income Table (87CGDT);

For claims incurred prior to January 1, [YEAR]:

Use of the 87CGDT is optional.

(2) Single Premium Credit Disability

(a) Contract Reserves:

(i) For contracts issued on or after [effective date of this amendment]:

(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 percent (12%).

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

(ii) For contracts issued prior to [effective date of this amendment], each insurer may elect either Item (I) or (II) to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Item (i), all future valuations must be on that basis.

(I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, an indd i ro5.1 (n)-1.5 5.7c b cu,es-8.9 ( )]s

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(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

II. 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.

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APPENDIX B. GLOSSARY OF TECHNICAL TERMS USED

As used in this valuation standard, the following terms have the following meaning:

ANNUAL-CLAIM COST. 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.

CLAIMS ACCRUED. 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.

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LEVEL PREMIUM. 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.

LONG-TERM CARE INSURANCE. 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. 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.

MODAL PREMIUM. This 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.

NEGATIVE RESERVE. Normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

PRELIMINARY TERM RESERVE METHOD. Under this method of valuation 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.

PRESENT VALUE OF AMOUNTS NOT YET DUE ON CLAIMS. The reserve for “cl.4 (e)0.7 .7 (i)-6 h s th2.6 (a)-1 (d)-5SENeeoN

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APPENDIX C. RESERVES FOR WAIVER OF PREMIUM
(Supplementary explanatory material)

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.

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