WEST VIRGINIA
SECRETARY OF STATE
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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AGENCY: Insurance Commissioner TITLE NUMBER: 114

AMENDMENT TO AN EXISTING RULE: YES___, NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 44

TITLE OF RULE BEING PROPOSED: Minimum Reserve Standards for Individual & Group Health Insurance Contracts

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) SB 171

SECTION 64-7-3(g), PASSED ON March 7, 1996.

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON THE FOLLOWING DATE: April 2, 1996

B Kent Huffman

AUTHORIZED SIGNATURE

7.00

PROMULGATION HISTORY

West Virginia Insurance Commission
Minimum Reserve Standards for Individual and Group Health Insurance Contracts
Title 114, Series 44

6/27/95	Notice of Comment Period Filed
7/27/95	Last Date Comments Were Received
7/28/95	Agency Approved Legislative Rule Filed
10/26/95	Date Reviewed by Legislative Rule-Making Review Committee
11/27/95	Date Modified and Approved Rule Filed
04/02/96	Filing Date
04/02/96	Effective Date

114CSR44

LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 44
MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE CONTRACTS

Section

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114CSR44

LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 44
MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE CONTRACTS

§ 114-44-1. Authority.

1.1. Scope. -- This legislative rule establishes minimum reserve standards for all individual and group health [accident and sickness] insurance coverages, except credit insurance.

1.2. Authority. -- West Virginia Code §§ 33-2-10 and 33-7-9(m).

1.3. Filing date. --

1.4. Effective date. --

§ 114-44-2. Purpose.

2.1. The purpose of this rule is to establish the minimum reserve standards for individual and group health (accident and sickness) insurance coverages.

§ 114-44-3. Scope.

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

3.2. With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The gross premium valuation shall take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected

premiums, adjusted for future premium increases reasonably expected to be put into effect.

3.3. The insurer is to perform a gross premium valuation 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 the contracts under the standards in this rule.

3.4. Whenever minimum reserves, as defined in this rule, exceed reserve requirements as determined by a prospective gross premium valuation, the minimum reserves remain the minimum requirement under this rule.

§ 114-44-4. Categories of Reserves.

4.1. This rule establishes minimum standards for three categories of health insurance reserves: claims reserves, premium reserves and contract reserves.

4.2. The adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, this rule emphasizes the importance of determining appropriate reserves for each of the three categories separately.

§ 114-44-5. Appendices.

5.1. This rule contains two appendices which are an integral part of the standards, and one additional "supplementary" appendix which is not part of the standards as such, but is included for explanatory and illustrative purposes only.

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

b. Appendix B sets forth a glossary of technical terms used.

c. Appendix C is a supplementary appendix which establishes standards for reserves taking into consideration waiver of premium.

§ 114-44-6. Claim Reserves.

6.1. General.

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.

6.2. Minimum Standards for Claim Reserves.

a. Disability Income.

A. Interest. The maximum interest rate for claim reserves is specified in Appendix A of this rule.

B. Morbidity. Minimum standards with respect to morbidity are those specified in Appendix A of this rule; except that, at the option of the insurer:

(a) For claims with a duration from date of disablement of less than two years, reserves may 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; and

(b) For group disability income claims with a duration from date of disablement of more than two (2) years but less than five (5) 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 approval of a plan of modification to the reserve basis must include:

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

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

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

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

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

(F) Any other information considered necessary by the commissioner.

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

b. All Other Benefits.

A. Interest. The maximum interest rate for claim reserves is specified in Appendix A of this rule.

B. Morbidity or other Contingency. 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.

6.3. Claim Reserve Methods Generally.

a. The insurer may use any generally accepted or reasonable actuarial method or combination of methods 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.

§ 114-44-7. Premium Reserves.

7.1. General.

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, 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 must 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 evaluation 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.

7.2. Minimum Standards for Unearned Premium Reserves.

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

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

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

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. 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.

7.3. Premium Reserve Methods Generally.

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

§ 114-44-8. Contract Reserves.

8.1. General.

a. Contract reserves are required, unless otherwise specified in paragraph b of this subsection for:

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

B. All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The values specified in this subparagraph shall be determined on the basis specified in subsection 8.2 of this rule.

b. Contracts not requiring a contract reserve are:

A. Contracts which cannot be continued after one year from issue; or

B. Contracts already in force on the effective date of this rule for which no contract reserve was previously required.

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

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

8.2. Minimum Standards for Contract Reserves.

a. Basis

A. Morbidity or other Contingency. The minimum standards with respect to morbidity are those set forth in Appendix A of this rule. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of the insured, contract duration and the period for which gross premiums have been calculated. Contracts for which tabular morbidity standards are not specified in Appendix A of this rule shall be

valued using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

B. Interest. The maximum interest rate is specified in Appendix A of this rule.

C. Termination Rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in Appendix A of this rule except as noted in the following part.

(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 the rates exceed specified mortality table rates, but not in excess of the lesser of:

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

(B) Eight percent.

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

D. Reserve Method.

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

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

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

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

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

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

E. 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.

8.3. 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 subsection 8.2 of this rule; an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated in subsection 8.2 of this rule in determining a sound value of its liabilities under

the 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.

8.4. Tests For Adequacy and Reasonableness of Contract Reserves.

a. Annually, the insurer shall make an appropriate review 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 the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate; subject, however, to the minimum standards of subsection 8.2 of this rule.

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, Insurance Commissioner's rules, 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 the shortfall in the aggregate.

§ 114-44-9. Reinsurance.

9.1. Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with the minimum reserve standards set forth in this rule and with all applicable provisions

of the reinsurance contracts which affect the insurer's liabilities.

§ 114-44-10. Severability.

10.1. If any provision of this rule or the application of this rule to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of the provisions to other persons or circumstances shall not be affected by the holding.

APPENDIX A. SPECIFIC STANDARDS FOR MORBIDITY, INTEREST AND MORTALITY

I. MORBIDITY

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

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

(a) Contract Reserves:

Contracts issued on or after January 1, 1965 and prior to January 1, 1986:

The 1964 Commissioners Disability Table (64 CDT).

Contracts issued on or after January 1, 1997:

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

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

Contracts issued during 1986 through 1996:

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

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

(b) Claim Reserves:

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

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

(a) Contract Reserves:

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

The 1956 Intercompany Hospital-Surgical Tables.

Contracts issued on or after January 1, 1982:

The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(b) Claim Reserves:
No specific standard. See (5).

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

(a) Contract Reserves:

Contracts issued on or after January 1, 1986:

The 1985 NAIC Cancer Claim Cost Tables.

(b) Claim Reserves:

No specific standard. See (5).

(4) Accidental Death Benefits.

(a) Contract Reserves:

Contracts issued on or after January 1, 1965:

The 1959 Accidental Death Benefits Table.

(b) Claim Reserves:

Actual amount incurred.

(5) Other Individual Contract Benefits.

(a) Contract Reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim Reserves:

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

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

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

(a) Contract Reserves:

Contracts issued prior to January 1, 1997:

The same basis, if any, as that employed by the insurer as of December 31, 1996;

Contracts issued on or after January 1, 1997:

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

(b) Claim Reserves:

For claims incurred on or after January 1, 1997:

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

For claims incurred prior to January 1, 1997:

Use of the 87CGDT is optional.

(2) Other Group Contract Benefits.

(a) Contract Reserves:

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

(b) Claim Reserves:

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

II. INTEREST

A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

B. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

C. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate

permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

III. MORTALITY

A. Except as provided in paragraph B, the mortality basis used 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.

B. Other mortality tables adopted by the National Association of Insurance Commissioners and promulgated by the commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the commissioner. The request for such approval must include the proposed mortality table and the reason that the standard specified in paragraph A is inappropriate.

APPENDIX B. GLOSSARY OF TECHNICAL TERMS USED.

As used in this rule, the following terms have the following meaning:

ANNUAL-CLAIM COST. The net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies;

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

CLAIMS REPORTED. 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;

CLAIMS UNACCRUED. 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. 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;

DATE OF DISABLEMENT. 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. 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. 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. The term group insurance includes blanket insurance and franchise insurance and any other forms of group insurance;

LEVEL PREMIUM. A premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time.

Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the

contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums;

LONG-TERM CARE INSURANCE. Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage;

MODAL PREMIUM. This refers to the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9;

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

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

PRESENT VALUE OF AMOUNTS NOT YET DUE ON CLAIMS. The reserve for "claims unaccrued" (see definition), which may be discounted at interest;

RESERVE. The term "reserve" is used to include all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

An insurer under its contracts promises benefits which result in:

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

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

TERMINAL RESERVE. This is 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. This reserve 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 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;

VALUATION NET MODAL PREMIUM. This 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.

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

Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are NOT reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

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

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

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

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.

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

4263

H. B. 4263

(By Delegates Douglas, Gallagher, Faircloth, Compton, Linch and Riggs)

(Introduced January 29, 1996; referred to the Committee on Banking and Insurance then the Judiciary.)

1144

A BILL to amend and reenact section four, article seven, chapter sixty-four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to authorizing the insurance commissioner to promulgate legislative rules relating to minimum reserve standards for individual and group health insurance contracts.

Be it enacted by the Legislature of West Virginia:

That section four, article seven, chapter sixty-four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted, to read as follows:

ARTICLE 7. AUTHORIZATION FOR DEPARTMENT OF TAX AND REVENUE TO PROMULGATE LEGISLATIVE RULES.

§64-7-4. Insurance commissioner.

4263

(a) The legislative rules filed in the state register on the seventeenth day of August, one thousand nine hundred ninety-three, authorized under the authority of sections four and five, article twenty-eight, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the seventeenth day of June, one thousand nine hundred ninety-four, relating to the insurance commissioner (individual accident and sickness insurance minimum standards, 114 CSR 12), are authorized.

(b) The legislative rules filed in the state register on the fifteenth day of August, one thousand nine hundred ninety-four, authorized under the authority of section ten, article two, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the twenty-eighth day of November, one thousand nine hundred ninety-four, relating to the insurance commissioner (regulation of credit life insurance and credit accident and sickness insurance, 114 CSR 6), are authorized.

(c) The legislative rules filed in the state register on the twelfth day of August, one thousand nine hundred

ninety-four, authorized under the authority of section ten, article two, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the twenty-third day of November, one thousand nine hundred ninety-four, relating to the insurance commissioner (credit for reinsurance, 114 CSR 40), are authorized.

(d) The legislative rules filed in the state register on the twenty-eighth day of July, one thousand nine hundred ninety-five, authorized under the authority of section nine, article seven, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the twenty-seventh day of November, one thousand nine hundred ninety-five, relating to the insurance commissioner (minimum reserve standards for individual and group health insurance contracts, 114 CSR 44), are authorized.

NOTE: The purpose of this bill is to authorize the Insurance Commissioner to promulgate legislative rules relating to minimum reserve standards for individual and group health insurance contracts.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.

SENATE BILL NO. 192

(By Senators Ross, Anderson, Boley, Buckalew, Grubb and Macnaughtan)

[Introduced January 29,1996; referred to the Committee on BANKING AND INSURANCE THE JUDICIARY

114-44

A BILL to amend and reenact section four, article seven, chapter sixty-four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to authorizing the insurance commissioner to promulgate legislative rules relating to minimum reserve standards for individual and group health insurance contracts.

Be it enacted by the Legislature of West Virginia:

That section four, article seven, chapter sixty-four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted, to read as follows:

ARTICLE 7. AUTHORIZATION FOR DEPARTMENT OF TAX AND REVENUE TO PROMULGATE LEGISLATIVE RULES.

§64-7-4. Insurance commissioner.

(a) The legislative rules filed in the state register on the seventeenth day of August, one thousand nine hundred ninety-three, authorized under the authority of sections four and five, article twenty-eight, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the seventeenth day of June, one thousand nine hundred ninety-four, relating to the insurance commissioner (individual accident and sickness insurance minimum standards, 114 CSR 12), are authorized.

(b) The legislative rules filed in the state register on the fifteenth day of August, one thousand nine hundred ninety-four, authorized under the authority of section ten, article two, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the twenty-eighth day of November, one thousand nine hundred ninety-four, relating to the insurance commissioner (regulation of credit life insurance and credit accident and sickness insurance, 114 CSR 6), are authorized.

(c) The legislative rules filed in the state register on the twelfth day of August, one thousand nine hundred

ninety-four, authorized under the authority of section ten, article two, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the twenty-third day of November, one thousand nine hundred ninety-four, relating to the insurance commissioner (credit for reinsurance, 114 CSR 40), are authorized.

(d) The legislative rules filed in the state register on the twenty-eighth day of July, one thousand nine hundred ninety-five, authorized under the authority of section nine, article seven, chapter thirty-three, of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the twenty-seventh day of November, one thousand nine hundred ninety-five, relating to the insurance commissioner (minimum reserve standards for individual and group health insurance contracts, 114 CSR 44), are authorized.

NOTE: The purpose of this bill is to authorize the Insurance Commissioner to promulgate legislative rules relating to minimum reserve standards for individual and group health insurance contracts.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

April 2, 1996

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Attached for filing with your office is the "final filing" form for the rule Series 44 titled "Minimum Reserve Standards for Individual and Group Health Insurance Contracts." This rule was authorized in Senate Bill 171 and passed by the Legislature on March 7, 1996.

We are also providing your office with a computer disk containing the aforementioned rule and a hard copy of the promulgation history of that rule. The filing date and effective date have already been inserted onto the computer disk.

If you have any questions about the enclosed forms or the computer disk, please do not hesitate to call me.

Sincerely,

B. Keith Huffman
General Counsel

BKH/sar
Attachment

P.O. Box 50540
Charleston, West Virginia 25305-0540

"We are an Equal Opportunity Employer"

Telephone (304) 558-0401
Facsimile (304) 558-0412

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Legal Division

GASTON CAPERTON
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KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

STEPHEN N. REED
Deputy Secretary of State

CATHERINE FREROTTE
Executive Assistant

Telephone: (304) 558-6000
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STATE OF WEST VIRGINIA
SECRETARY OF STATE

Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305-0770

WILLIAM H. HARRINGTON
Chief of Staff

JUDY COOPER
Director, Administrative Law

PENNEY BARKER
Supervisor, Corporations

(Plus all the volunteer help we can get)

RECEIVED
APR 23 1996
LEGAL DIVISION
W. VA. INS. DEPT.

TO: Donna Quensebery

AGENCY: Insurance Commission

FROM: JUDY COOPER, DIRECTOR, ADMINISTRATIVE LAW DIVISION

DATE: April 19, 1996

THE ATTACHED RULE FILED BY YOUR AGENCY HAS BEEN ENTERED INTO OUR COMPUTER SYSTEM. PLEASE REVIEW, PROOF AND RETURN IT WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS, PLEASE SIGN THIS MEMO AND RETURN IT TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF THE RULE FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

SERIES: 44 TITLE: 114 Insurance Commission

* THE ATTACHED RULE HAS BEEN REVIEWED AND IS CORRECT.

SIGNED: _____

TITLE OF PERSON SIGNING: _____

DATE: _____

FILED
MAY 13 2 42 PM '96
OFFICE OF WEST VIRGINIA SECRETARY OF STATE

****

* THE ATTACHED RULE HAS BEEN REVIEWED AND NEEDS CORRECTING. THE CORRECTIONS HAVE BEEN MARKED.

SIGNED: Donna L. Quensebery

TITLE OF PERSON SIGNING: Associate Counsel

DATE: 5/10/96

NOTE: IF YOU ARE NOT THE PERSON WHO HANDLES THIS RULE, PLEASE FORWARD TO THE CORRECT PERSON.

KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

STEPHEN N. REED
Deputy Secretary of State

CATHERINE FREROTTE
Executive Assistant

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(Plus all the volunteer help we can get)

STATE OF WEST VIRGINIA
SECRETARY OF STATE

Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305-0770

March 12, 1996

Donna S Quesenberry
Insurance
PO Box 50540
2019 Washington Street East
Charleston, WV 25305-0540

SB 171 authorizing, **Title 114, Series 44**, **Minimum Reserve Standards for Individual & Group Health Insurance Contracts** passed the Legislature on **March 7, 1996**. It is now awaiting the Governor's signature.

You have sixty (60) days after the Governor signs **SB 171** to final file the legislative rule with the Secretary of State's office. To final file your legislative rule, fill in the blanks on the enclosed form #6, the "Final Filing" form and file the form with our office with a promulgation history of the rule. Authorization for your legislative rule is cited in **SB 171 Section 64-7-3(g)** . The agency may set the effective date of the legislative rule up to ninety (90) days from the date the legislative rule is final filed with the Secretary of State's office. Please have an authorized signature on the bottom line.

***IMPORTANT: IF YOUR AGENCY HAS COMPLETED THE LEGISLATIVE RULE ON A WORD PERFECT OR WORD PERFECT COMPATIBLE COMPUTER SYSTEM THAT USES A 3 1/2" DISK, **YOU MUST SUBMIT A CLEAN COPY WITH ALL UNDERLINING AND STRIKE-THROUGHS, HEADERS OR FOOTERS REMOVED,** TO OUR OFFICE WHEN FINAL FILING THE RULE. REMEMBER, THE TEXT OF THE COMPUTER FILED RULE **MUST BE** IDENTICAL - WORD FOR WORD, COMMA FOR COMMA, **WITH ALL UNDERLINING, STRIKE-THROUGHS, HEADERS OR FOOTERS REMOVED,** AS THE HARD COPY AUTHORIZED BY THE LEGISLATURE. **NOTICE: ALL ELECTRONIC FILINGS NOT COMPLYING WITH THIS WILL BE REJECTED AND SENT BACK TO THE AGENCY TO BE RESUBMITTED!**

After the final rule is entered into the data base, the rule will be sent back to the agency for review and proofing. The agency has ten (10) working days to send a confirmation or corrections to the Secretary of States. If the agency fails to return this within ten (10) working days, the rule will be filed in the data base with a disclaimer attached stating that the agency failed to review the rule. Following confirmation, corrections or failure to review, as the case may be, the Secretary of State shall submit to the agency a final version of the rule for their records.

If you have any questions or need any assistance, please do not hesitate to contact our office.

Thank you,
Administrative Law Division