State of Connecticut
Regulation of
Insurance Department
Concerning
Health Insurance Reserves Regulation

Section 1. Sections 38a-78-11 to 38a-78-15, inclusive, of the Regulations of Connecticut State Agencies are amended to read as follows:

Minimum Reserve Standards for Individual and Group Health Insurance Contracts

Sec. 38a-78-11. Introduction

(a) **Scope.** Sections 38a-78-11 to 38a-78-16, inclusive, of these regulations shall apply to all individual and group health (accident and sickness) insurance coverages [except credit insurance.] including single premium credit disability insurance. All other credit insurance is not subject to this regulation.

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.

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.

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.

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.

(b) **Categories of Reserves.** The following sections set forth minimum standards for three categories of health insurance reserves:

Sec. 38a-78-13. Claim reserves
Sec. 38a-78-14. Premium reserves
Sec. 38a-78-15. 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 the three categories separately.

(c) **Appendices.** These standards contain two appendices: one is an integral part of the standards,

and one is a "supplementary" appendix which is not part of the standards as such, but is included for explanatory and illustrative purposes only.

Appendix A. Specific minimum standards with respect to morbidity, mortality and interest, which apply to claim reserves according to year of incurral and to contract reserves according to year of issue.

Appendix B. (Supplementary) Waiver of Premium Reserves.

Sec. 38a-78-12. Definitions

As used in Sections 38a-78-11 to 38a-78-16, inclusive of these regulations:

(a) "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 $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.

(b) "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, shall be established.

(c) "Claims Reported" means when an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

(d) "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), shall be established.

(e) "Claims Unreported" means when an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

(f) "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.

(g) "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.

(h) "Guarantee Duration" of a health insurance contract is the maximum number of years the health insurance contract can remain in force on the basis guaranteed in the contract.

(i) "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.

(j) "Group Insurance" includes blanket insurance and franchise insurance and any other forms of group insurance.

(k) "Group Long-Term Disability Income" includes group contracts providing group disability

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income coverage with a maximum benefit duration longer than two years. Group long-term disability income contracts are based on a group pricing structure. The term "group long-term disability" does not include group short-term disability (coverage with benefit periods of two years or less in maximum duration). It also does not include voluntary group disability income coverage that is priced on an individual risk structure and generally sold in the workplace.

[(k)] (*l*) "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 is 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.

[(*l*)](m) "Long-Term Care Insurance" means 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 care centers, 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, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

[(m)] (n) "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 $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9.

[(n)] (o) "Negative Reserve" means the value of the terminal reserve when it is a negative value. 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.

[(o)] (p) "Preliminary Term Reserve Method" means that 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.

[(p)] (q) "Present Value of Amounts Not Yet Due on Claims" means the reserve for "claims unaccrued" (see definition), which may be discounted at interest.

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

[(q)] (s) "Reserve" includes 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:

(1) 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

(2) 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.

[(r)] (t) "Terminal Reserve" means the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

[(s)] (u) "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 $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.

[(t)] (v) "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.

(w) "Worksite Disability Policies" means individual short-term disability policies that are sold at the worksite through employer-sponsored enrollment, cover normal pregnancy, and that have benefit periods up to 24 months. Worksite disability policies do not include personal disability policies sold to an individual and not associated with employer-sponsored enrollment. They also do not include business overhead expense, disability buyout, or key person policies, in whatever manner those policies are sold.

Sec. 38a-78-13. Claim reserves

(a) **General**.

(1) 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.

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

(3) 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.

(4) 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.

(5) The maximum interest rate for claim reserves is specified in Appendix A.

(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.

(b) **[Minimum Standards for Claim Reserves] Minimum Morbidity Standards for Individual Disability Income Claim Reserves.**

[(1)] Disability Income.

[(A)] Interest. The maximum interest rate for claim reserves is specified in Appendix A.

[(B)] Morbidity. Minimum standards with respect to morbidity are those specified in Appendix A,

except that, at the option of the insurer for the portion of claims payable within (i) three years for group disability income claims, or (ii) two years for all other disability claims, from the date of disablement, reserves may be based on the insurer's experience to the extent that such experience is credible, or, with the approval of the commissioner, upon other assumptions designed to place a sound value on the liabilities.

[(C)] Duration of Disablement. For contracts with an elimination period, the duration of disablement should be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

[(2)] All Other Benefits.

[(A)] Interest. The maximum interest rate for claim reserves is specified in Appendix A.

[(B)] Morbidity or Other Contingency. The reserve should be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(1) Each insurer may elect the standards as defined in subsection (b)(2) or (3) of this section applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in either subsection (b)(2) or (3) of this section, all future valuations must be on that basis.

(2) Prior to the effective date for the company as determined in subsection (b)(5) of this section, the minimum standards with respect to morbidity are those specified in Appendix A, except that, at the option of the insurer, assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the insurer's experience, if such experience is considered credible, or, with the approval of the Commissioner, upon other assumptions designed to place a sound value on the liabilities.

(3) For claims incurred on or after January 1, 2020, the minimum standards are those specified in Appendix A, including (as derived in accordance with Actuarial Guideline L, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*):

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

(B) An adjustment to include an own experience measurement margin; and

(C) The application of a credibility factor.

(4) In determining the minimum reserves in accordance with subsection (b)(3) of this section, the provisions of subsection (b)(3)(A), (B) and (C) of this section are not required if:

(A) The insurer meets the Own Experience Measurement Exemption provided in Actuarial Guideline L, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*; or

(B) For worksite disability 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, with the approval of the Commissioner, upon other assumptions and methods designed to place a sound value on the liabilities.

(5) An insurer may begin to use the minimum reserve standards in subsection (b)(3) of this section above at a date earlier than January 1, 2020, but not prior to January 1, 2017.

(6) An insurer may, within three years of January 1, 2020, (or such earlier date it elects under subsection (b)(5) of this section) apply the new standards in subsection (b)(3) of this section to all open claims incurred prior to the effective date for subsection (b)(3) of this section for the insurer. Once an insurer elects to calculate reserves for all open claims based on subsection (b)(3) of this section, all future valuations must be on that basis.

(c) **Minimum Morbidity Standards for Group Disability Income Claim Reserves.**

(1) For group long-term disability income claims incurred prior to the effective date selected by the company in subsection (c)(3) of this section, and group disability income claims that are not

group long-term disability income, the minimum standards with respect to morbidity are those specified in Appendix A except that, at the option of the insurer:

(A) Assumptions regarding claim termination rates for the period less than three (3) years from the date of disablement may be based on the insurer's experience, if the experience is considered credible, or, with the approval of the Commissioner, upon other assumptions designed to place a sound value on the liabilities.

(B) For group long-term disability income claims, the standards as defined in subsection (c)(2) of this section, may be 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.

(2) For group long-term disability income claims incurred on or after January 1, 2020, the minimum standards with respect to morbidity shall be based on the 2012 GLTD termination table or subsequent table with consideration of:

(A) The insurer's own experience computed in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*, and

(B) An adjustment to include an own experience measurement margin derived in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*, and

(C) A credibility factor derived in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*.

(3) An insurer may begin to use the minimum reserve standards in subsection (c)(2) of this section at a date earlier than January 1, 2020, but not prior to the effective date of this regulation. An insurer may apply the standards in subsection (c)(2) of this section to all open claims incurred prior to the effective date for subsection (c)(2) of this section for the insurer. Once an insurer elects to calculate reserves for all open claims based on subsection (c)(2) of this section, all future valuations must be on that basis.

(d) **Minimum Morbidity Standard for Other Health Insurance Claim Reserves**. The reserve should be based on the insurer's experience, if the experience is considered credible, or, with the approval of the commissioner, upon other assumptions designed to place a sound value on the liabilities.

[(c)] (e) **Claim Reserve Methods Generally.** [Any] A generally accepted [or reasonable actuarial method or combination of methods may be used to estimate all claim liabilities] actuarial reserving method or a combination of generally accepted methods may be used to estimate all claim liabilities. Any other reasonable method, if the method is approved by the Commissioner prior to the statement date, 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, shall be determined in the aggregate.

Sec. 38a-78-14. Premium reserves

(a) **General**.

(1) [Unearned] Except as noted in subdivision (2) of this subsection, 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) Single premium credit disability insurance, both individual and group, is excluded from unearned premium reserve requirements of this section.

[(2)] (3) 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] shall be carried as an offsetting liability.

[(3)] (4) 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.

(b) **Minimum Standards for Unearned Premium Reserves**.

(1) 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.

(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. 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.

(c) **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.

Sec. 38a-78-15. Contract reserves

(a) **General**.

(1) Contract reserves are required, unless otherwise specified in [subdivision (2) of subsection (a)] subsection (a)(2) of this section, for:

(A) all individual and group contracts with which level premiums are used; or

(B) 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 this [subdivision] subparagraph shall be determined on the basis specified in subsection (b) of this section.

(2) Contracts not requiring a contract reserve are:

(A) Contracts which are not guaranteed renewable after one year from issue; or

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

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

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

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

(b) **Minimum Standards for Contract Reserves**.

(1) Basis.

(A) Morbidity or other Contingency. Minimum standards with respect to morbidity are those set forth in Appendix A. 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 the 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 Appendix A shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the Commissioner. The morbidity tables shall contain a pattern of incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

(i) 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.

(ii) Business in force as of the effective date of subsection (b)(1)(C)(ii) of this section may be permitted to retain the original reserve basis which may not meet the provisions of subsection (b)(1)(A)(i) of this section, subject to the acceptability to the Commissioner.

(B) Interest. The maximum interest rate is specified in Appendix A.

(C) Termination Rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in Appendix A except as noted in the following [paragraph.] items:

(i) 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)] (I) eighty percent of the total termination rate used in the calculation of the gross premiums; or

[(ii)] (II) eight percent.

[Where a morbidity standard specified in Appendix A 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 Commissioner.]

(ii) For long-term care individual policies or group certificates issued on or after the effective date of this regulation, the contract reserve shall be established on the basis of:

(I) Mortality (as specified in Appendix A); and

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

• For policy year one (1), 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 (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 where the two percent (2%) shall be three percent (3%). For purposes of this subclause only, group insurance means a long-term care insurance policy that is delivered or issued for delivery in this state and 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 the labor organizations.

(iii) Where a morbidity standard specified in Appendix A is on an aggregate basis, the 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 Commissioner.

[(D)] (2) Reserve Method.

[(i)] (A) 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.

[(ii)] (B) For long-term care insurance, the minimum reserve is the reserve calculated on the one-year full preliminary term method.

[(iii)] (C) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

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

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

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.

[(E)] (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 combined may not be less than zero.

(4) Nonforfeiture Benefits for Long-Term Care Insurance. For long-term care individual policies or group certificates issued on or after the effective date of this regulation, 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.

(c) **Alternative Contract Reserve 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/or 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.

(d) **Tests For Adequacy and Reasonableness of Contract Reserves.** Annually, an [appropiate] 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 subsection (b) of this section.

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 [insufficent] insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

Sec. 2. Appendix A of sections 38a-78-11 to 38a-78-16, inclusive, of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 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 (references to Commissioners' Table refers to the valuation table version as opposed to the basic table version as applicable):

(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, 1986:

The 1964 Commissioners Disability Table (64 CDT)

Contracts issued on or after January 1, 1994 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 1986 through 1993:

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 in the minimum standard. The insurer may, however, elect to use 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, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*.

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;

(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;

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

(B) Claim Reserves:

[The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.]

(i) For claims incurred on or after January 1, 2017 and prior to 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

Duration	Adjustment Factor	Adjusted Termination Rates*
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, 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).

For claims incurred on or after 2020, the 2013 IDI Valuation Table with modifiers and adjustments for company experience as prescribed in the Actuarial Guideline L, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*, except for worksite disability policies with benefit periods of 24 months or less.

(ii) For worksite disability policies, 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.

(iii) For claims incurred prior to January 1, 2017, each insurer may elect which of the following to use as the minimum standard for claims incurred prior to January 1, 2017:

(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 Appendix A, subsection (a)(1)(B)(i) or (ii) of this section I Morbidity, applied to all open non-worksite claims, provided the insurer maintains adequate claim records to allow the insurer to apply the standard defined in Appendix A, subsection (a)(1)(B)(i) or (ii) of this section I Morbidity appropriately. Once an insurer elects to calculate reserves for all open claims on the standard defined in Appendix A, subsection (a)(1)(B)(i) or (ii) of this section I Morbidity, all future valuations must be on that basis. This option, with respect to Appendix A, subsection (a)(1)(B)(ii) of this section I Morbidity, may be selected only if the insurer maintains adequate claim records for all claims incurred to use the 2013 IDI Valuation Table appropriately.

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

(A) Contract Reserves:

Contracts issued on or after January 1, 1955, and before January 1, 1982:

The 1956 Intercompany Hospital-Surgical Tables.

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 [(5)] (6).

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

(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) Contracts issued on or after January 1, 2019:
(I) For first occurrence and hospitalization benefits:
The 2016 Cancer Claim Cost Valuation Tables (2016 CCCVT);
http://www.naic.org/documents/01_naic_2017_cancer_claim_cost_valuation_table.xlsx
(II) For all other benefits:
Assumptions based on company experience, relevant industry experience, and actuarial judgment. Such assumptions should be appropriate for valuation which considers margin for adverse experience.
(iii) For contracts issued on or after January 1, 2018 and before January 1, 2019, a company may elect to use morbidity basis described in Appendix A, subsection (a)(3)(A)(ii) of this section I Morbidity. Once a company begins use of the 2016 CCVT for new issues, it may not revert to the 1985 CCCT.
(B) Claim Reserves:
No specific standard. See [(5)] (6).
(4) 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.
(5) Single Premium Credit Disability.
(A) Contract Reserves:
(i) For contracts issued on or after January 1, 2017:
(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 Appendix A, subsection (a)(5)(A)(i)(I) of this section I Morbidity.
(ii) For contracts issued prior to January 1, 2017, each insurer may elect either subclause (I) or (II) of this clause to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Appendix A, subsection (a)(5)(A)(i) of this section I Morbidity, 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 Appendix A, subsection (a)(5)(A)(i) of this section I Morbidity, as applied to all contracts.
(B) Claim Reserves:
Claim reserves are to be determined as provided in section 38a-78-13(c) of the Regulations of Connecticut State Agencies.
[(5)] (6) 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, 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:

(1) Disability Income Benefits Due to Accident or Sickness, where sections 38a-78-11 to 38a-78-16, inclusive, of the Regulations of Connecticut State Agencies reference this Appendix A; otherwise Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*.

(A) Contract Reserves:

Contracts issued prior to January 1, 1994: The same basis, if any, as that employed by the insurer as of January 1, 1994;

Contracts issued on or after January 1, 1994:

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

(B) Claim Reserves:

For claims incurred on or after January 1, 1994:

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

For claims incurred prior to January 1, 1994:

Use of the 87CGDT is optional.

(2) Single Premium Credit Disability.

(A) Contract Reserves:

(i) For contracts issued on or after January 1, 2017:

(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 Appendix A, subsection (b)(2)(A)(i)(I) of this section I Morbidity.

(ii) For contracts issued prior to January 1, 2017, each insurer may elect either subclause (I) or (II) of this clause to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Appendix A, subsection (b)(2)(A)(i) of this section I Morbidity, 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 Appendix A, subsection (b)(2)(A)(i) of this section I Morbidity, applied to all contracts.

(B) Claim Reserves:

Claim reserves are to be determined as provided in section 38a-78-13(c) of the Regulations of Connecticut State Agencies.

[(2)] (3) 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, 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 annual premium ordinary life insurance for appropriate guarantee duration and issued on the same date as the health insurance contract.

(b) For claim reserves on policies for which contract reserve is required, the maximum interest

rate is the maximum rate permitted by law in the valuation of annual premium ordinary life insurance for appropriate guarantee duration and issued on the same day as the claim incurral date.

(c) For claim reserves on policies for which no contract reserve is required, 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 incurred date, such rate reduced by one hundred basis points (1%).

III. Mortality.

[(a)] The mortality basis used shall be according to a table (but without use of selection factors) permitted by law for the valuation of ordinary life insurance issued on the same date as the health insurance contract.

[(b)] Subject to approval of the commissioner, other mortality tables adopted by the NAIC and promulgated by the Commissioner may be issued in the calculation of the minimum reserves if appropriate for the type of benefits.

(a) Unless subsection (b) or (c) of this section III Mortality applies, the mortality basis used for all policies except long term care individual policies and group certificates and for long-term care individual polices or group certificates issued before the effective date of subsection (b)(1)(C)(ii) of section 38a-78-15 of the Regulations of Connecticut State Agencies, 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 the effective date of subsection (b)(1)(C)(ii) of section 38a-78-15 of the Regulations of Connecticut State Agencies, 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 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 subsection (a) of this section III Mortality is inappropriate.

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

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Statement of Purpose

To adopt changes made to the National Association of Insurance Commissioners Health Insurance Reserves Model Regulation and to make other technical changes.