Risk-Based Capital for Health Organizations

This Act:

- establishes risk-based capital requirements for health organizations;
- establishes a minimum standard of valuation for health insurance, and
- enacts model regulations of the National Association of Insurance Commissioners that regulates loss revenue certifications and disclosure of information to certain investigatory entities.

Submitted as:
Minnesota
Chapter 285 of 2004
Status: Enacted into law in 2004.

Suggested State Legislation

(Title, enacting clause, etc.)

1 Section 1. [*Short Title*.] This Act may be cited as "An Act to Establish Risk-Based
2 Capital Requirements for Health Organizations."
3
4 Article I
5 Risk-Based Capital for Health Organizations
6
7 Section 1. [*Definitions*.] As used in this Article I:
8 (A) [Adjusted RBC Report.] "Adjusted RBC report" means an RBC report which has
9 been adjusted by the [commissioner] in accordance with section 2 of this Article I.
10 (B) [Commissioner.] "Commissioner" means the [commissioner who regulates the health
11 organization].
12 (C) [Corrective Order.] "Corrective order" means an order issued by the [commissioner]
13 specifying corrective actions which the [commissioner] has determined are required.
14 (D) [Domestic Health Organization.] "Domestic health organization" means a health
15 organization domiciled in this state.
16 (E) [Foreign Health Organization.] "Foreign health organization" means a health
17 organization that is licensed to do business in this state but is not domiciled in this state.
18 (F) [NAIC] "NAIC" means the National Association of Insurance Commissioners.
19 (G) [Health Organization.] "Health organization" means an entity licensed under [insert
20 citation]. This definition does not include an organization that is licensed or regulated as either a
21 life and health insurer or a property and casualty insurer that is otherwise subject to either the life
22 or property and casualty risk-based capital requirements.
23 (H) [RBC Instructions.] "RBC instructions" means the RBC report including risk-based
24 capital instructions adopted by the NAIC, as these RBC instructions may be amended by the
25 NAIC from time to time in accordance with the procedures adopted by the NAIC.
26 (I) [RBC Level.] "RBC level" means a health organization's company action level RBC,
27 regulatory action level RBC, authorized control level RBC, or mandatory control level RBC
28 where:
29 (1) "company action level RBC" means, with respect to any health organization,
30 the product of 2.0 and its authorized control level RBC;

31 (2) “regulatory action level RBC” means the product of 1.5 and its authorized
32 control level RBC;
33 (3) “authorized control level RBC” means the number determined under the risk-
34 based capital formula in accordance with the RBC instructions; and
35 (4) “mandatory control level RBC” means the product of .70 and the authorized
36 control level RBC.
37 (J) [RBC Plan.] “RBC plan” means a comprehensive financial plan containing the
38 elements specified in section 2 of this Article. If the [commissioner] rejects the RBC plan, and it
39 is revised by the health organization, with or without the [commissioner's] recommendation, the
40 plan must be called the “revised RBC plan.”
41 (K) [RBC Report.] “RBC report” means the report required in section 2 of this Article.
42 (L) [Total Adjusted Capital.] “Total adjusted capital” means the sum of:
43 (1) a health organization's statutory capital and surplus as determined in
44 accordance with the statutory accounting applicable to the annual financial statements required to
45 be filed; and
46 (2) such other items, if any, as the RBC instructions may provide.
47
48 Section 2. [*RBC Reports*.]
49 (A) [Submissions.] A domestic health organization shall, on or before each [April 1],
50 prepare and submit to the [commissioner] a report of its RBC levels as of the [end of the calendar
51 year just ended], in a form and containing the information required by the RBC instructions. In
52 addition, a domestic health organization shall file its RBC report:
53 (1) with the NAIC in accordance with the RBC instructions; and
54 (2) with the [insurance commissioner in any state in which the health organization
55 is authorized to do business], if the insurance commissioner has notified the health organization
56 of its request in writing, in which case the health organization shall file its RBC report not later
57 than the later of:
58 (i) [15 days] from the receipt of notice to file its RBC report with that
59 state; or
60 (ii) the filing date.
61 (B) [Determination.] A health organization's RBC must be determined in accordance with
62 the formula set forth in the RBC instructions. The formula must take the following into account,
63 and may adjust for the covariance between, determined in each case by applying the factors in
64 the manner set forth in the RBC instructions:
65 (1) asset risk;
66 (2) credit risk;
67 (3) underwriting risk; and
68 (4) all other business risks and such other relevant risks as are set forth in the
69 RBC instructions.
70 (C) [Adjusted Report.] If a domestic health organization files an RBC report that in the
71 judgment of the [commissioner] is inaccurate, then the [commissioner] shall adjust the RBC
72 report to correct the inaccuracy and shall notify the health organization of the adjustment. The
73 notice must contain a statement of the reason for the adjustment. An RBC report as so adjusted is
74 referred to as an “adjusted RBC report.”
75
76 Section 3. [*Company Action Level Event*.]
77 (A) [Definition.] "Company action level event" means the following events:

(1) the filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(2) notification by the [commissioner] to the health organization of an adjusted RBC report that indicates an event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 7 of this Article, or

(3) if, pursuant to section 7 of this Article, a health organization challenges an adjusted RBC report that indicates the event in clause (1), the notification by the [commissioner] to the health organization that the [commissioner] has, after a hearing, rejected the health organization's challenge.

(B) [RBC Plan Required.] In the event of a company action level event, the health organization shall prepare and submit to the [commissioner] an RBC plan that:

(1) identifies the conditions that contribute to the company action level event;

(2) contains proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event;

(3) provides projections of the health organization's financial results in the current year and at least the [two succeeding years], both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) identifies the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(5) identifies the quality of, and problems associated with, the health organization's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(C) [RBC Plan Submission.] The RBC plan must be submitted:

(1) within [45 days] of the Company Action Level Event; or

(2) if the health organization challenges an adjusted RBC report pursuant to section 7 of this Article, within [45 days] after notification to the health organization that the [commissioner] has, after a hearing, rejected the health organization's challenge.

(D) [RBC Plan Implementation.] Within [60 days] after the submission by a health organization of an RBC plan to the [commissioner], the [commissioner] shall notify the health organization whether the RBC plan must be implemented or is, in the judgment of the [commissioner], unsatisfactory. If the [commissioner] determines the RBC plan is unsatisfactory, the notification to the health organization must set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the [commissioner]. Upon notification from the [commissioner], the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the [commissioner], and shall submit the revised RBC plan to the [commissioner]:

(1) within [45 days] after the notification from the [commissioner]; or

(2) if the health organization challenges the notification from the [commissioner] under section 7 of this Article, within [45 days] after a notification to the health organization that the [commissioner] has, after a hearing, rejected the health organization's challenge.

(E) [Unsatisfactory Plan.] In the event of a notification by the [commissioner] to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the [commissioner] may, at the [commissioner's] discretion, subject to the health organization's right

126 to a hearing under section 7 of this Article, specify in the notification that the notification
127 constitutes a regulatory action level event.
128 (F) [Additional Filing.] Every domestic health organization that files an RBC plan or
129 revised RBC plan with the [commissioner] shall file a copy of the RBC plan or revised RBC plan
130 with the insurance commissioner in any state in which the health organization is authorized to do
131 business if:
132 (1) the state has an RBC provision substantially similar in section 8, subdivision 1
133 of this Article; and
134 (2) the insurance commissioner of that state has notified the health organization of
135 its request for the filing in writing, in which case the health organization shall file a copy of the
136 RBC plan or revised RBC plan in that state no later than the later of:
137 (i) [15 days] after the receipt of notice to file a copy of its RBC plan or
138 revised RBC plan with the state; or
139 (ii) the date on which the RBC plan or revised RBC plan is filed under
140 subdivisions (C) and (D) of this section.
141
142 Section 4. [*Regulatory Action Level Event*.]
143 (A) [Definition.] "Regulatory action level event" means, with respect to a health
144 organization, any of the following events:
145 (1) the filing of an RBC report by the health organization that indicates that the
146 health organization's total adjusted capital is greater than or equal to its authorized control level
147 RBC but less than its regulatory action level RBC;
148 (2) notification by the [commissioner] to a health organization of an adjusted
149 RBC report that indicates the event in clause (1), provided the health organization does not
150 challenge the adjusted RBC report under section 7 of this Article;
151 (3) if, pursuant to section 7 of this Article, the health organization challenges an
152 adjusted RBC report that indicates the event in clause (1), the notification by the [commissioner]
153 to the health organization that the [commissioner] has, after a hearing, rejected the health
154 organization's challenge;
155 (4) the failure of the health organization to file an RBC report by the filing date,
156 unless the health organization has provided an explanation for the failure that is satisfactory to
157 the [commissioner] and has cured the failure within [ten days] after the filing date;
158 (5) the failure of the health organization to submit an RBC plan to the
159 [commissioner] within the time period set forth in section 3(3) of this Article;
160 (6) notification by the [commissioner] to the health organization that:
161 (i) the RBC plan or revised RBC plan submitted by the health
162 organization is, in the judgment of the [commissioner], unsatisfactory; and
163 (ii) notification constitutes a regulatory action level event with respect to
164 the health organization, provided the health organization has not challenged the determination
165 under section 7 of this Article;
166 (7) if, pursuant to section 7 of this Article, the health organization challenges a
167 determination by the [commissioner] under clause (6), the notification by the [commissioner] to
168 the health organization that the [commissioner] has, after a hearing, rejected the challenge;
169 (8) notification by the [commissioner] to the health organization that the health
170 organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has
171 a substantial adverse effect on the ability of the health organization to eliminate the company
172 action level event in accordance with its RBC plan or revised RBC plan and the [commissioner]
173 has so stated in the notification, provided the health organization has not challenged the
174 determination under section 1; or

175 (9) if, pursuant to section 7 of this Article, the health organization challenges a
176 determination by the [commissioner] under clause (8), the notification by the [commissioner] to
177 the health organization that the commissioner has, after a hearing, rejected the challenge.
178 (B) [Commissioner's Duties.] In the event of a regulatory action level event the
179 [commissioner] shall:
180 (1) require the health organization to prepare and submit an RBC plan or, if
181 applicable, a revised RBC plan;
182 (2) perform any examination or analysis the commissioner considers necessary of
183 the assets, liabilities, and operations of the health organization, including a review of its RBC
184 plan or revised RBC plan; and
185 (3) after the examination or analysis, issue a corrective order specifying the
186 corrective actions the commissioner determines are required.
187 (C) [Corrective Actions.] In determining corrective actions, the [commissioner] may take
188 into account factors the [commissioner] considers relevant with respect to the health organization
189 based upon the [commissioner's] examination or analysis of the assets, liabilities, and operations
190 of the health organization, including, but not limited to, the results of any sensitivity tests
191 undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must be
192 submitted:
193 (1) within [45 days] after the occurrence of the regulatory action level event;
194 (2) if the health organization challenges an adjusted RBC report pursuant to
195 section 7 of this Article and the challenge is not frivolous in the judgment of the [commissioner]
196 within [45 days] after the notification to the health organization that the [commissioner] has,
197 after a hearing, rejected the health organization's challenge; or
198 (3) if the health organization challenges a revised RBC plan pursuant to section 7
199 of this Article and the challenge is not frivolous in the judgment of the [commissioner], within
200 [45 days] after the notification to the health organization that the [commissioner] has, after a
201 hearing, rejected the health organization's challenge.
202 (D) [Consultants.] The [commissioner] may retain actuaries and investment experts and
203 other consultants as may be necessary in the judgment of the [commissioner] to review the health
204 organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and
205 operations, including contractual relationships, of the health organization and formulate the
206 corrective order with respect to the health organization. The fees, costs, and expenses relating to
207 consultants must be borne by the affected health organization or such other party as directed by
208 the [commissioner].
209
210 Section 5. [*Authorized Control Level Event.*]
211 (A) [Definition.] "Authorized control level event" means any of the following events:
212 (1) the filing of an RBC report by the health organization that indicates that the
213 health organization's total adjusted capital is greater than or equal to its mandatory control level
214 RBC but less than its authorized control level RBC;
215 (2) the notification by the commissioner to the health organization of an adjusted
216 RBC report that indicates the event in clause (1), provided the health organization does not
217 challenge the adjusted RBC report under section 7 of this Article;
218 (3) if, pursuant to section 7 of this Article, the health organization challenges an
219 adjusted RBC report that indicates the event in clause (1), notification by the [commissioner] to
220 the health organization that the [commissioner] has, after a hearing, rejected the health
221 organization's challenge;

(4) the failure of the health organization to respond, in a manner satisfactory to the [commissioner], to a corrective order, provided the health organization has not challenged the corrective order under section 7 of this Article; or

(5) if the health organization has challenged a corrective order under section 7 of the Article and the [commissioner] has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the [commissioner], to the corrective order subsequent to rejection or modification by the [commissioner].

(B) [Commissioner’s Duties.] In the event of an authorized control level event with respect to a health organization, the [commissioner] shall:

(1) take such actions as are required under section 7 of this Article regarding a health organization with respect to which a regulatory action level event has occurred; or

(2) if the [commissioner] considers it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under [insert citation]. In the event the [commissioner] takes such actions, the authorized control level event is considered sufficient grounds for the [commissioner] to take action under [insert citation], and the [commissioner] shall have the rights, powers, and duties with respect to the health organization as are set forth in [insert citation]. In the event the [commissioner] takes actions under this clause pursuant to an adjusted RBC report, the health organization is entitled to the protections afforded health organizations under [insert citation] pertaining to summary proceedings.

Section 6. [*Mandatory Control Level Event.*]

(A) [Definition.] “Mandatory control level event” means any of the following events:

(1) the filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(2) notification by the [commissioner] to the health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 7; or

(3) if, pursuant to section 7, the health organization challenges an adjusted RBC report that indicates the event in clause (1), notification by the [commissioner] to the health organization that the [commissioner] has, after a hearing, rejected the health organization's challenge.

(B) [Commissioner’s Duties.]

(1) In the event of a mandatory control level event, the [commissioner] shall take such actions as are necessary to place the health organization under regulatory control under [insert citation]. In that event, the mandatory control level event is considered sufficient grounds for the [commissioner] to take action under [insert citation], and the [commissioner] shall have the rights, powers, and duties with respect to the health organization as are set forth in section [insert citation]. If the [commissioner] takes actions pursuant to an adjusted RBC report, the health organization is entitled to the protections of [insert citation] pertaining to summary proceedings.

(2) The [commissioner] may forego action for up to [90 days] after the mandatory control level event if the [commissioner] finds there is a reasonable expectation that the mandatory control level event may be eliminated within the [90-day] period.

Section 7. [*Hearings.*] Upon the occurrence of any of the following events, the health organization has the right to a confidential departmental hearing, on a record, at which the health

271 organization may challenge any determination or action by the [commissioner]. The health
272 organization shall notify the [commissioner] of its request for a hearing within [five days] after
273 the notification by the [commissioner] under clause (1), (2), (3), or (4). Upon receipt of the
274 health organization's request for a hearing, the [commissioner] shall set a date for the hearing,
275 which must be [no less than ten nor more than 30 days] after the date of the health organization's
276 request. The events include:
277 (1) notification to a health organization by the [commissioner] of an adjusted
278 RBC report;
279 (2) notification to a health organization by the [commissioner] that:
280 (i) the health organization's RBC plan or revised RBC plan is
281 unsatisfactory; and
282 (ii) notification constitutes a regulatory action level event with respect to
283 the health organization;
284 (3) notification to a health organization by the [commissioner] that the health
285 organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a
286 substantial adverse effect on the ability of the health organization to eliminate the company
287 action level event with respect to the health organization in accordance with its RBC plan or
288 revised RBC plan; or
289 (4) notification to a health organization by the [commissioner] of a corrective
290 order with respect to the health organization.
291
292 Section 8. [*Access to and Use of RBC Information*.]
293 (A) [Confidentiality; Prohibition on Announcements.] Regarding confidentiality and
294 prohibitions on announcements, see [insert citation].
295 (B) [Prohibition for Rate Making or Premium Setting.] The RBC instructions, RBC
296 reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by
297 the [commissioner] in monitoring the solvency of health organizations and the need for possible
298 corrective action with respect to health organizations and shall not be used by the
299 [commissioner] for rate making nor considered or introduced as evidence in any rate proceeding
300 nor used by the [commissioner] to calculate or derive any elements of an appropriate premium
301 level or rate of return for any line of insurance that a health organization or any affiliate is
302 authorized to write.
303
304 Section 9. [*Supplemental Provisions*.]
305 (A) [Effect.] Sections 1 through Section 12 of this Article are supplemental to any other
306 provisions of the laws of this state, and must not preclude or limit any other powers or duties of
307 the [commissioner] under such laws, including, but not limited to [insert citation].
308 (B) [Exemption.] The [commissioner] may exempt from the application of sections 1
309 through 12 of this Article a domestic health organization that:
310 (1) writes direct business only in this state;
311 (2) assumes no reinsurance in [excess of five percent] of direct premium written;
312 and
313 (3) writes direct annual premiums for comprehensive medical business of
314 [$2,000,000 or less].
315
316 Section 10. [*Foreign Health Organizations*.]
317 (A) [RBC Report.]

318 (1) A foreign health organization shall, upon the written request of the
319 [commissioner], submit to the [commissioner] an RBC report as of the end of the calendar year
320 just ended the later of:
321 (i) the date an RBC report would be required to be filed by a domestic
322 health organization under sections 1 through 12 of this Article; or
323 (ii) [15 days] after the request is received by the foreign health
324 organization.
325 (2) A foreign health organization shall, at the written request of the
326 [commissioner], promptly submit to the [commissioner] a copy of any RBC plan that is filed
327 with the insurance [commissioner] of any other state.
328 (B) [RBC Plan.] In the event of a company action level event, regulatory action level
329 event, or authorized control level event with respect to a foreign health organization as
330 determined under the RBC statute applicable in the state of domicile of the health organization
331 or, if no RBC statute is in force in that state, under sections 1 to 12 of this Article, if the
332 insurance [commissioner] of the state of domicile of the foreign health organization fails to
333 require the foreign health organization to file an RBC plan in the manner specified under that
334 state's RBC statute or, if no RBC statute is in force in that state, under section 3 of this Article,
335 the [commissioner] may require the foreign health organization to file an RBC plan with the
336 [commissioner]. In such event, the failure of the foreign health organization to file an RBC plan
337 with the [commissioner] shall be grounds to order the health organization to cease and desist
338 from writing new insurance business in this state. This section does not limit the
339 [commissioner]'s authority to require a foreign insurer to file a copy of the risk-based capital plan
340 submitted to the [commissioner] in the state of domicile.
341 (C) [Liquidation of Property.] In the event of a mandatory control level event with
342 respect to a foreign health organization, if no domiciliary receiver has been appointed with
343 respect to the foreign health organization under the rehabilitation and liquidation statute
344 applicable in the state of domicile of the foreign health organization, the [commissioner] may
345 make application to the [district court] permitted under [insert citation] with respect to the
346 liquidation of property of foreign health organizations found in this state, and the occurrence of
347 the mandatory control level event shall be considered adequate grounds for the application.
348
349 Section 11. [*Immunity*.] There is no liability on the part of, and no cause of action arises
350 against, the [commissioner] or the department or its employees or agents for any action taken by
351 them in the performance of their powers and duties under sections 1 to 12 of this Article.
352
353 Section 12. [*Notices*.] All notices by the [commissioner] to a health organization that
354 may result in regulatory action under sections 1 to 12 of this Article are effective upon dispatch
355 if transmitted by registered or certified mail, or in the case of any other transmission are effective
356 upon the health organization's receipt of notice.
357
358 Article II
359 Minimum Standard of Valuation for Health Insurance
360
361 Section 1. [*Purpose and Scope*.]
362 (A) [Applicability.] Sections 1 to 9 of this Article apply to all individual and group
363 accident and health insurance coverages as defined in [insert citation], including single premium
364 credit disability insurance. Other credit insurance is not subject to sections 1 to 9 of this Article
365 of this Act.

366 (B) [Adequacy of Reserves.] When an insurer determines that adequacy of its health
367 insurance reserves requires reserves in excess of the minimum standards specified in sections 1
368 to 9 of this Article, the increased reserves must be held and must be considered the minimum
369 reserves for that insurer.
370 (C) [Gross Premium Valuation.] With respect to any block of contracts, or with respect to
371 an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test
372 of reserve adequacy as of a given valuation date. The prospective gross premium valuation must
373 take into account, for contracts in force, in a claims status, or in a continuation of benefits status
374 on the valuation date, the present value as of the valuation date of all expected benefits unpaid,
375 all expected expenses unpaid, and all unearned or expected premiums, adjusted for future
376 premium increases reasonably expected to be put into effect. The prospective gross premium
377 valuation must be performed whenever a significant doubt exists as to reserve adequacy with
378 respect to any major block of contracts, or with respect to the insurer's health business as a
379 whole. In the event inadequacy is found to exist, immediate loss recognition must be made and
380 the reserves restored to adequacy. Adequate reserves, inclusive of claim, premium, and contract
381 reserves, if any, must be held with respect to all contracts, regardless of whether contract
382 reserves are required for such contracts under sections 1 to 9 of this Article.
383 (D) [Minimum Reserves Exceed Reserve Requirements.] Whenever minimum reserves,
384 as defined in sections 1 to 9 of this Article, exceed reserve requirements as determined by a
385 prospective gross premium valuation, such minimum reserves remain the minimum requirement
386 under sections 1 to 9 of this Article.
387
388 Section 2. [*Glossary of Technical Terms Used.*]
389 (A) [Scope.] As used in sections 1 to 9 of this Article:
390 (B) [Annual Claim Cost.] "Annual claim cost" means the net annual cost per unit of
391 benefit before the addition of expenses, including claim settlement expenses, and a margin for
392 profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit,
393 for a maximum disability benefit period of one year, with an elimination period of one week,
394 with respect to a male at age 35, in a certain occupation might be $12, while the gross premium
395 for this benefit might be $18. The additional $6 would cover expenses and profit or
396 contingencies.
397 (C) [Claims Accrued.] "Claims accrued" means that portion of claims incurred on or
398 prior to the valuation date which result in liability of the insurer for the payment of benefits for
399 medical services which have been rendered on or before the valuation date, and for the payment
400 of benefits for days of hospitalization and days of disability which have occurred on or prior to
401 the valuation date, which the insurer has not paid as of the valuation date, but for which it is
402 liable, and will have to pay after the valuation date. This liability is sometimes referred to as a
403 liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued
404 claim liability, must be established.
405 (D) [Claims Reported.] "Claims reported" means when an insurer has been informed that
406 a claim has been incurred, if the date reported is on or before the valuation date, the claim is
407 considered as a reported claim for annual statement purposes.
408 (E) [Claims Unaccrued.] "Claims unaccrued" means that portion of claims incurred on or
409 before the valuation date which result in liability of the insurer for the payment of benefits for
410 medical services expected to be rendered after the valuation date, and for benefits expected to be
411 payable for days of hospitalization and days of visability occurring after the valuation date. This
412 liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which
413 represents an estimate of the unaccrued claim payments expected to be made (which may or may
414 not be discounted with interest) must be established.

415 (F) [Claims Unreported.] "Claims unreported" means when an insurer has not been
416 informed, on or before the valuation date, concerning a claim that has been incurred on or prior
417 to the valuation date, the claim is considered as an unreported claim for annual statement
418 purposes.
419 (G) [Date of Disablement.] "Date of disablement" means the earliest date the insured is
420 considered as being disabled under the definition of disability in the contract, based on a doctor's
421 evaluation or other evidence. Normally this date will coincide with the start of any elimination
422 period.
423 (H) [Elimination Period.] "Elimination period" means a specified number of days, weeks,
424 or months starting at the beginning of each period of loss, during which no benefits are payable.
425 (I) [Gross Premium.] "Gross premium" means the amount of premium charged by the
426 insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading
427 for expenses, profit, or contingencies.
428 (J) [Group Insurance.] "Group insurance" means the term group insurance includes
429 blanket insurance and franchise insurance and any other forms of group insurance.
430 (K) [Level Premium.] "Level premium" means a premium calculated to remain
431 unchanged throughout either the lifetime of the policy, or for some shorter projected period of
432 years. The premium need not be guaranteed; in which case, although it is calculated to remain
433 level, it may be changed if any of the assumptions on which it was based are revised at a later
434 time. Generally, the annual claim costs are expected to increase each year and the insurer, instead
435 of charging premiums that correspondingly increase each year, charges a premium calculated to
436 remain level for a period of years or for the lifetime of the contract. In this case, the benefit
437 portion of the premium is more than needed to provide for the cost of benefits during the earlier
438 years of the policy and less than the actual cost in the later years. The building of a prospective
439 contract reserve is a natural result of level premiums.
440 (L) [Long-Term Care Insurance.] "Long-term care insurance" means a qualified long-
441 term care insurance policy or rider as defined in [insert citation] and a nonqualified long-term
442 insurance policy or rider as defined in [insert citation].
443 (M) [Modal Premium.] "Modal premium" refers to the premium paid on a contract based
444 on a premium term which could be annual, semiannual, quarterly, monthly, or weekly. Thus if
445 the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal
446 premium is $9.
447 (N) [Negative Reserve.] "Negative reserve" means normally the terminal reserve is a
448 positive value. However, if the values of the benefits are decreasing with advancing age or
449 duration it could be a negative value, called a negative reserve.
450 (O) [Preliminary term reserve method.] "Preliminary term reserve method" means that
451 under this method of valuation the valuation net premium for each year falling within the
452 preliminary term period is exactly sufficient to cover the expected incurred claims of that year,
453 so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary
454 term period, a new constant valuation net premium (or stream of changing valuation premiums)
455 becomes applicable such that the present value of all such premiums is equal to the present value
456 of all claims expected to be incurred following the end of the preliminary term period.
457 (P) [Present Value of Amounts Not Yet Due on Claims.] "Present value of amounts not
458 yet due on claims" means the reserve for "claims unaccrued' which may be discounted at
459 interest.
460 (Q) [Rating Block.] "Rating block" means a grouping of contracts determined by the
461 valuation actuary based on common characteristics, such as a policy form or forms having
462 similar benefit designs.

463 (R) [Reserve.] "Reserve" includes all items of benefit liability, whether in the nature of
464 incurred claim liability or in the nature of contract liability relating to future periods of coverage,
465 and whether the liability is accrued or unaccrued. An insurer under its contracts promises
466 benefits, which result in:
467 (1) claims which have been incurred, that is, for which the insurer has become
468 obligated to make payment, on or prior to the valuation date. On these claims, payments
469 expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of
470 the insurer which should be provided for by establishing claim reserves; or
471 (2) claims which are expected to be incurred after the valuation date. Any present
472 liability of the insurer for these future claims should be provided for by the establishment of
473 contract reserves and unearned premium reserves.
474 (S) [Terminal Reserve.] "Terminal reserve" means the reserve at the end of a contract
475 year, and is defined as the present value of benefits expected to be incurred after that contract
476 year minus the present value of future valuation net premiums.
477 (T) [Unearned Premium Reserve.] "Unearned premium reserve" means that portion of the
478 premium paid or due to the insurer which is applicable to the period of coverage extending
479 beyond the valuation date. Thus if an annual premium of $120 was paid on November 1, $20
480 would be earned as of December 31 and the remaining $100 would be unearned. The unearned
481 premium reserve could be on a gross basis as in this example, or on a valuation net premium
482 basis.
483 (U) [Valuation Net Modal Premium.] "Valuation net modal premium" means the modal
484 fraction of the valuation net annual premium that corresponds to the gross modal premium in
485 effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is
486 quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual
487 premium.
488
489 Section 3. [*Categories of Reserves*.]
490 (A) The following sections set forth minimum standards for three categories of health
491 insurance reserves:
492 (1) section 4 of this Article, claim reserves;
493 (2) section 5 of this Article, premium reserves; and
494 (3) section 6 of this Article, contract reserves.
495 Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three
496 categories combined. However, sections 1 to 9 of this Article emphasize the importance of
497 determining appropriate reserves for each of the three categories separately.
498
499 Section 4. [*Claim Reserves*.]
500 (A) [Generally.]
501 (1) Claim reserves are required for all incurred but unpaid claims on all health
502 insurance policies.
503 (2) Appropriate claim expense reserves are required with respect to the estimated
504 expense of settlement of all incurred but unpaid claims.
505 (3) Claim reserves for prior valuation years are to be tested for adequacy and
506 reasonableness along the lines of claim runoff schedules in accordance with the statutory
507 financial statement including consideration of any residual unpaid liability.
508 (B) [Minimum Standards for Claim Reserves for Disability Income.]
509 (1) The maximum interest rate for claim reserves is specified in section 9 of this
510 Article.

(2) Minimum standards with respect to morbidity are those specified in section 9 of this Article, 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; and

(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 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 deemed necessary by the [commissioner].

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

(C) [Minimum Standards for Claims Reserves for All Other Benefits.]

(1) The maximum interest rate for claim reserves is specified in section 9 of this Article.

(2) The reserve must 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.

(D) [Claim Reserve Methods Generally.] A generally accepted actuarial reserving method or other reasonable method if the method is approved by the [commissioner] before the statement date, or a combination of methods as described in this section, 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, must be determined in the aggregate.

Section 5. [*Premium Reserves*.]

(A) [Generally.]

(1) Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(2) 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.

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

(B) [Minimum Standards for Unearned Premium Reserves.]

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

(i) the valuation net modal premium on the contract reserve basis applying to the contract; or

(ii) the gross modal premium for the contract if no contract reserve applies.

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

(C) [Premium Reserve Methods Generally.] The insurer may employ suitable approximations and estimates, including, but not limited to, groupings, averages, and aggregate estimation, in computing premium reserves. Approximations or estimates should be tested periodically to determine the continuing adequacy and reliability.

Section 6. [*Contract Reserves Required*.]

(A) Contract reserves are required, unless otherwise specified in paragraph (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 evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary must state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary must also disclose the reasons for and magnitude of the recovery. The values specified in this clause must be determined on the basis specified in section 7 of this Article, subdivisions (A) to (D).

(B) Contracts not requiring a contract reserve are:

(1) contracts that cannot be continued after [one year] from issue; or

(2) contracts already in force on the effective date of sections 1 to 9 of this Article 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 must be consistent with those for claim reserves for a 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.

Section 7. [*Minimum Standards for Contract Reserves*.]

(A) [Basis.]

(1) Minimum standards with respect to morbidity are those set forth in section 9 of this Article. 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 insured, contract duration, and period for which gross premiums have been calculated. Contracts for which tabular morbidity standards are not specified in section 9 of this Article must be valued using tables established for reserve purposes by a qualified actuary and acceptable to the

609 [commissioner]. The morbidity tables must contain a pattern of incurred claims cost that reflects
610 the underlying morbidity and must not be constructed for the primary purpose of minimizing
611 reserves.
612 (2) The maximum interest rate is specified in section 9 of this Article.
613 (3) Termination rates used in the computation of reserves must be on the basis of
614 a mortality table as specified in section 9 of this Article except as noted in clauses (i) to (iii):
615 (i) under contracts for which premium rates are not guaranteed, and where
616 the effects of insurer underwriting are specifically used by policy duration in the valuation
617 morbidity standard or for return of premium or other deferred cash benefits, total termination
618 rates may be used at ages and durations where these exceed specified mortality table rates, but
619 not in excess of the lesser of:
620 (a) [80 percent] of the total termination rate used in the calculation
621 of the gross premiums; or
622 (b) [eight percent];
623 (ii) for long-term care individual policies or group certificates issued after
624 [January 1, 1997], the contract reserve may be established on a basis of separate:
625 (a) mortality as specified in section 9 of this Article; and
626 (b) terminations other than mortality, where the terminations are
627 not to exceed:
628 (I) for policy years [one through four], the lesser of [80
629 percent] of the voluntary lapse rate used in the calculation of gross premiums and [eight percent];

630 (II) for policy years [five and later], the lesser of [100
631 percent] of the voluntary lapse rate used in the calculation of gross premiums and [four percent];
632 (iii) where a morbidity standard specified in section 9 of this Article is on
633 an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer
634 underwriting by policy duration. The adjustments must be appropriate to the underwriting and be
635 acceptable to the [commissioner].
636 (B) [Reserve Method.]
637 (1) For insurance, except long-term care and return of premium or other deferred
638 cash benefits, the minimum reserve is the reserve calculated on the [two-year] full preliminary
639 term method; that is, under which the terminal reserve is [zero] at the first and also the second
640 contract anniversary.
641 (2) For long-term care insurance, the minimum reserve is the reserve calculated as
642 follows:
643 (i) for individual policies and group certificates issued on or before
644 [December 31, 1991], reserves calculated on the [two-year] full preliminary term methods;
645 (ii) for individual policies and group certificates issued on or after
646 [January 1, 1992], reserves calculated on the [one-year] full preliminary term method.
647 (3) For return of premium or other deferred cash benefits, the minimum reserve is
648 the reserve calculated as follows:
649 (i) on the [one-year] preliminary term method if the benefits are provided
650 at any time before the [20th anniversary];
651 (ii) on the [two-year] preliminary term method if the benefits are only
652 provided on or after the [20th anniversary]. The preliminary term method may be applied only in
653 relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate
654 increases, revisions in assumptions, for example projected inflation rates, or for other reasons,
655 are to be applied immediately as of the effective date of adoption of the adjusted basis.

656 (C) [Negative Reserves.] Negative reserves on any benefit may be offset against positive
657 reserves for other benefits in the same contract, but the total contract reserve with respect to all
658 benefits combined may not be less than zero.
659 (D) [Nonforfeiture Benefits for Long-Term Care Insurance.] The contract reserve on a
660 policy basis must not be less than the net single premium for the nonforfeiture benefits at the
661 appropriate policy duration, where the net single premium is computed according to the
662 specifications in this section. While the consideration for nonforfeiture benefits in this section is
663 specific to long-term care insurance, similar consideration may be applicable for other lines of
664 business.
665 (E) [Alternative Valuation Methods and Assumptions.] Provided the contract reserve on
666 all contracts to which an alternative method or basis is applied is not less in the aggregate than
667 the amount determined according to the applicable standards specified in this section, an insurer
668 may use any reasonable assumptions as to interest rates, termination and mortality rates, and
669 rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may
670 employ methods other than the methods stated in this section in determining a sound value of its
671 liabilities under such contracts, including, but not limited to, the following: the net level
672 premium method; the [one-year] full preliminary term method; prospective valuation on the basis
673 of actual gross premiums with reasonable allowance for future expenses; the use of
674 approximations such as those involving age groupings, groupings of several years of issue,
675 average amounts of indemnity, and grouping of similar contract forms; the computation of the
676 reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract
677 reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim
678 cost for all or any combination of the benefits included in the contracts valued.
679 (F) [Test for Adequacy and Reasonableness of Contract Reserves.] Annually, an
680 appropriate review must be made of the insurer's prospective contract liabilities on contracts
681 valued by tabular reserves, to determine the continuing adequacy and reasonableness of the
682 tabular reserves giving consideration to future gross premiums. The insurer shall make
683 appropriate increments to such tabular reserves if such tests indicate that the basis of such
684 reserves is no longer adequate; subject, however, to the minimum standards of section 7,
685 subdivisions (A) to (D). In the event a company has a contract or a group of related similar
686 contracts for which future gross premiums will be restricted by contract, department rule, or for
687 other reasons, such that the future gross premiums reduced by expenses for administration,
688 commissions, and taxes will be insufficient to cover future claims, the company shall establish
689 contract reserves for such shortfall in the aggregate.
690
691 Section 8. [*Reinsurance.*] Increases to or credits against reserves carried, arising because
692 of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with
693 sections 1 to 9 of this Article and with all applicable provisions of the reinsurance contracts
694 which affect the insurer's liabilities.
695
696 Section 9. [*Specific Standards for Morbidity, Interest, And Mortality.*]
697 (A) [Morbidity.] Minimum morbidity standards for valuation of specified individual
698 contract health insurance benefits are as follows:
699 (1) Disability Income Benefits Due to Accident or Sickness.
700 (a) Contract Reserves: Contracts issued on or after [January 1, 2004]:
701 (i) The 1985 Commissioner's Individual Disability Tables A
702 (85CIDA); or
703 (ii) The 1985 Commissioner's Individual Disability Tables B
704 (85CIDB). Each insurer shall elect, with respect to all individual contracts issued in any one

705 statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer
706 may, however, elect to use the other tables with respect to any subsequent statement year.
707 (b) Claim Reserves: For claims incurred on or after [January 1, 2004]:
708 The 1985 Commissioner's Individual Disability Table A (85CIDA) with claim termination rates
709 multiplied by the following adjustment factors:

	Duration	Adjustment Factor	Adjusted Termination Rates*
713	Week 1	0.366	0.04831
714	2	0.366	0.04172
715	3	0.366	0.04063
716	4	0.366	0.04355
717	5	0.365	0.04088
718	6	0.365	0.04271
719	7	0.365	0.04380
720	8	0.365	0.04344
721	9	0.370	0.04292
722	10	0.370	0.04107
723	11	0.370	0.03848
724	12	0.370	0.03478
725	13	0.370	0.03034
726	Month 4	0.391	0.08758
727	5	0.371	0.07346
728	6	0.435	0.07531
729	7	0.500	0.07245
730	8	0.564	0.06655
731	9	0.613	0.05520
732	10	0.663	0.04705
733	11	0.712	0.04486
734	12	0.756	0.04309
735	13	0.800	0.04080
736	14	0.844	0.03882
737	15	0.888	0.03730
738	16	0.932	0.03448
739	17	0.976	0.03026
740	18	1.020	0.02856
741	19	1.049	0.02518
742	20	1.078	0.02264
743	21	1.107	0.02104
744	22	1.136	0.01932
745	23	1.165	0.01865
746	24	1.195	0.01792
747	Year 3	1.369	0.16839
748	4	1.204	0.10114
749	5	1.199	0.07434
750	6 and later	1.000	**

751
752 *The adjusted termination rates derived from the application of the adjustment factors to the
753 DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (Transactions of the

754 Society of Actuaries (TSA) XXXVII, pages 457-463) is displayed. The adjustment factors for
755 age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be
756 applied to the adjusted termination rates shown in this table.
757 **Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pages
758 462-463). The 85CIDA table so adjusted for the computation of claim reserves shall be known as
759 85CIDC (The 1985 Commissioner's Individual Disability Table C).
760
761 (2) Hospital Benefits, Surgical Benefits, and Maternity Benefits (Scheduled
762 benefits or fixed time period benefits only).
763 (a) Contract Reserves. Contracts issued on or after [January 1, 1982]: The
764 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX,
765 page 63. Refer to the paper (in the same volume, page 9) to which this table is appended,
766 including its discussions, for methods of adjustment for benefits not directly valued in Table A:
767 "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.
768 (b) Claim Reserves: No specific standard. See (6).
769 (3) Cancer Expense Benefits (Scheduled benefits or fixed time period benefits
770 only).
771 (a) Contract Reserves: Contracts issued on or after [January 1, 2004]: The
772 1985 NAIC Cancer Claim Cost Tables.
773 (b) Claim Reserves: No specific standard. See (6).
774 (4) Accidental Death Benefits.
775 (a) Contract Reserves: Contracts issued on or after [January 1, 2004]: The
776 1959 Accidental Death Benefits Table.
777 (b) Claim Reserves: Actual amount incurred.
778 (5) Single Premium Credit Disability.
779 (a) Contract Reserves:
780 (i) For contracts issued on or after [January 1, 2004]:
781 (I) For plans having less than a [30-day elimination
782 period], the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence
783 rates increased by [12 percent].
784 (II) For plans having a [30-day and greater] elimination
785 period, the 85CIDA for a [14-day] elimination period with the adjustment in item (I).
786 (b) Claim Reserves: Claim reserves are to be determined as provided in
787 section 4 of this Article.
788 (6) Other Individual Contract Benefits.
789 (a) Contract Reserves: For all other individual contract benefits, morbidity
790 assumptions are to be determined as provided in section 6 of this Article.
791 (b) Claim Reserves: For all benefits other than disability, claim reserves
792 are to be determined as provided in section 4 of this Article.
793 (B) Minimum morbidity standards for valuation of specified group contract health
794 insurance benefits are as follows:
795 (1) Disability Income Benefits Due to Accident or Sickness.
796 (a) Contract Reserves: Contracts issued on or after [January 1, 2004]: The
797 1987 Commissioners Group Disability Income Table (87CGDT).
798 (b) Claim Reserves: For claims incurred on or after [January 1, 2004]:
799 The 1987 Commissioners Group Disability Income Table (87CGDT);
800 (2) Single Premium Credit Disability
801 (a) Contract Reserves:
802 (i) For contracts issued on or after [January 1, 2004]:

803 (I) For plans having less than a [30-day] elimination
804 period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence
805 rates increased by [12 percent].
806 (II) For plans having a [30-day and greater] elimination
807 period, the 85CIDA for a [14-day] elimination period with the adjustment in item (I).
808 (b) Claim Reserves: Claim reserves are to be determined as provided in
809 section 4 of this Article.
810 (3) Other Group Contract Benefits.
811 (a) Contract Reserves: For all other group contract benefits, morbidity
812 assumptions are to be determined as provided in section 6 of this Article.
813 (b) Claim Reserves: For all benefits other than disability, claim reserves
814 are to be determined as provided in section 4 of this Article.
815 (C) [Interest.]
816 (1) For contract reserves the maximum interest rate is the maximum rate
817 permitted by law in the valuation of whole life insurance issued on the same date as the health
818 insurance contract.
819 (2) For claim reserves on policies that require contract reserves, the maximum
820 interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued
821 on the same date as the claim incurred date.
822 (3) For claim reserves on policies not requiring contract reserves, the maximum
823 interest rate is the maximum rate permitted by law in the valuation of single premium immediate
824 annuities issued on the same date as the claim incurred date, reduced by [100 basis points].
825 (D) [Mortality.]
826 (1) For individual long-term care insurance policies or group long-term care
827 insurance certificates issued on or after [January 1, 2004], the mortality basis used must be the
828 1983 Group Annuity Mortality Table without projection.
829 (2) Other mortality tables adopted by the NAIC and adopted by the
830 [commissioner] may be used in the calculation of the minimum reserves if appropriate for the
831 type of benefits and if approved by the [commissioner]. The request for approval must include
832 the proposed mortality table and the reason that the standard specified in subsection (1) is
833 inappropriate.
834 (3) For single premium credit insurance using the 85CIDA table, no separate
835 mortality must be assumed.
836
837 Article III
838 Miscellaneous
839
840 Section 1. [*Loss Reserve Certification.*]
841 (A) [Loss Reserve Certification.]
842 (1) Each domestic company engaged in providing the types of coverage described
843 in [insert citation], must have its loss reserves certified by a qualified actuary. The company must
844 file the certification with the [commissioner] within [30 days] of completion of the certification,
845 but not later than [June 1]. The actuary providing the certification may be an employee of the
846 company but the [commissioner] may still require an independent actuarial certification as
847 described in subdivision 1. This subdivision does not apply to township mutual companies, or to
848 other domestic insurers having less than [$1,000,000 of premiums written in any year] and fewer
849 than [1,000 policyholders]. The [commissioner] may allow an exception to the stand alone
850 certification where it can be demonstrated that a company in a group has a pooling or 100
851 percent reinsurance agreement used in a group which substantially affects the solvency and

852 integrity of the reserves of the company, or where it is only the parent company of a group which
853 is licensed to do business in this state. If these circumstances exist, the company may file a
854 written request with the [commissioner] for an exception. Companies writing reinsurance alone
855 are not exempt from this requirement. The certification must contain the following statement: "In
856 my opinion, the reserves described in this certification are consistent with reserves computed in
857 accordance with standards and principles established by the Actuarial Standards Board and are
858 fairly stated."
859 (2) Each foreign company engaged in providing the types of coverage described
860 in [insert citation], required by this section to file an annual audited financial report, whose total
861 net earned premium for [Schedule P, Part 1A to Part 1H plus Part 1R, (Schedule P, Part 1A to
862 Part 1H plus Part 1R, Column 4, current year premiums earned, from the company's most
863 currently filed annual statement) is equal to one-third or more of the company's total net earned
864 premium (Underwriting and Investment Exhibit, Part 2, Column 4, total line, of the annual
865 statement)] must have a reserve certification by a qualified actuary at least every three years. In
866 the year that the certification is due, the company must file the certification with the
867 [commissioner] within [30 days] of completion of the certification, but not later than [June 1].
868 The actuary providing the certification may be an employee of the company. Companies writing
869 reinsurance alone are not exempt from this requirement. The certification must contain the
870 following statement:
871
872 "*The loss reserves and loss expense reserves have been examined and found to be*
873 *calculated in accordance with generally accepted actuarial principles and practices and are*
874 *fairly stated*."
875
876 Section 2. [*Risk-Based Capital Requirement*.] A service plan corporation is subject to
877 regulation of its financial solvency under Article I of this Act.
878
879 Section 3. [*Application Review.*] Upon receipt of an application for a certificate of
880 authority, the [commissioner] of health shall determine whether the applicant for a certificate of
881 authority has:
882 (1) demonstrated the willingness and potential ability to assure that health care
883 services will be provided in such a manner as to enhance and assure both the availability and
884 accessibility of adequate personnel and facilities;
885 (2) arrangements for an ongoing evaluation of the quality of health care;
886 (3) a procedure to develop, compile, evaluate, and report statistics relating to the
887 cost of its operations, the pattern of utilization of its services, the quality, availability and
888 accessibility of its services, and such other matters as may be reasonably required by regulation
889 of the [commissioner] of health;
890 (4) reasonable provisions for emergency and out of area health care services;
891 (5) demonstrated that it is financially responsible and may reasonably be expected
892 to meet its obligations to enrollees and prospective enrollees. In making this determination, the
893 [commissioner] of health shall require the amount of initial net worth required in [insert citation],
894 compliance with the risk-based capital standards under Article I of this Act, the deposit required
895 in [insert citation], and in addition shall consider:
896 (a) the financial soundness of its arrangements for health care services and
897 the proposed schedule of charges used in connection therewith;
898 (b) arrangements which will guarantee for a reasonable period of time the
899 continued availability or payment of the cost of health care services in the event of
900 discontinuance of the health maintenance organization; and

(c) agreements with providers for the provision of health care services;

(6) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(a) a health maintenance organization from obtaining insurance or making other arrangements

(i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds [$5,000] in any year,

(ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or

(iii) for not more than [95 percent] of the amount by which the health maintenance organization's costs for any of its fiscal years exceed [105 percent] of its income for such fiscal years; and

(b) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of [insert citation];

(7) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in [insert citation]. However, the [commissioner] is not precluded from finding that a particular transaction is an unreasonable expense as described in [insert citation] even if the directors follow the required procedures; and otherwise met the requirements of sections [insert citation].

Section 4. [*Required Deposit*.] Each health maintenance organization shall deposit with any organization or trustee acceptable to the [commissioner] through which a custodial or controlled account is utilized, bankable funds in the amount required in this section. The [commissioner] may allow a health maintenance organization's deposit requirement to be funded by an organization approved by the [commissioner].

Section 5. [*Definition*.] If a health maintenance organization offers supplemental benefits as described in [insert citation], “expenses” does not include any expenses attributable to the supplemental benefit.

Section 6. [*Initial Net Worth Requirement*.] Beginning organizations shall maintain net worth of at least [8-1/3 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or $1,500,000,] whichever is greater.

Section 7. [*Solvency*.] A community integrated service network is exempt from the deposit, reserve, and solvency requirements specified in sections 4 and 5 of this Article and [insert citation] and shall comply instead with sections [insert citation]. To the extent that there are analogous definitions or procedures in [insert citation] or in rules promulgated thereunder, the [commissioner] shall follow those existing provisions rather than adopting a contrary approach or interpretation.

950 Section 8. [*Applicability*.] For purposes of sections [insert citation], the terms defined in
951 this section have the meanings given. Other terms used in those sections have the meanings
952 given in sections 4 and 5 of this Article and [insert citation].
953
954 Section 9. [*Guaranteeing Organization*.]
955 (A) [Use of Guaranteeing Organization.]
956 (1) A community network may satisfy its net worth and deposit requirements, in
957 whole or in part, through the use of [one] or more guaranteeing organizations, with the approval
958 of the [commissioner], under the conditions permitted in this section. If the guaranteeing
959 organization is used only to satisfy the deposit requirement, the requirements of this section do
960 not apply to the guaranteeing organization.
961 (2) For purposes of this section, a "guaranteeing organization" means an
962 organization that has agreed to assume the responsibility for the obligation of the community
963 network's net worth requirement.
964 (3) Governmental entities, such as counties, may serve as guaranteeing
965 organizations subject to the requirements of this section.
966 (B) [Responsibilities of Guaranteeing Organization.] Upon an order of rehabilitation or
967 liquidation, a guaranteeing organization shall transfer funds to the [commissioner] in the amount
968 necessary to satisfy the net worth requirement.
969 (C) [Requirements for a Guaranteeing Organization.]
970 (1) A community network's net worth requirement may be guaranteed provided
971 that the guaranteeing organization:
972 (a) transfers into a restricted asset account cash or securities permitted by
973 [insert citation] in an amount necessary to satisfy the net worth requirement. Restricted asset
974 accounts shall be considered admitted assets for the purpose of determining whether a
975 guaranteeing organization is maintaining sufficient net worth. Permitted securities shall not be
976 transferred to the restricted asset account in excess of the limits applied to the community
977 network, unless approved by the [commissioner] in advance;
978 (b) designates the restricted asset account specifically for the purpose of
979 funding the community network's net worth requirement;
980 (c) maintains positive working capital subsequent to establishing the
981 restricted asset account, if applicable;
982 (d) maintains net worth, retained earnings, or surplus in an amount in
983 excess of the amount of the restricted asset account, if applicable, and allows the guaranteeing
984 organization:
985 (i) to remain a solvent business organization, which shall be
986 evaluated on the basis of the guaranteeing organization's continued ability to meet its maturing
987 obligations without selling substantially all its operating assets and paying debts when due; and
988 (ii) to be in compliance with any state or federal statutory net
989 worth, surplus, or reserve requirements applicable to that organization or lesser requirements
990 agreed to by the [commissioner]; and
991 (e) fulfills requirements of clauses (a) to (d) by [April 1] of each year.
992 (2) The [commissioner] may require the guaranteeing organization to complete
993 the requirements of (C) (1) more frequently if the amount necessary to satisfy the net worth
994 requirement increases during the year.
995 (D) [Exceptions to Requirements.] When a guaranteeing organization is a governmental
996 entity, section 9 (C) of this Article III is not applicable. The [commissioner] may consider factors
997 which provide evidence that the governmental entity is a financially reliable guaranteeing
998 organization. Similarly, when a guaranteeing organization is a state-licensed health maintenance

999 organization, health service plan corporation, or insurer, subdivision (C)(1), paragraphs a and b
1000 are not applicable.
1001 (E) [Amounts Needed To Meet Net Worth Requirements.] The amount necessary for a
1002 guaranteeing organization to satisfy the community network's net worth requirement is the lesser
1003 of an amount needed to bring the community network's net worth to the amount required by
1004 [insert citation]; or an amount agreed to by the guaranteeing organization.
1005 (F) [Consolidated Calculations For Guaranteed Community Networks.]
1006 (1) If a guaranteeing organization guarantees one or more community networks,
1007 the guaranteeing organization may calculate the amount necessary to satisfy the community
1008 networks' net worth requirements on a consolidated basis.
1009 (2) Liabilities of the community network to the guaranteeing organization must be
1010 subordinated in the same manner as preferred ownership claims under section [insert citation].
1011 (G) [Agreement Between Guaranteeing Organization And Community Network.] A
1012 written agreement between the guaranteeing organization and the community network must
1013 include the [commissioner] as a party and include the following provisions:
1014 (1) any or all of the funds needed to satisfy the community network's net worth
1015 requirement shall be transferred, unconditionally and upon demand, according to subdivision 2;
1016 (2) the arrangement shall not terminate for any reason without the [commissioner]
1017 being notified of the termination at least nine months in advance. The arrangement may
1018 terminate earlier if net worth requirements will be satisfied under other arrangements, as
1019 approved by the [commissioner];
1020 (3) the guaranteeing organization shall pay or reimburse the [commissioner] for
1021 all costs and expenses, including reasonable attorney fees and costs, incurred by the
1022 [commissioner] in connection with the protection, defense, or enforcement of the guarantee;
1023 (4) the guaranteeing organization shall waive all defenses and claims it may have
1024 or the community network may have pertaining to the guarantee including, but not limited to,
1025 waiver, release, res judicata, statute of frauds, lack of authority, usury, illegality;
1026 (5) the guaranteeing organization waives present demand for payment, notice of
1027 dishonor or nonpayment and protest, and the [commissioner] shall not be required to first resort
1028 for payment to other sources or other means before enforcing the guarantee;
1029 (6) the guarantee may not be waived, modified, amended, terminated, released, or
1030 otherwise changed except as provided by the guarantee agreement, and as provided by applicable
1031 statutes;
1032 (7) the guaranteeing organization waives its rights under the Federal Bankruptcy
1033 Code, United States Code, title 11, section 303, to initiate involuntary proceedings against the
1034 community network and agrees to submit to the jurisdiction of the [commissioner] and state
1035 courts in any rehabilitation or liquidation of the community network;
1036 (8) the guarantee shall be governed by and construed and enforced according to
1037 the laws of this state; and
1038 (9) the guarantee must be approved by the [commissioner].
1039 (H) [Submission of Guaranteeing Organization's Financial Statements.] The community
1040 network shall submit to the [commissioner] the guaranteeing organization's audited financial
1041 statements annually by [April 1] or at a different date if agreed to by the [commissioner]. The
1042 community network shall also provide other relevant financial information regarding a
1043 guaranteeing organization as may be requested by the [commissioner].
1044 (I) [Performance as Guaranteeing Organization Voluntary.] No provider may be
1045 compelled to serve as a guaranteeing organization.
1046 (J) [Guarantor Status in Rehabilitation or Liquidation.] Any or all of the funds in excess
1047 of the amounts needed to satisfy the community network's obligations as of the date of an order

1048 of liquidation or rehabilitation shall be returned to the guaranteeing organization in the same
1049 manner as preferred ownership claims under [insert citation].
1050
1051 Article IV
1052 Securities Regulation Technical Changes
1053
1054 Section 1. [*Authorized Disclosures of Information and Data*.]
1055 (A) [Authorized Disclosures of Information and Data.] The [commissioner] may release
1056 and disclose any active or inactive investigative information and data to any national securities
1057 exchange or national securities association registered under the Securities Exchange Act of 1934
1058 when necessary for the requesting agency in initiating, furthering, or completing an
1059 investigation.
1060 (B) The [commissioner] may release any active or inactive investigative data relating to
1061 the conduct of the business of insurance to the [Office of the Comptroller of the Currency or the
1062 Office of Thrift Supervision] in order to facilitate the initiation, furtherance, or completion of the
1063 investigation.
1064
1065 Section 2. [Confidentiality of Information.] The [commissioner] may not be required to
1066 divulge any information obtained in the course of the supervision of insurance companies, or the
1067 examination of insurance companies, including examination-related correspondence and
1068 workpapers, until the examination report is finally accepted and issued by the [commissioner],
1069 and then only in the form of the final public report of examinations. Nothing contained in this
1070 subdivision prevents or shall be construed as prohibiting the [commissioner] from disclosing the
1071 content of this information to the insurance department of another state, the National Association
1072 of Insurance Commissioners, or any national securities association registered under the
1073 Securities Exchange Act of 1934, if the recipient of the information agrees in writing to hold it as
1074 nonpublic data as defined in section 13.02, in a manner consistent with this subdivision. This
1075 subdivision does not apply to the extent the [commissioner] is required or permitted by law, or
1076 ordered by a court of law to testify or produce evidence in a civil or criminal proceeding. For
1077 purposes of this subdivision, a subpoena is not an order of a court of law.
1078
1079 Section 3. [*Examination Report; Foreign And Domestic Companies*.]
1080 (A) [Examination Report; Foreign And Domestic Companies.] The [commissioner] shall
1081 make a full and true report of every examination conducted pursuant to this chapter, which shall
1082 include:
1083 (1) a statement of findings of fact relating to the financial status and other matters
1084 ascertained from the books, papers, records, documents, and other evidence obtained by
1085 investigation and examination or ascertained from the testimony of officers, agents, or other
1086 persons examined under oath concerning the business, affairs, assets, obligations, ability to fulfill
1087 obligations, and compliance with all the provisions of the law of the company, applicant,
1088 organization, or person subject to this chapter and
1089 (2) a summary of important points noted in the report, conclusions,
1090 recommendations and suggestions as may reasonably be warranted from the facts so ascertained
1091 in the examinations. The report of examination shall be verified by the oath of the examiner in
1092 charge thereof, and shall be prima facie evidence in any action or proceedings in the name of the
1093 state against the company, applicant, organization, or person upon the facts stated therein.
1094 (B) [Verified Written Report of Examination.] No later than [60 days] following
1095 completion of the examination, the examiner in charge shall file with the department a verified
1096 written report of examination under oath. Upon receipt of the verified report, the department

shall transmit the report to the company examined, together with a notice which provides the company examined with a reasonable opportunity of not more than [30 days] to make a written submission or rebuttal with respect to matters contained in the examination report.

(C) [Review Written Report of Examination.] Within [30 days] of the end of the period allowed for the receipt of written submissions or rebuttals, the [commissioner] shall fully consider and review the report, together with the written submissions or rebuttals and the relevant portions of the examiner's workpapers and enter an order:

(1) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, or prior order of the [commissioner], the [commissioner] may order the company to take any action the [commissioner] considers necessary and appropriate to cure the violation;

(2) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refiling the report as required under paragraph (B); or

(3) calling for an investigatory hearing with no less than [20 days]' notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(D) [Orders to be Accompanied by Applicable Material.]

(1) All orders entered under paragraph (C), clause (1), must be accompanied by findings and conclusions resulting from the [commissioner]'s consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. The order is a final administrative decision and may be appealed as provided under [insert citation]. The order must be served upon the company by certified mail, together with a copy of the adopted examination report. Within [30 days] of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) A hearing conducted under paragraph (C), clause (3), by the [commissioner] or authorized representative, must be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the [commissioner]'s review of relevant workpapers or by the written submission or rebuttal of the company. Within [20 days] of the conclusion of the hearing, the [commissioner] shall enter an order as required under paragraph (C), clause (1).

(3) The [commissioner] shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing must proceed expeditiously. Discovery by the company is limited to the examiner's workpapers which tend to substantiate assertions in a written submission or rebuttal. The [commissioner] or the [commissioner]'s representative may issue subpoenas for the attendance of witnesses or the production of documents considered relevant to the investigation whether under the control of the department, the company, or other persons. The documents produced must be included in the record. Testimony taken by the [commissioner] or the [commissioner]'s representative must be under oath and preserved for the record. This section does not require the department to disclose information or records which would indicate or show the existence or content of an investigation or activity of a criminal justice agency.

(4) The hearing must proceed with the [commissioner] or the [commissioner]'s representative posing questions to the people subpoenaed. Thereafter, the company and the [department] may present testimony relevant to the investigation. Cross-examination may be conducted only by the [commissioner] or the [commissioner]'s representative. The company and the [department] shall be permitted to make closing statements and may be represented by counsel of their choice.

1146 (E) [Confidentiality of Examination Report.]
1147 (1) Upon the adoption of the examination report under paragraph (C), clause (1),
1148 the [commissioner] shall continue to hold the content of the examination report as private and
1149 confidential information for a period of [30 days] except as otherwise provided in paragraph (B).
1150 Thereafter, the [commissioner] may open the report for public inspection if a court of competent
1151 jurisdiction has not stayed its publication.
1152 (2) Nothing contained in this subdivision prevents or shall be construed as
1153 prohibiting the [commissioner] from disclosing the content of an examination report, preliminary
1154 examination report or results, or any matter relating to the reports, to the [commerce department]
1155 or the insurance department of another state or country, or to law enforcement officials of this or
1156 another state or agency of the federal government at any time, if the agency or office receiving
1157 the report or matters relating to the report agrees in writing to hold it confidential and in a
1158 manner consistent with this subdivision.
1159 (3) If the [commissioner] determines that regulatory action is appropriate as a
1160 result of an examination, the [commissioner] may initiate proceedings or actions as provided by
1161 law.
1162 (F) [Confidentiality of Documents Related to Examination.] All working papers, recorded
1163 information, documents and copies thereof produced by, obtained by, or disclosed to the
1164 [commissioner] or any other person in the course of an examination made under this subdivision
1165 must be given confidential treatment and are not subject to subpoena and may not be made
1166 public by the [commissioner] or any other person, except to the extent provided in paragraph (E).
1167 Access may also be granted to the National Association of Insurance Commissioners and any
1168 national securities association registered under the Securities Exchange Act of 1934. The parties
1169 must agree in writing prior to receiving the information to provide to it the same confidential
1170 treatment as required by this section, unless the prior written consent of the company to which it
1171 pertains has been obtained.
1172
1173 Section 4. [*Severability*.] [Insert severability clause.]
1174
1175 Section 5. [*Repealer*.] [Insert repealer clause.]
1176
1177 Section 6. [*Effective Date.*] [Insert effective date.]