INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Minimum Reserve Standards for Individual and Group Health Insurance Contracts

Proposed Repeal and New Rules: N.J.A.C. 11:4-6

Authorized by: Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17B:19-5

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2002-332

Submit comments by November 15, 2002 to:

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The agency proposal follows:

Summary

N.J.S.A. 17B:19-5 as amended by P.L. 2001, c. 2, §3, removes specific references to interest rates and requires the Commissioner to promulgate regulations establishing the minimum standards applicable to the valuation of health insurance reserves.

Prior to this amendment, N.J.S.A. 17B:19-5 stated that the Commissioner may promulgate regulations providing minimum reserve standards and mortality, morbidity or other contingency bases to be used in connection therewith. Based on that authority, the Commissioner promulgated N.J.A.C. 11:4-6, Reserve Standards for Individual Health Insurance Policies, which became effective November 5, 1984 and was amended effective January 2, 2001.

In addition, in Bulletin No. 99-15, the Department required all insurers to utilize the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners ("NAIC") effective January 1, 2001 while continuing to comply with all existing requirements of law. The manual contains the NAIC Model for Minimum Reserve Standards for Individual and Group Health Insurance Contracts upon which these rules are modeled. Since then, insurers have been required to follow those standards. These new rules combine the standards found in the Accounting Practices and Procedures Manual (the "NAIC standards") which became effective January 1, 2001 and the standards found in the rules proposed for repeal in N.J.A.C. 11:4-6 (the "historical standards"), Both the historical standards and the NAIC standards are restated and realigned in the format of the NAIC Model resulting in the proposed regulations (the "new standards"). The restatement of the historical standards also reflects the elimination of the statutory references previously found in N.J.S.A. 17B:19-5 and the inclusion of the actual interest rates to which they refer.

While previously the historical standards were applicable to individual health insurance contracts only, the NAIC standards and the new standards include standards for group health insurance contracts. In addition, while the historical standards were formatted first by the type of contract then by the applicable reserves, the NAIC model is formatted by the type of reserves: claim reserves, premium reserves and contract reserves. The general requirements minimum standards for reserves and the methodology for each type of reserve is then subdivided by contract type, where applicable. The new standards follows the NAIC model, further subdividing the reserve standards by effective date, resulting in the use of the historical standards for prior to January 1, 2001 and the NAIC standard for post January 1, 2001.

In addition to group health insurance, the NAIC standards include minimum standards for contract reserves for cancer expense benefits, standards which were not part of the historical standards. These new minimum cancer expense contract standards which are effective on all contracts issued on or after January 1, 2001 may also be used at the option of the insurer for contracts issued prior to that date. Similarly for other NAIC standards which are significantly different from the historical standard, insurers are given the option, with the approval of the Commissioner, to use either the historical standard or the NAIC standard. When calculating interest for claim reserves, insurers may calculate these reserves, with approval of the Commissioner based on the claims incurred date as opposed to the contract date. Further, for claims reserves on policies not requiring contract reserves, where the claim incurral date is prior to January 1, 2001 the insurer may elect to use the maximum rate permitted by law in the valuation of single premium annuities issued on the same date as the claim incurral date, reduced by one hundred basis points, the NAIC standard for claims incurred on or after January 1, 2001.

Further enhancements to the new standards include specific references to locations of all the tables which are used in the new standards. These tables which are incorporated by reference include:

1956 Intercompany Hospital Surgical Tables, those tables developed by the Task Force 4, a Subcommittee of the Society of Actuaries Joint Committee on Health Insurance, and adopted by the National Association of Insurance Commissioners ("NAIC") in December 1956, as the standard for valuation of individual health insurance benefits;

1959 Accidental Death Benefits Table, the table adopted by the NAIC in December 1964 as the standard for valuation of accidental death benefits included in health insurance policies;

1964 Commissioners Disability Table, the table adopted by the NAIC in December 1964 as the minimum standard for valuation of individual disability benefits;

1974 Medical Expense Table, the table adopted by the NAIC in June 1981 as a minimum standard for valuation of medical expense benefits;

1983 Group Annuity Mortality Table, the mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for the valuation of annuities in December of 1983 by the NAIC;

1985 Commissioners Individual Disability Tables A and B, the tables adopted by the NAIC in December 1985 as standards for the valuation of individual disability income benefits;

1985 NAIC Cancer Claim Cost Tables, the tables adopted by the NAIC in June 1985 as a standard for the valuation of policies; and

1987 Commissioners Group Disability Income Table, the table adopted by the NAIC in December 1987 as the standard for the valuation of group long-term disability benefits.

In accordance with the amended N.J.S.A. 17B:19-5, the Department is now proposing the adoption of Minimum Reserve Standards for Individual and Group Health Insurance Contracts, based on the NAIC Model Act of the same name; and repeal of N.J.A.C. 11:4-6: Reserve Standards for Individual Health Insurance Policies.

This rule proposal provides for a comment period of 60 days, and therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

The Department's proposed repeal and new rules include the following:

N.J.A.C. 11:4-6 Reserve Standards for Individual Health Insurance Policies is to be repealed in its entirety.

A new Subchapter 6, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, is to be adopted. The new subchapter 6 consists of:

N.J.A.C. 11:4–6.1 sets forth the purpose and scope of the subchapter.

N.J.A.C. 11:4–6.2 defines terms used within the subchapter.

N.J.A.C. 11:4–6.3 sets forth general requirements pertaining to claim reserves.

N.J.A.C. 11:4–6.4 sets forth the minimum standards for interest and morbidity to be used in assessing claim reserves.

N.J.A.C. 11.4–6.5 sets forth the methods to be used for determining claim reserves.

N.J.A.C. 11:4–6.6 sets forth general requirements pertaining to premium reserves.

N.J.A.C. 11.4–6.7 sets forth the standards to be used in determining unearned premium reserves.

N.J.A.C. 11:4–6.8 refers to the methods to be used for determining premium reserves.

N.J.A.C. 11:4–6.9 sets forth general requirements pertaining to contract reserves.

N.J.A.C. 11:4–6.10 sets forth minimum standards to be used for contract reserves.

N.J.A.C. 11:4–6.11 sets forth alternative methods and assumptions for contract reserves and the conditions of their use.

N.J.A.C. 11:4–6.12 sets forth the requirement for annual testing of the adequacy and reasonableness of contract reserves.

N.J.A.C. 11:4–6.13 sets forth the requirements for increasing or crediting reserves arising because of reinsurance assumed or ceded in a manner consistent with minimum reserve standards.

N.J.A.C. 11:4–6.14 sets forth the minimum morbidity standards for valuation of specified individual contract health insurance.

N.J.A.C. 11:4–6.15 sets forth the minimum morbidity standards for valuation of specified group contract health insurance.

N.J.A.C. 11:4–6.16 sets forth the specific standards for interest to be used for individual and group health insurance contracts.

N.J.A.C. 11:4–6.17 sets forth the specific standards for mortality to be used for individual and group health insurance contracts.

N.J.A.C. 11:4–6:18 sets forth the specific standards for waiver of premium reserves.

Social Impact

These proposed repeal and new rules should have a favorable impact on insurers, policyholders and the Department. The promulgation of continuing minimum standards for health insurance reserves should continue to clarify the reserve process and its review for insurers. The addition of standards for group health insurance and for cancer expense contracts allows insurers to be assured that their established liabilities for reserves in these areas are in compliance with regulations. The rules continue to provide insurers with standards and procedures for other reserves while continuing to allow the insurers to rely on them in their everyday operations and be assured that they are in compliance with the law. In addition, the proposed rules allow insurers the flexibility, in the calculation of some reserves, to choose the standard of greatest benefit to them, where they can demonstrate that those reserves are adequate and will enable the insurer to meet their obligations.

While being of benefit to the insurers, the proposed rules continue to afford protection to consumers by assuring the financial stability of their policies. The addition of the new standards for group health polices and cancer expense contracts assure consumers of those coverages that adequate funds will be available when needed. The proposed rules also continue to allow the

Department to fulfill its regulatory duties and enhances that ability by providing clear and comprehensive guidelines for the Department as well.

Economic Impact

The proposed new rule should have a favorable economic impact on insurers, policyholders and the Department. Defined standards should allow companies to reserve and therefore compete on a more equal footing. Insurers can continue to be assured that their established liabilities for reserves remain in compliance. For those reserves calculations which allow, with the approval of the Commissioner the use of either historical or NAIC standards, insurers can opt for the standard most economically beneficial to their company while still insuring consumer safety.

The Department does not believe that there will be any additional costs of compliance for insurers because of the proposed rules. All insurers reserve and employ staff to perform the necessary calculations in reserving.

Policyholders can be assured that adequate portions of their premiums are being held to assure the financial stability of their company of choice. This continues to assure consumers that they are spending their insurance dollars wisely and are ensured that they will be able to obtain the benefits to which they are entitled.

The Department will continue to incur the costs involved in implementing the rules.

Federal Standards Statement

A Federal standards analysis is not required because the proposed new rule is not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that this proposed new rule will result in the generation or loss of jobs. Insurers already employ professional and other staff to establish reserves and the implementation of revised standards should have no significant effect in the number of jobs involved. The Department invites commenters to submit any data or studies concerning the jobs impact of the proposed rules together with their written comments on other aspects of this proposal.

Agriculture Industry Impact

The Department does not expect any agriculture industry impact as a result of the proposed repeal and new rules.

Regulatory Flexibility Analysis

A regulatory flexibility analysis is required because some insurers to whom this proposed repeal and new rules apply may employ fewer than 100 full-time employees, and therefore are "small businesses" as that term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. As discussed in the Summary above, the proposed new rules implement minimum standards for an existing practice. The Department does not believe any additional professional services will be needed to comply with the minimum standards as stated in the jobs impact statement nor will there be additional costs for compliance anticipated as set forth in the Economic Impact Statement.

There has been no distinction in the minimum reserve standards for small businesses, as the standards relate to the Department's oversight of all individual and group health insurers. The Department's interest in oversight of these insurers applies regardless of the business size. Accordingly, no undue burden would be imposed, and no differentiation in compliance requirements is made based on business size.

Smart Growth Impact

The proposed repeal and new rules have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:4-6

Full text of the proposed new rules follows:

SUBCHAPTER 6. MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE CONTRACTS

11:4–6.1 Purpose and scope

(a) This subchapter applies to all insurers authorized to write health insurance in this State. These standards apply to all individual and group health insurance coverage except credit insurance.

(b) When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified in this subchapter, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

(c) 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 an important 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.

(d) 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.

(e) 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.

(f) The following subchapter sets forth minimum standards for three categories of health insurance reserves:

1. Claim reserves;

2. Premium reserves; and

3. Contract reserves.

(g) 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.

11:4-6.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"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 $100.00 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 $12.00, while the gross premium for this benefit might be $18.00. The additional $6.00 would cover expenses and profit or contingencies.

"Claims accrued" means that portion of claims incurred on or prior to the valuation date which results 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 (otherwise called a claim liability for annual statement reporting purposes), which represents an estimate of this accrued claim liability, must be established.

“Claims reported” means those claims that have been incurred and the insurer has been informed that they have 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.

“ 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.

“Claims unreported” means those claims that have been incurred on or before the valuation date, and the insurer has not been informed that they have been incurred. The claim is considered as an unreported claim for annual statement purposes.

“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.

“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.

“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.

“Group insurance” means any policy or contract of health insurance which covers more than one person and which, for the purposes of this subchapter, includes blanket insurance and franchise insurance and any other forms of group insurance.

“Health insurance” means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include worker’s compensation.

“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.

"Long-term care insurance" means an 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. 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 shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

"Modal premium" 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 $100.00 and if, instead, monthly premiums of $9.00 are paid then the modal premium is $9.00.

"Negative reserve" means a terminal reserve with 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.

"1956 Intercompany Hospital Surgical Tables" means those tables developed by the Task Force 4, a Subcommittee of the Society of Actuaries Joint Committee on Health Insurance, and adopted by the National Association of Insurance Commissioners ("NAIC") in December 1956, as the standard for valuation of individual health insurance benefits. See page 334 to 410 of Volume IX of the Transactions of the Society of Actuaries (Society of Actuaries, 1957; www.soa.org) for the tables.

"1959 Accidental Death Benefits Table" means the table adopted by the NAIC in December 1964 as the standard for valuation of accidental death benefits included in health insurance policies. See pages 749 to 762 of Volume XI of the Transactions of the Society of Actuaries (Society of Actuaries, 1959; www.soa.org) for the table.

"1964 Commissioners Disability Table" means the table adopted by the NAIC in December 1964 as the minimum standard for valuation of individual disability benefits. See pages AII-1 to AII-6 of the 1965 Proceedings of the NAIC, Volume I, for the table.

"1974 Medical Expense Table" means the table adopted by the NAIC in June 1981 as a minimum standard for valuation of medical expense benefits. See Transactions of the Society of Actuaries, Volume XXX, pg. 63, (Society of Actuaries, 1978; www.soa.org) for the table. 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.

"1983 Group Annuity Mortality Table" means the mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for the valuation of annuities in December of 1983 by the NAIC. See pages 414 to 415 of the 1984 Proceedings of the NAIC, Volume I, for the table.

"1985 Commissioners Individual Disability Tables A and B" mean the tables adopted by the NAIC in December 1985 as standards for the valuation of individual disability income benefits. See pages 449 to 601 of Volume XXXVII of the Transactions of the Society of Actuaries (Society of Actuaries, 1985; www.soa.org) for Table A. See pages 469 to 540 of the 1985 Proceedings of the NAIC, Volume I for Table B.

"1985 NAIC Cancer Claim Cost Tables" means the tables adopted by the NAIC in June 1985 as a standard for the valuation of policies. See pages 609 to 623 of the 1986 Proceedings of the NAIC, Volume I for the tables.

"1987 Commissioners Group Disability Income Table" means the table adopted by the NAIC in December 1987 as the standard for the valuation of group long-term disability benefits. See pages 393 to 458 of Volume XXXIX of the Transactions of the Society of Actuaries (Society of Actuaries, 1987; www..soa.org) for the table.

"Preliminary term reserve method" means a method of valuation whereby the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

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

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

"Reserve" means a and 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.

"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.

"Unearned premium reserve" means the reserve which values 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 $120.00 was paid on November 1, $20.00 would be earned as of December 31 and the remaining $100.00 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

"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.

11:4–6.3 Claim reserves – general requirements

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

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

(c) All claim 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.

11:4–6.4 Claim reserves - minimum standards for claim reserves

(a) The following applies to disability income:

1. The maximum interest rate for claim reserves is specified in N.J.A.C. 11:4-6.16.

2. Minimum standards with respect to morbidity are those specified in N.J.A.C. 11:4-6.14 and 6.15, except that, at the option of the insurer:

i. For claims with a duration from date of disablement of less than two years, reserves may 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.

ii. For group disability income claims with a duration from date of disablement of more than two years but less than five years, reserves may, with the approval of the Commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis shall include:

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

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

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

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

(5) A copy of the approval of the proposed plan of modification by the Commissioner of the state of domicile; and

(6) Any other information deemed necessary by the Commissioner.

iii. For experience to be considered credible for the purposes of this subsection, the company should be able to provide claim termination patterns 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.

iv. For claims 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.

3. 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.

(b) The following applies to all other benefits:

1. The maximum interest rate for claim reserves is specified in N.J.A.C. 11:4-6.16.

2. The reserve should be based on the insurer's experience for morbidity or other contingency, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

11:4–6.5 Claim reserves – claim reserve methods

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

11:4–6.6 Premium reserves – general requirements

(a) 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.

(b) If premiums due and unpaid are carried as an asset, such premiums shall 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.

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

11:4–6.7 Premium reserves – minimum standards for unearned premium reserves

(a) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

1. The valuation net modal premium on the contract reserve basis applying to the contract; or

2. The gross modal premium for the contract if no contract reserve applies.

(b) 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.

11:4–6.8 Premium reserves – premium reserve methods

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 shall be tested periodically to determine their continuing adequacy and reliability.

11:4–6.9 Contract reserves – general requirements

(a) **Contract** reserves are required, unless otherwise specified in N.J.A.C. 11:4-6.9(b), for:

1. All individual and group contracts with which level premiums are used; or

2. 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 valuation 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 shall state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover the year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary shall also disclose the reasons for and magnitude of such recovery. The values specified in this paragraph shall be determined on the basis specified in N.J.A.C. 11:4-6.10.

(b) Contracts not requiring a contract reserve are contracts:

1. Which cannot be continued after one year from issue; or

2. Are already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

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

(d) The methods and procedures for contract reserves 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.

11:4–6.10 Contract reserves – minimum standards for contract reserves

(a) The following applies to the basis for contract reserves:

1. Minimum standards with respect to morbidity or other contingency are those set forth in N.J.A.C. 11:4-6.14 and 6.15. Valuation net premiums used under each contract shall have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated.

i. Contracts for which tabular morbidity standards are not specified in N.J.A.C. 11:4-6.14 or. 6.15 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.

2. The maximum interest rate is specified in N.J.A.C. 11:4-6.16

3. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in N.J.A.C. 11:4-6.17 except as noted in the following paragraph.

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:

(1) Eighty percent of the total termination rate used in the calculation of the gross premiums, or

(2) Eight percent;

ii. For long-term care individual policies or group certificates issued after January 1, 2001 the contract reserve may be established on a basis of separate:

(1) Mortality (as specified in N.J.A.C. 11:4-6.17); and

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

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

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

iii. Where a morbidity standard specified in N.J.A.C. 11:4-6.14 or 6.15 is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and be acceptable to the Commissioner.

(b) The following reserve methods apply to contract reserves:

1. For insurance other than 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.

2. For long-term care insurance, the minimum reserve is the reserve calculated as follows:

i. For individual policies and group certificates issued on or before December 31, 2000, reserves calculated on the two-year full preliminary term method;

ii. For individual policies and group certificates issued on or after January 1, 2001, reserves calculated on the one-year full preliminary term method.

3. For return of premium or other deferred cash benefits for individual policies and group certificates issued on or after January 1, 2001, the minimum reserve is the reserve calculated as follows:

i. On the one-year preliminary term method if the benefits are provided at any time before the 20th anniversary; or

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

4. 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 (for example, projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

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

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

11:4-6.11 Contract reserves – alternative valuation methods and assumptions generally

(a) 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 N.J.A.C. 11:4-6.10, an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency.

(b) Subject to the condition in (a) above, 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:

1. The net level premium method;

2. The one-year full preliminary term method;

3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

4. The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, or grouping of similar contract forms;

5. 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; or

6. The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

11:4-6.12 Tests for adequacy and reasonableness of contract reserves

(a) 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 N.J.A.C. 11:4-6.10.

(b) 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, regulations of the Department or any other regulatory entity, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

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11:4-6.13 Reinsurance

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

11:4–6.14 Specific standards for morbidity for valuation of specified individual contract health insurance benefits

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

1. For disability income benefits due to accident or sickness use:

i. When calculating contract reserves:

(1) For contracts issued on or after January 1, 1965 and prior to January 1, 2001: The 1964 Commissioners Disability Table (64 CDT) (incorporated herein by reference).

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

(A) The 1985 Commissioners Individual Disability Tables A (85CIDA (incorporated herein by reference); or

(B) The 1985 Commissioners Individual Disability Tables B (85CIDB) (incorporated herein by reference).

(3) For contracts issued from January 1, 1999 through December 31, 2000:

(A) Optional use of either the 1964 Table or the 1985 Tables.

(B) Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to individual contracts issued in any subsequent statement year.

ii. When calculating claim reserves use:

(1) For claims incurred on or after January 1, 2002:

(A) The 85CIDA Tables with claim termination rates multiplied by the following adjustment factors:

Duration	**Adjustment Factor**	**Adjusted Termination Rates***

Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309

13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448
17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

* The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in Exhibits 3a, 3b, 3c, 4 and 5 (*Transactions of the Society of Actuaries* (TSA) XXXVII, pp. 457-463) as displayed (incorporated herein by

reference). The adjustment factors for age, elimination period, sex, and cause displayed in Exhibits 3a, 3b, 3c and 4 shall 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).

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

(2) For claims incurred prior to January 1, 2002, each insurer may elect which of the following to use as the minimum standard:

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

(B) The standard as defined in subparagraph (a)1.ii(1) above applied to all open claims.

(C) Once an insurer elects to calculate reserves for all open claims on the standard defined in (a)1ii(1), all future valuations shall be on that basis.

2. For hospital benefits, surgical benefits and maternity (scheduled benefits or fixed time period benefits only).

i. When calculating contract reserves use:

(1) For contracts issued on or after January 1, 1955, and before January 1, 1986: The 1956 Intercompany Hospital Tables and the 1956 Intercompany Surgical Tables (incorporated herein by reference).

(2) For contracts issued on or after January 1, 1986: The 1974 Medical Expense Tables (incorporated herein by reference)

ii. When calculating claim reserves use: No specific standard. See (a)5 below.

3. For cancer expense benefits (scheduled benefits or fixed time period benefits only).

i. When calculating contract reserves use:

(1) For contracts issued on or after January 1, 2001, and at the option of the insurer, contracts issued on or after January 1, 1986: The 1985 NAIC Cancer Claim Cost Tables (incorporated herein by reference).

ii. When calculating claim reserves use: No specific standard. See (a)5 below.

4. For accidental death benefits:

i. When calculating contract reserves use :

i. on contracts issued on or after January 1, 1966: The 1959 Accidental Death Benefits Table (incorporated herein by reference).

ii. When calculating claim reserves use the actual amount incurred.

5. For other individual contract benefits:.

i. When calculating contract reserves for all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

ii When calculating claim reserves for all benefits other than disability, claim reserves are to be determined as provided in the standards.

11:4–6.15 Specific standards for morbidity for valuation of specified group contract health insurance benefits

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

1. For disability income benefit due to accident or sickness:

i. When calculating contract reserves use:

(1) For contracts issued prior to January 1, 2001: The same basis, if any, as that employed by the insurer as of January 1, 2001;

(2) For contracts issued on or after January 1, 2001: The 1987 Commissioners Group Disability Income Table (87CGDT) (incorporated herein by reference).

ii. When calculating claim reserves use:

(1) For claims incurred on or after January 1, 2001: The 1987 Commissioners Group Disability Income Table (87CGDT);

(2) For claims incurred prior to January 1, 2001: Use of the 87CGDT is optional.

2. For other group contract benefits:

i. When calculating contract reserves: For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

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

11:4-6.16 Specific standards for interest

(a) For contract reserves the maximum interest rate is:

2. For contracts issued prior to January 1, 1973: 3 ½ percent

2. For contracts issued on or after January 1, 1973 through December 31, 2000: A rate of interest not exceeding the maximum rate of interest specified in N.J.S.A. 17B:19-8 for policies of life insurance which are issued the same year and, if relevant, for policies of life insurance containing a maximum guaranteed duration of more than 10 years but not more than 20 years.

3. For contracts issued on or after January 1, 2001: The maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

(b) For claim reserves on policies that require contract reserves where the claim incurral date is prior to January 1, 2001, the maximum rate of interest is:

1. For contracts issued prior to January 1, 1973: 3 ½ percent.

2. For contracts issued on or after January 1, 1973 through December 31, 2000: A rate of interest not exceeding the maximum rate of interest specified in N.J.S.A. 17B:19-8 for policies of life insurance which are issued the same year and, if relevant, for policies of life insurance containing a maximum guaranteed duration of more than 10 years but not more than 20 years.

3. Upon demonstrating the adequacy of the reserves and with the approval of the Commissioner, a company may determine the maximum interest rate to be used in calculating the claim reserve using the rates specified in (b)1 and 2 above, based on the incurral date of the claim instead of the contract issue date. Once an insurer elects to calculate reserves based on the incurral date of the claim, all future valuations must be on that basis.

(c) For claim reserves on policies that require contract reserves, where the claim incurral date is on or after January 1, 2001, the maximum rate of interest is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

(d) For claim reserves on policies not requiring contract reserves, where the claims incurral date is prior to January 1, 2001, the maximum rate of interest is:

1. For contracts issued prior to January 1, 1973: 3 ½ percent.

2. For contracts issued on or after January 1, 1973 through December 31, 2000: A rate of interest not exceeding the maximum rate of interest specified in N.J.S.A. 17B:19-8 for policies of life insurance which are issued the same year and, if relevant, for policies of life insurance containing a maximum guaranteed duration of more than 10 years but not more than 20 years.

3. Upon demonstrating the adequacy of the reserves and with the approval of the Commissioner, a company may determine the maximum interest rate to be used in calculating the claim reserve using the rates specified in (d)1 and 2 above, based on the incurral date of the claim instead of the contract issue date. Once an insurer elects to calculate reserves based on the incurral date of the claim, all future valuations must be on that basis.

(e) For claim reserves on policies not requiring contract reserves, where the claim incurral date is on or after January 1, 2001, the maximum rate of interest 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. Upon demonstrating the adequacy of the reserves and with the prior approval of the Commissioner, an insurer may elect to use this rate for claims incurred prior to January 1, 2001. Once an insurer makes such an election, all future valuations must be on that basis.

11:4–6.17 Specific standards for mortality

The mortality basis used for all policies except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued before January 1, 2001 shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after January 1, 2001 the mortality basis used shall be the 1983 Group Annuity Mortality Table, incorporated herein by reference, without projection.

11:4–6:18 Reserves for waiver of premium

(a) Where an insurer calculates tabular reserves using the 1964 CDT, 85CIDA, 85CIDB or any other table based on exposures that include contracts on premium waiver as in-force contracts rather than a table based on "active lives," reserves shall be valued on the following basis:

1. Claim reserves shall include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

2. Premium reserves shall include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

1. Contract reserves shall 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.

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