

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
REGULATION NO. 56
11 NYCRR 94
VALUATION OF INDIVIDUAL AND GROUP
ACCIDENT AND HEALTH INSURANCE RESERVES

I, Eric R. Dinallo, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, 1303, 1304, 1305, 1308, 4117, 4217, 4310, and 4517 of the Insurance Law of the State of New York, do hereby repeal Part 94 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 56) and promulgate a new Part 94 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 56), to take effect upon publication in the State Register.

(All Material is New)

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SECTION 94.1 Purposes

The purposes of this Part are:

(a) to implement sections 1303, 4117, 4217(d), 4517(d) and 4517(f) of the Insurance Law regarding reserves for accident and health insurance policies; and

(b) to prescribe rules for valuing certain specified accident and health benefits in life insurance policies and annuity contracts.

SECTION 94.2 Applicability

This Part shall apply to every insurance company and fraternal benefit society doing business in this State and every insurance company and fraternal benefit society holding a certificate from the superintendent as being accredited for the reinsurance of life insurance, annuities or accident and health insurance. It shall apply to all individual and group accident and health insurance policies including credit disability insurance policies issued by such insurers, whether funded in the general account or in a separate account, no matter where issued or assumed, and no matter where shown in

the annual statement. This Part shall also apply to certain specified accident and health benefits in life insurance policies and annuity contracts. This Part shall be applicable to such societies and insurers for all statements filed after the effective date of this Part. For the purposes of this Part, "insurer" shall mean such a society or insurer.

SECTION 94.3 Definitions

As used in this Part:

(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, must be established.

(c) "Claims reported" means that, 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), must be established.

(e) "Claims unreported" means that, 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) "Gross premium" means the amount of premium charged by the insurer, including the net premium (based on claim cost) for the risk, together with any loading for expenses, profit or contingencies.

(i) "Group insurance" means blanket insurance, franchise insurance and any other form of group insurance. For purposes of reserves, franchise insurance is treated as individual insurance.

(j) "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.

(k) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 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. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. Long-term care insurance also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term insurance contracts. Long-term care insurance shall not include any insurance policy that 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. With regard to life insurance, long-term care insurance does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary intervention or permanent institutional confinement, and that provide a lien against the policy or the option of a lump-sum payment for those benefits, and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Long-term care also includes those policies, riders, or certificates covered by Parts 52.12 and 52.13 of this Title (Regulation 62).

(l) "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 \$120 and if, instead, monthly premiums of \$10 are paid, then the modal premium is \$10.

(m) "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.

(n) "Preliminary term reserve method" means a method of valuation under which 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.

(o) "Present value of amounts not yet due on claims" means the reserve for "claims unaccrued" (as defined in subdivision (d) of this section), which may be discounted at interest.

(p) "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.

(q) "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 that 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 that 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) "Terminal reserve" means the reserve at the end of a contract year, and is the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(s) "Unearned premium reserve" values that portion of the premium paid or due to the insurer that 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) "Valuation net modal premium" is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus, if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

SECTION 94.4 Claim reserves

(a) General

(1) Claim reserves are required for all incurred but unpaid claims on all health insurance policies.

(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.

(b) Minimum Standards for Claim Reserves

(1) Disability Income

(i) Interest. The maximum interest rate for claim reserves is specified in section 94.10 of this Part.

(ii) Morbidity. Minimum standards with respect to morbidity are those specified in section 94.10 of this Part, except that, at the option of the insurer:

(a) In calculating the claim reserve on any valuation date for a claim incurred under an individual policy:

(1) Claim termination rates for claim durations from date of disablement of less than two years may be based on the insurer's own claim termination rate experience if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities; and

(2) Claim termination rates for claim durations after the first two years from the date of disablement must be those specified in section 94.10 of this Part.

(3) Example: A study of your company's claim termination rates shows that for claims terminating in the first 24 months from date of disablement its claim termination rates are 110 percent of the Adjusted Termination Rates shown in section 94.10 of this Part. Your company has an open claim as of December 31, 2002 that has a date of disablement of March 31, 2002 and an elimination period of 90 days;

(i) In order to calculate the claim reserve as of December 31, 2002 your company may increase the Adjusted Termination Rates for months ten through 24 by ten percent, but must use 100 percent of the Adjusted Termination Rates for all claim durations beyond the 24th month.

(ii) In order to calculate the claim reserve as of December 31, 2003 your company may increase the Adjusted Termination Rates for months 22 through 24 by ten percent, but must use 100 percent of the Adjusted Termination Rates for all claim durations beyond the 24th month.

(b) In calculating the claim reserve on any valuation date for a claim incurred under a group policy:

(1) Claim termination rates for claim durations from date of disablement of less than two years, may be based on the insurer's own claim termination rate experience if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities;

(2) Claim termination rates for claim durations from date of disablement of more than two years but less than five years may, with the approval of the superintendent, be based on the insurer's own claim termination experience for claim durations of more than two years but less than five years and for which the insurer maintains underwriting and claim administration control. For experience to be considered credible for purposes of this subclause, the company must be able to provide claim termination patterns of its own over no more than six years reflecting at least 5,000 claims terminations during the third through fifth claims durations on reasonably similar applicable policy forms; and

(3) Claim termination rates for claim durations after the first five years from the date of disablement of such claims must be those specified in section 94.10 of this Part.

(4) Example: A study of your company's group claim termination rates shows that for claims terminating in the first 24 months from date of disablement its claim termination rates are 120 percent of those of the 1987 Commissioners Group Disability Income Table found in Group Long-Term Disability Valuation Tables, *Transactions of Society of Actuaries 1987, Volume XXXIX, pp. 393 through 457*¹ (87CGDT) and for months 25 through 60 (years three through five) are 110 percent of the 87CGDT. A copy of such document, as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1988 is available for public inspection at the Insurance Department offices at One Commerce Plaza, Albany, New York 12257 and at 25 Beaver Street, New York, New York 10004. Your company has an open claim as of December 31, 2002 that has a date of disablement of July 31, 2001 and an elimination period of 180 days. In order to calculate the claim reserve:

(i) As of December 31, 2002, your company may increase the claim termination rates of the 87CGDT for months 18 through 24 by 20 percent, and may increase the claim termination rates of the 87CGDT for durations three through five years by ten percent (if approved by the superintendent) but must use 100 percent of the claim termination rates of the 87CGDT for all claim durations beyond the fifth claim year.

(ii) As of December 31, 2003 and thereafter, your company may increase the claim termination rates of the 87CGDT for months 30 through 60 by ten percent, (if approved by the superintendent) but must use 100 percent of the claim termination rates of the 87CGDT for all claim durations beyond the fifth claim year.

(5) The request for approval described in subclause (2) of this clause regarding the use of the insurer's own experience must include:

¹ TRANSACTIONS SOCIETY OF ACTUARIES 1987, VOLUME XXXIX Copyright © 1988 by Society of Actuaries, in Schaumburg, Illinois.

(i) an analysis of the credibility of the experience;

(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 superintendent of the state of domicile; and

(vi) any other information deemed necessary by the superintendent.

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

(2) All Other Benefits

(i) Interest. The maximum interest rate for claim reserves is specified in section 94.10 of this Part.

(ii) Morbidity or Other Contingency. If section 94.10 of this Part does not specify a minimum standard, the reserve should be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(3) For claim reserves to reflect "sound values" and reasonable margins, reserve tables based on credible experience should be adjusted regularly to maintain reasonable margins. Demonstrations may be required by the superintendent based on published literature.

(4) Claim Reserve Methods Generally. A generally accepted actuarial reserving method or other reasonable method, if, after a public hearing, the method is approved by the superintendent prior to the statement date, or a combination of such methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

SECTION 94.5 Premium reserves

(a) General

(1) Except as noted in paragraph (2) of this subdivision, 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. For all credit disability contracts in the aggregate, if the premium refund reserve exceeds the aggregate recorded reserve, an additional reserve shall be established. This premium refund reserve may include consideration of commission, premium tax, and other expenses recoverable.

(3) If premiums due and unpaid are carried as an asset, the 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 shall be carried as an offsetting liability.

(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 a contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the 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.

(2) 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.

(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. Approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

SECTION 94.6 Contract reserves

(a) General

(1) Contract reserves are required, unless otherwise specified in paragraph (2) of this subdivision for:

(i) All individual and group contracts with which level premiums, whether or not such premiums are guaranteed, 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 or where the contract provides for the extension of benefits after the termination of the coverage, e.g., deferred maternity and other similar benefits. 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 subparagraph shall be determined on the basis specified in subdivision (b) of this section.

(2) Contracts that cannot be continued after one year from issue do not require a contract reserve.

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

(4) The methods and procedures for contract reserves shall be consistent with those for claim reserves for a contract, or else appropriate adjustment shall be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral shall be the same in both determinations. The methods and procedures for contract reserves shall also be consistent with those used for setting premium reserves.

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

(b) Minimum Standards for Contract Reserves

(1) Basis

(i) Morbidity or Other Contingency

(a) Minimum standards with respect to morbidity are those set forth in section 94.10 of this Part. Valuation net premiums used under each contract shall be a uniform percentage of 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.

(b) Clause (a) of this subparagraph applies only to the premium structure applicable to each contract. The relationship among gross premiums for different contracts (e.g., variations by age) has no bearing on the new premium structure. If, for a policy form, there is no gross premium variation by age, the valuation net premium will nonetheless vary based on age at issue for each contract since,

at issue, the present value of valuation net premiums for a contract must equal the present value of tabular net costs.

(c) Contracts for which tabular morbidity standards are not specified in section 94.10 of this Part 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 of incurred claims so that it reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

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. The last sentence is intended to provide allowances for a known event, such as a new drug release. At the time of adoption, there were no specific examples that could be pointed to in the recent past that would have met this standard. This is intended to be an extremely rare event.

(ii) Interest. The maximum interest rate is specified in section 94.10 of this Part.

(iii) Termination Rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in section 94.10 of this Part except as noted in the following clauses:

(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 80 percent of the total termination rate used in the calculation of the gross premiums, or eight percent.

(b) For long-term care individual policies or group certificates issued on or after January 1, 1997 and before January 1, 2003, the contract reserve may be established on a basis of separate:

(1) Mortality (as specified in section 94.10 of this Part); and

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

(i) For policy years one through four, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or eight percent;

(ii) For policy years five and later, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums or four percent.

(c) For long-term care individual policies or group certificates issued on or after January 1, 2003, the contract reserve shall be established on the basis of:

(1) Mortality (as specified in section 94.10 of this Part); and

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

(i) For policy year one, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or six percent;

(ii) For policy years two through four, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or four percent; and

(iii) For policy years five and later:

(A) For individual policies, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums or two percent; and

(B) For group certificates, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums or three percent.

(d) Where a morbidity standard specified in section 94.10 of this Part 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 superintendent.

(2) Reserve Method

(i) 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) 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, 1994, reserves calculated on the two-year full preliminary term method; and

(b) For individual policies and group certificates issued on or after January 1, 1995, reserves calculated on the one-year full preliminary term method.

(iii) For return of premium or other deferred cash benefits, excluding the premium refund reserve on single premium credit disability insurance, the minimum reserve is the reserve calculated as follows:

(a) On the one-year preliminary term method if the benefits are provided at any time before the 20th anniversary; and

(b) On the two-year preliminary term method if the benefits are only provided on or after the 20th anniversary.

(iv) 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 combined may not be less than zero.

(4) Nonforfeiture Benefits. The contract reserve for each policy 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 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 in subdivision (b) of this section; 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 in subdivision (b)(2) of this section 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.

(1) 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 subsection 94.6(b) of this Part.

(2) In the event an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, Insurance Department regulations, regulatory approval for rate changes, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfall in the aggregate.

SECTION 94.7 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 that affect the insurer's liabilities.

SECTION 94.8 Reserves for waiver of premium on accident and health policies

The morbidity tables required by this Part 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 Commissioners Disability Table *Volume III Committee Recommendation and Basic Tables pp. i, iii, and 1 through 16*² (64CDT) and for both the 1985 Commissioners Individual Disability Tables A found in Report of the Committee to Recommend New Disability Tables for Valuation *Transactions of Society of Actuaries 1985, Volume XXXVII, pp. 449 through 466*³ (85CIDA) and 1985 Commissioners Individual Disability Tables B found in APPENDIX to Report of October 18, 1984 to National Association of Insurance Commissioners (NAIC) Life, Health and Accident Standing Technical Actuarial (EX5) Task Force concerning Proposed New Minimum Valuation Standards for Loss of Time (Disability Income) Benefits *NAIC Proceedings – 1985 Vol. I, pp. 486 through 540*⁴ (85CIDB). Copies of such documents, as adopted by the Health Insurance Association of America, 1201 F Street, NW – Suite 500, Washington, DC 20004-1204, in 1965, the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1986, and the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662, in 1983, respectively, are available for public inspection at the Insurance Department offices at One Commerce Plaza, Albany, New York 12257 and at 25 Beaver Street, New York, New York 10004. 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.

(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.

SECTION 94.9 Reserve adequacy

² 1964 COMMISSIONERS DISABILITY TABLE © Copyright 1965 by Health Insurance Association of America, in Washington, DC.

³ TRANSACTIONS OF SOCIETY OF ACTUARIES 1985, VOLUME XXXVII © Copyright 1986 by Society of Actuaries, in Schaumburg, Illinois.

⁴ NAIC PROCEEDINGS – 1985 VOL. I © Copyright 1985 by National Association of Insurance Commissioners, in Kansas City, Missouri.

(a) The insurer shall maintain reserves for all individual and group accident and health insurance policies, which reserves shall reflect a sound value placed on its liabilities under such policies.

(b) 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 for that insurer.

(c) A premium deficiency reserve is a reserve that is established when future premiums and current reserves are not sufficient to cover future claim payments and expenses for the remainder of a contract period. This reserve is in addition to claim reserves and contract reserves.

When the expected present value of claims payments or incurred costs, claim adjustment expenses and administration costs exceed the present value of premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional reserve for the deficiency. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A reserve shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

(d) 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 a 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.

(e) A gross premium valuation as specified in subdivision (d) of this section 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 otherwise required for such contracts under this Part.

(f) 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 this Part.

(g) Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined (i.e., claim, premium, and contract reserves). However, the standards of this Part are intended to emphasize the importance of determining appropriate reserves for each of the three categories separately.

SECTION 94.10 Specific standards for morbidity, interest and mortality

(a) Morbidity

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

(i) Disability Income Benefits Due to Accident or Sickness

(a) Contract Reserves. In establishing contract reserves:

(1) For contracts issued prior to January 1, 1965: The minimum standard is the standard used prior to that date provided it puts a sound value on the liabilities under the policy. Otherwise the 64CDT shall be used;

(2) For contracts issued on or after January 1, 1965 and prior to January 1, 1989: 64CDT shall be used; and

(3) For contracts issued on or after January 1, 1989: 85CIDA or 85CIDB shall be used. Each insurer shall elect, with respect to all individual policies issued in any one statement year, whether it will use 85CIDA or 85CIDB as the minimum standard.

(b) Claim Reserves

(1) For claims incurred on or after January 1, 2001, an insurer shall use the 85CIDA with claim termination rates multiplied by the following adjustment factor:

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

Duration	Adjustment Factor	Adjusted Termination Rates*
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 termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (*Transactions of the Society of Actuaries (TSA) XXXVII, pp. 457-465*) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 are 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 tables so adjusted for the computation of claim reserves shall be known as The Commissioners Individual Disability Tables C (85CIDC).

(2) For claims incurred prior to January 1, 2001, each insurer may elect one of the following to use as the minimum standard:

(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 subclause (1) of this clause, applied to all open claims.

Once an insurer elects to calculate reserves for all open claims on the standard defined in subclause (1) of this clause, all future valuations must be on that basis.

(3) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(4) A new disability connected directly or indirectly with a previous disability, which had a duration of at least one year and terminated within six months of the new disability, should be considered a continuation of the previous disability.

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

(a) Contract Reserves. In establishing contract reserves:

(1) For contracts issued on or after January 1, 1955, and before January 1, 1982: The 1956 Intercompany Hospital-Surgical Tables found in Edwin L. Bartleson's and James J. Olsen's paper Reserves for Individual Hospital and Surgical Expense Insurance *Transactions of Society of Actuaries 1957, Volume IX, pp. 334 through 417* (56 Hospital/Surgical Tables)⁵ shall be used; and

(2) For contracts issued on or after January 1, 1982: The 1974 Medical Expense Tables, Table A (page 63), found in Anthony J. Houghton's and Ronald M. Wolf's paper Development of the 1974 Medical Expense Tables *Transactions of the Society of Actuaries, Volume XXX, pp. 9 through 123*⁶ shall be used. Refer to the paper, including its discussions, for methods of adjustment for benefits not directly valued in Table A.

Copies of the Reserves for Individual Hospital and Surgical Expense Insurance – 1956 Hospital Surgical Table and Development of the 1974 Medical Expense Tables as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1957 and 1978, respectively, are available for public inspection at the Insurance Department offices at One Commerce Plaza, Albany, New York 12257 and at 25 Beaver Street, New York, New York 10004.

(b) Claim Reserves. No specific standard is required; subject, however, to all other applicable requirements of this Part.

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

⁵ TRANSACTIONS OF SOCIETY OF ACTUARIES 1957, VOLUME IX Published by Society of Actuaries in Schaumburg, Illinois; not copyrighted.

⁶TRANSACTIONS OF SOCIETY OF ACTUARIES 1978, VOLUME XXX Published by Society of Actuaries in Schaumburg, Illinois; not copyrighted.

(a) Contract Reserves. For contracts issued on or after January 1, 1986: The 1985 NAIC Cancer Claim Cost Tables, ATTACHMENT FOUR – D, *NAIC Proceedings - 1986 Vol. I, pp. 601 through 624*⁷ shall be used. A copy of such document as adopted by the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662, in 1986 is available for public inspection at the Insurance Department offices at One Commerce Plaza, Albany, New York 12257 and at 25 Beaver Street, New York, New York 10004.

(b) Claim Reserves. No specific standard is required; subject, however, to all other applicable requirements of this Part.

(iv) Accidental Death Benefits

(a) Contract Reserves. For contracts issued on or after January 1, 1965: The 1959 Accidental Death Benefits Table found in Norman Brodie's and William J. November's paper A New Table for Accidental Death Benefits *Transactions of Society of Actuaries 1959, Volume XI, pp. 749 through 763*⁸ (59ADB Table) shall be used. A copy of such document as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1959 is available for public inspection at the Insurance Department offices at One Commerce Plaza, Albany, New York 12257 and at 25 Beaver Street, New York, New York 10004.

(b) Claim Reserves. Actual amount incurred shall be used.

(v) Credit Disability

(a) Contract Reserves

(1) Single Premium and Level Premium Credit Disability

(i) For contracts issued on or after January 1, 2001:

(A) For plans having less than a 30-day elimination period, the 1985 Commissioners Individual Disability Tables A (85CIDA) with claim incidence rates increased by 12 percent.

(B) For plans having a 30-day or greater elimination period, the 85CIDA for a 14-day elimination period with claim incidence rates increased by 12 percent.

(ii) For contracts issued prior to January 1, 2001, each insurer may elect either subitem (A) or (B) of this item to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in item (i) of this subclause, all future valuations must be on that basis.

⁷ NAIC PROCEEDINGS – 1986 VOL. I © Copyright 1986 by National Association of Insurance Commissioners, in Kansas City, Missouri.

⁸ TRANSACTIONS OF SOCIETY OF ACTUARIES 1959, VOLUME XI Published by Society of Actuaries in Schaumburg, Illinois; not copyrighted.

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

(B) The standard, as defined in item (i) of this subclause, applied to all contracts.

(2) All other Credit Disability. No specific standard; subject, however, to all other applicable requirements of this Part.

(b) Claim Reserves. No specific standard; subject, however, to all other applicable requirements of this Part.

(vi) Long-Term Care Benefits

(a) Contract Reserves. No specific standard shall be required; subject, however, to all other applicable requirements of the Part.

(b) Claim Reserves. No specific standard shall be required; subject to all other applicable requirements of this Part.

(vii) Other Individual Contract Benefits

(a) Contract Reserves. For all other individual contract benefits, no specific standard shall be required; subject, however, to all other applicable requirements of this Part.

(b) Claim Reserves. For all benefits other than disability, no specific standard shall be required; subject, however, to all other applicable requirements of this Part.

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

(i) Disability Income Benefits Due to Accident or Sickness

(a) Contract Reserves

(1) For contracts issued prior to January 1, 1989, contract reserves shall be on the same basis, if any, as that employed by the insurer as of January 1 of the year of issue; and

(2) For contracts issued on or after January 1, 1989, the 1987 Commissioners Group Disability Income Table (87CGDT) shall be used.

(b) Claim Reserves

(1) For claims incurred prior to January 1, 1989, claim reserves shall be on the same basis, if any, as that employed by the insurer as of January 1 of the year of incurral; and

(2) For claims incurred on or after January 1, 1989, the 1987 Commissioners Group Disability Income Table (87CGDT) shall be used.

(ii) Credit Disability

(a) Contract Reserves

(1) Single Premium and Level Premium Credit Disability

(i) For contracts issued on or after January 1, 2001:

(A) For plans having less than a 30-day elimination period, the 1985 Commissioners Individual Disability Tables A (85CIDA) with claim incidence rates increased by 12 percent shall be used; and

(B) For plans having a 30-day or greater elimination period, the 85CIDA for a 14-day elimination period with claim incidence rates increased by 12 percent shall be used; and

(ii) For contracts issued prior to January 1, 2001, each insurer may elect either subitem (A) or (B) of this item to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in item (i) of this subclause, all future valuations must be on that basis.

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

(B) The standard, as defined in item (i) of this subclause, applied to all contracts.

(2) All other Credit Disability. No specific standard shall be required; subject, however, to all other applicable requirements of this Part.

(b) Claim Reserves. No specific standard shall be required; subject, however, to all other applicable requirements of this Part.

(iii) Long-Term Care Benefits

(a) Contract Reserves. No specific standard shall be required; subject, however, to all other applicable requirements of the Part.

(b) Claim Reserves. No specific standard shall be required; subject, however, to all other applicable requirements of this Part.

(iv) Other Group Contract Benefits

(a) Contract Reserves. For all other group contract benefits, no specific standard shall be required; subject, however, to all other applicable requirements of this Part.

(b) Claim Reserves. For all benefits other than disability, no specific standard shall be required; subject, however, to all other applicable requirements of this Part.

(b) Interest

(1) For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of life insurance policies with guarantee durations in excess of 20 years issued on the same date as the health insurance contract.

(2) For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of life insurance with guarantee durations in excess of 20 years issued on the same date as the claim incurral date.

(3) For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

(c) Mortality

(1) Unless paragraph (3) or (4) of this subdivision applies, the mortality basis used for all individual policies and group certificates, except long-term care insurance individual policies or group certificates issued on or after January 1, 1997, shall be the table specified in the Insurance Law or other Parts of this Title (but without use of selection factors) as the minimum standard permitted, for the valuation of whole life insurance issued on the same date as the health insurance contract. For example: the 1980 Commissioners Standard Ordinary Table found in Report of the Special Committee to Recommend New Mortality Tables for Valuation *Transactions of Society of Actuaries 1981, Volume XXXIII, pp.617 through 669* (80CSO)⁹ could be used on an optional basis as of January 1, 1981 and therefore for this purpose the appropriate date would be January 1, 1981. A copy of such document as adopted by the Society of Actuaries, 475 N. Martingale Road, Suite 800, Schaumburg, IL 60173-2226, in 1981 is available for public inspection at the Insurance Department offices at One Commerce Plaza, Albany, New York 12257 and at 25 Beaver Street, New York, New York 10004.

(2) For long-term care insurance individual policies or group certificates issued on or after January 1, 1997 and before January 1, 2005, the mortality basis used shall be the 1983 Group Annuity Mortality Table (83GAM), contained in Part 99.10(i)(3) of this Title (Regulation 151), without projection.

(3) For long-term care insurance individual policies or group certificates issued on or after January 1, 2005, the mortality basis used shall be the 1994 Group Annuity Mortality Static Table. Rates of mortality for such basis are shown in the qx¹⁹⁹⁴ column of the 1994 Group Annuity Reserving Table contained in Part 99.10(i)(4) of this Title (Regulation 151).

⁹TRANSACTIONS OF SOCIETY OF ACTUARIES, VOLUME XXXIII © Copyright 1982 by Society of Actuaries in Schaumburg, Illinois.

(4) Other mortality tables adopted by the NAIC and promulgated by regulation 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 for use by the insurer in calculating such reserves. The request for approval shall include the proposed mortality table and the reason that the standard specified in paragraph (1) of this subdivision is inappropriate.

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

SECTION 94.11 Grading to higher reserves

Where the requirements of this Part produce higher reserves than those calculated for the 2002 year-end valuation, the insurer may linearly interpolate between the higher reserves required by this Part and the lower reserves based on the standards used for 2002 year-end as follows:

- (a) 25 percent and 75 percent, respectively, starting with year-end 2003;
- (b) 50 percent and 50 percent, respectively, starting with year-end 2004;
- (c) 75 percent and 25 percent, respectively, starting with year-end 2005; and
- (d) the insurer shall hold the full amount of such higher reserves starting with year-end 2006.

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I, Eric Dinallo, Superintendent of Insurance of the State of New York, do hereby repeal Part 94 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 56) and do hereby certify that the foregoing is the new Part 94 of Title 11 (Regulation No. 56), promulgated by me on June 19, 2007, pursuant to the authority granted by Sections 201, 301, 1303, 1304, 1305, 1308, 4117, 4217, 4310, and 4517 of the Insurance Law, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure, prior notice of the proposal was published in the State Register on April 25, 2007. No other publication or prior notice is required by statute.

Eric Dinallo
Superintendent of Insurance

Date: June 19, 2007