PROJECT HISTORY - 2016

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Referencing 2016 Cancer Claim Cost Valuation Tables)

1. Description of the Project, Issues Addressed, etc.

The 2016 Cancer Claim Cost Valuation Tables (2016 CCCVT) were proposed by the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Cancer Claim Cost Tables Work Group as the basis for a new minimum valuation standard for cancer insurance contracts issued on or after Jan. 1, 2019, to replace the current 1985 NAIC Cancer Claim Cost Tables. To do so, Model #10 had to be amended to make reference to the new tables.

2. Name of Group Responsible for Drafting the Model and States Participating

The Cancer Claims Cost Table (B) Subgroup—comprising regulator representatives from California, Georgia, Nebraska, New York and Utah—oversaw the drafting of the proposed amendments to Model #10.

3. Project Authorized by What Charge and Date First Given to the Group

In May 2004, the Accident and Health Working Group of the Life and Health Actuarial Task Force (predecessor of the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force) charged the Academy and the SOA with developing tables to replace the 1985 NAIC Cancer Claim Cost Tables for active life reserves associated with contracts issued past a date to be specified later. As the Academy neared completion of its charge to develop the tables, the Health Actuarial (B) Task Force appointed the Cancer Claims Cost Table (B) Subgroup. The Subgroup was charged with overseeing the addition of references to the table to Model #10, and collaborating with the Statutory Accounting Principles (E) Working Group to add references to the table in the *Accounting Practices and Procedures Manual*.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The initial draft of the amendments to Model #10 was provided to the Cancer Claims Cost Table (B) Subgroup by America's Health Insurance Plans (AHIP). The draft was discussed and modified, with input from interested regulators and the industry, on an open conference call of the Subgroup held Dec. 22, 2016. The final version of the proposed amendments to Model #10 was adopted by the Subgroup on a conference call held Feb. 8, 2017. The Health Actuarial (B) Task Force adopted the proposed amendments to Model #10 on a conference call held Feb. 24, 2017. The Health Insurance and Managed Care (B) Committee adopted the proposed amendments to Model #10 on a conference call held March 16, 2017.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force voted at the 2016 Summer National Meeting to expose the 2016 CCCVT for a public comment period ending Oct. 6, 2016. Several comments from regulators and the industry were received concerning how to compute reserves for benefits other than those addressed by the two CCCVT tables, first occurrence and hospitalization. Regulators, the industry and the Academy participated in drafting amendments to Model #10 to incorporate the 2016 CCCVT, and to address the valuation of benefits not covered by the two tables. The final version of the proposed amendments to Model #10 was adopted by the Cancer Claims Cost Table (B) Subgroup, the Health Actuarial (B) Task Force and the Health Insurance and Managed Care (B) Committee (please see item #4 for the dates of adoption by each group).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Please see item #5.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2016

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Referencing 2013 IDI Valuation Table)

1. Description of the Project, Issues Addressed, etc.

The 2013 Individual Disability Income (IDI) Valuation Table was proposed by the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Individual Disability Tables Work Group as the basis for a new minimum reserve valuation standard for IDI claims incurred and contracts issued on or after Jan. 1, 2020, to replace the current standard and its 1985 Commissioners Individual Disability A (CIDA) and 1985 Commissioners Individual Disability C (CIDC) Tables. Model #10 needs to be amended to make reference to the new table and the actuarial guideline that gives detailed instructions for its application.

2. Name of Group Responsible for Drafting the Model and States Participating

The Individual Disability Valuation Table Implementation (B) Subgroup, comprising regulator representatives from Alabama, California, Florida, Kansas, Nebraska, New York and Texas oversaw the drafting of the proposed amendments to the model and the associated actuarial guideline. The Subgroup was directed by the Health Actuarial (B) Task Force to coordinate and oversee the drafting of both of these.

3. Project Authorized by What Charge and Date First Given to the Group

The Health Actuarial (B) Task Force charged the Academy at the 2012 Fall National Meeting with developing a table to replace the 1985 CIDA and CIDC for claims incurred and contracts issued past a date to be specified later. As the Academy neared completion of its charge to develop the table, the Task Force formed the Individual Disability Income Valuation Table Implementation (B) Subgroup during its Aug., 1, 2014, conference call. The Subgroup was charged with overseeing addition of references to the table to Model #10, developing an actuarial guideline to implement use of the table and methodologies for its use, and collaborating with the Statutory Accounting Principles (E) Working Group to add references to the table in the *Accounting Practices and Procedures Manual* (AP&P Manual).

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The initial draft of the amendments to the model and the actuarial guideline were provided to the Subgroup by America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI). The draft was discussed and modified with input from interested regulators, industry and Academy participants on open conference calls of the Subgroup on April 1, 2015, Sept. 24, 2015, and Feb. 12, 2016. The final version of the proposed amendments to the model and the actuarial guideline were adopted by the Subgroup during its April. 14, 2016, conference call. The Health Actuarial (B) Task Force adopted the proposed amendments and the actuarial guideline during its April 14, 2016, conference call, as did the Health Insurance and Managed Care (B) Committee on its May 16 conference call.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force voted at the 2013 Fall National Meeting to expose the 2013 IDI Valuation Table, proposed amendments to the model and the actuarial guideline to implement the table for a public comment period ending June 30, 2014. Several comments from regulators and industry concerning the complexity of the table relative to the 1985 CIDA and CIDC tables, the need for sub-tables for more than one medical occupation class, and the need for separate claim incidence modifiers for each of voluntary and mandatory employer-sponsored policies were received. Regulators, industry and the Academy participated in revising the table implementation methodology, and the final version of the proposed amendments to the model and the guideline were adopted by the Subgroup, the Health Actuarial (B) Task Force, and the Health Insurance and Managed Care (B) Committee. (Please see 4. for dates of adoption by each group.)

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Please see 5.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2012

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Referencing 2012 GLTD Valuation Table and Associated Actuarial Guideline)

1. Description of the Project, Issues Addressed, etc.

The 2012 Group-Long Term Disability (GLTD) Valuation Table was proposed by the American Academy of Actuaries (AAA)/Society of Actuaries (SOA) Group Long-Term Disability Work Group as the basis for a new minimum reserve valuation standard for GLTD claims incurred on or after Oct. 1, 2016, to replace the current standard and its 1987 Commissioners Group Disability Table (CGDT). The *Health Insurance Reserves Model Regulation* (#10) needs to be amended to make reference to the new table and the actuarial guideline that gives detailed instructions for its application.

2. Name of Group Responsible for Drafting the Model and States Participating

The Group Long-Term Disability Valuation Table Implementation (B) Subgroup—composed of regulator representatives from Kansas, Nebraska, New Jersey and New York—oversaw the drafting of the proposed amendments to the model and the drafting of the associated actuarial guideline. The Subgroup was directed by the Health Actuarial (B) Task Force to coordinate and oversee the drafting of both of these.

3. Project Authorized by What Charge and Date First Given to the Group

The Health Actuarial (B) Task Force charged the AAA with developing a table to replace the 1987 CGDT for claims incurred past a date to be specified later at the NAIC Spring National Meeting on March 25, 2011. As the AAA neared completion of its charge to develop the table, the Task Force charged the Group Long-Term Disability Valuation Table Implementation (B) Subgroup with the following at the NAIC Summer National Meeting on Aug, 10, 2012:

> The Subgroup, upon NAIC Executive (EX) Committee favorable consideration of the model regulation request, shall develop revisions to the *Health Insurance Reserves Model Regulation* (#10) to implement changes to:
>
> 1. Add reference to the 2012 GLTD Valuation Table for GLTD reserves.
> 2. Clarify distinction between group LTD and other group disability products.
> 3. Replace use of own experience with a credibility blending approach.
>
> Further, the Subgroup shall develop an Actuarial Guideline to implement these changes to the model regulation, taking into consideration elements discussed in the American Academy of Actuaries' Aug. 10, 2012, letter to the Health Actuarial (B) Task Force. The Subgroup will also draft appropriate changes to Statement of Statutory Accounting Practices (SSAP) No. 54—*Individual and Group Accident and Health Contracts* and Appendix A-010 of the *Accounting Practices and Procedures Manual*.
>
> The Subgroup will attempt to provide the above documents to the Task Force by Oct. 1, 2012, for its consideration and subsequent exposure.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The initial draft of the amendments to the model and the draft actuarial guideline were provided to the Subgroup by America's Health Insurance Plans and the American Council of Life Insurers. The draft was discussed and modified with input from interested regulators, industry and AAA participants on open conference calls of the Subgroup held June 5, July 10, Nov. 15 and Dec. 4, 2013. The final version of the proposed amendments to the model and the final actuarial guideline were adopted by the Subgroup during its Dec. 4 call. The Health Actuarial (B) Task Force and the Health Insurance and Managed Care (B) Committee both adopted the proposed amendments and the actuarial guideline during the 2013 NAIC Fall National Meeting.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The 2012 GLTD Valuation Table, proposed amendments to the model, and the actuarial guideline to implement the table were exposed Sept. 12, 2012, for a 30-day public comment period. Many industry commenters felt that 30 days was not enough time to evaluate the tables and how they would be implemented through instructions in the actuarial guideline, and the exposure period was extended to May 31, 2013. Several comments from regulators and industry concerning the methodology for applying credibility to company experience used in modifying the tables and the effective date for use of the new table were received. Regulators, industry, and the AAA participated in revising the implementation methodology in the actuarial guideline, and the final versions of the proposed amendments to the model and the guideline were adopted by the Subgroup, the Health Actuarial (B) Task Force and the Health Insurance and Managed Care (B) Committee. Please see item #4 above for dates of adoption by each group.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Please see the response to item #5 above.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2003

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Long-Term Care Insurance Contract Reserve Requirements)

Description of Project and Issues Intended to be Addressed

Regulators have expressed concern that current minimum contract reserve standards for long-term care insurance may be inadequate given the recent incidence of rate increases and the new rate stability standards of the NAIC Long-Term Care Insurance Model Regulation requiring provision for moderately adverse deviation. Conversely, industry has expressed concern that contract reserve requirements for long-term care insurance generate excessive reserves and thus adversely affect insurance carrier returns, premium rates charged to consumers and future product availability. In response, the Accident and Health Working Group of the Life and Health Actuarial Task Force formed a subgroup in June 2002 to study the issue of minimum standards for long-term care insurance contract reserves. Long-term and short-term issues were identified. Noting a desire to quickly act on those issues that are immediately identifiable, a decision was made to address contract reserve valuation assumptions contained in the model regulation, while deferring overall contract reserve methodology review to a later date. The subgroup quickly narrowed the focus of the valuation assumption review to three major issues:

1. Prohibiting the use of assumed improvement in valuation morbidity tables beyond the valuation date for contracts for which tabular morbidity tables are not specified in the model regulation.
2. The need to add explicit levels of conservatism in morbidity assumptions.
3. Possible reduction in maximum allowable mortality and voluntary termination rates to reflect developing experience.

States That Participated in Drafting the Amendment to the Model

Member states of the Accident and Health Working Group of the Life and Health Actuarial Task Force are New Mexico (Chair), Alaska, Arkansas, Connecticut, Florida, Illinois, Maine, Minnesota, Nebraska, New York, Oklahoma, Texas, and Vermont.

Charge Authorizing Project

One of the 2003 charges of the task force is, "Study the methodology currently applicable to statutory reserves for long-term care insurance. Make recommendations for appropriate changes no later than the Winter National Meeting."

Procedure Followed in Drafting the Amendment to the Model Including Efforts Made to Assure All Interested Parties Were Provided An Opportunity to Comment During the Drafting Process

A subgroup of the Accident and Health Working Group of the Life and Health Actuarial Task Force was formed in June 2002 to study the issue of minimum valuation standards for long-term care insurance contract reserves. This matter was included as a specific agenda item at each quarterly meeting of the working group from June 2002 through December 2003, and correspondence was included in numerous mailings of the *Life and Health Actuarial Subscription* over that time period. In addition, five interim conference calls were conducted by the subgroup or the working group to discuss this topic. Industry representatives were invited to participate in the conference calls, and a number of verbal and written comments were received, including ones from the American Council of Life Insurers and the Health Insurance Association of America.

During the course of the drafting process, three separate drafts of proposed changes to the Health Insurance Reserves Model Regulation were prepared by the subgroup and released by the Accident and Health Working Group for comment, the latest following the October 23, 2003 interim conference call. These drafts were posted on the NAIC website and included in mailings of the *Life and Health Actuarial Subscription.* At the 2003 Winter National Meeting the working group recommended the proposed language be forwarded to the Life and Health Actuarial Task Force. At this same meeting the task force voted to recommend that the Health Insurance and Managed Care (B) Committee adopt the amendments, which it did.

Significant Issues Raised During the Due Process and Group's Response

An issue of concern to some regulators was the uncertainty of the financial impact of the proposed changes on carriers. In response to this concern the support of the American Academy of Actuaries Long-Term Care Reserving Work Group was enlisted to prepare for regulators an impact study on contract reserves of various changes being considered.

Regulators and interested parties also expressed other concerns, and the American Academy of Actuaries work group provided input to help regulators make informed decisions on many of these as well. One concern was the limited amount of actual lapse and mortality experience available for use in accurately revising the maximum allowable termination assumptions in the minimum contract reserves standards. Acknowledging the limited nature of available experience, regulators compromised by agreeing on amendments containing greater maximum allowable mortality and voluntary lapse rate standards than proposed in the initial drafts.

Regulators also considered requiring an explicit load for conservatism in the morbidity table used for calculating contract reserves. Regulators agreed to remove this provision based on arguments from interested parties that it may be overly conservative. However, a general provision was added to the contract reserve section requiring the total contract reserve established for all health insurance products incorporate provisions for moderately adverse deviation.

Industry groups were supportive of the restriction on use of future morbidity improvement after compromise language was developed preventing unintended consequences identified by them, and so long as it was not retroactive. The proposed changes allow in force business as of the effective date of the amendment to retain the original reserve morbidity basis, which may have included future improvement in morbidity, so long as it is acceptable to the commissioner.

Implications of this Project for Accreditation and Codification

This change has no impact on Accreditation.

Appendix A- Volume I of the *Accounting Practices and Procedures Manual* contains document No. A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, which is referenced by several Statements of Statutory Accounting Principles. No. A-010 is a virtual copy of the Health Insurance Reserves Model Regulation to which this amendment applies.

PROJECT HISTORY - 2003

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Single Premium Credit Disability Minimum Reserve Requirements)

Description of Project and Issues Intended to be Addressed

The Health Insurance Reserves Model Regulation was amended in June 2001 implementing inclusion of single premium credit disability insurance. Specific valuation morbidity tables were added as minimum standards for determining contract reserves for individual and group single premium credit disability insurance.

Most states currently require entities to hold the gross unearned premium reserve as the minimum contract reserve. The intent of the June 2001 amendment was to establish, following the effective date of the amendment, the minimum standard for contract reserves using a defined morbidity table, and to replace the gross unearned premium as the minimum reserve standard. However, the amendment did not clearly exclude single premium credit disability insurance from unearned premium reserve requirements included in the HIRMR. Therefore, some readers might interpret the existing language to require an insurer to hold both unearned premium and morbidity-based contract reserves. In addition, a reserve test requiring the sum of unearned premium reserves and contract reserves be no less than the gross modal unearned premium reserve could also increase the reserve held for single premium credit disability above the morbidity-based contract reserve.

Since the intent of the June 2001 amendment was that an unearned premium reserve not be required for single premium credit disability insurance after implementation of the valuation morbidity tables, an amendment to exclude single premium credit disability from all unearned premium reserve requirements has been proposed to clarify the intent of the 2001 amendment.

States That Participated in Drafting the Amendment to the Model

Member states of the Accident and Health Working Group of the Life and Health Actuarial Task Force are New Mexico (Chair), Alaska, Arkansas, Connecticut, Florida, Illinois, Maine, Minnesota, Nebraska, New York, Oklahoma, Texas and Vermont.

Procedure Followed in Drafting the Amendment to the Model Including Efforts Made to Assure All Interested parties Were Provided An Opportunity to comment During the Drafting Process

Interested parties, Chris Hause (Hause Actuarial), Bob Butler (Assurant Group) and Steve Ostlund (Protective Life Corp.) brought this issue to the attention of the working group in March 2003. They noted that the legislature of the state of Ohio was considering a revision to the June 2001 amendments to the model, similar to the one proposed here, prior to adopting it.

At the 2003 Summer National Meeting, the working group reviewed language proposed by Mr. Hause to amend the model. Following discussion, the working group agreed immediate action was desirable and recommended the proposed language be released for comment. The June 2003 draft was posted on the NAIC website and was included in the June mailing of the *Life and Health Actuarial Subscription*. This matter was included as a specific agenda item at the June 2003 and September 2003 quarterly meetings of the working group.

Significant Issues Raised During the Due Process and Group's Response

No comments were received on the proposed language during the three-month comment period. At the 2003 Fall National Meeting the working group recommended adoption of the draft language released for exposure, but with a slight change in wording and the addition of a drafting note to further clarify the intent. The Life and Health Actuarial Task Force agreed with the working group recommendation to adopt the amendment.

Implications of this Project for Accreditation and Codification

This change has no impact on accreditation.

Appendix A- Volume I of the *Accounting Practices and Procedures Manual* (APPM) contains document No. A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, which is referenced by several Statements of Statutory Accounting Principles. No. A-010 is a virtual copy of the Health Insurance Reserves Model Regulation to which this amendment applies.

PROJECT HISTORY - 2003

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Disability Income Insurance Claim Reserve Requirements)

Description of Project and Issues Intended to be Addressed

The issue concerns interpretation of the proper length of the period for use of a company's own claim experience in determining morbidity assumptions used in setting disability income insurance claim reserves.

The Health Insurance Reserves Model Regulation provides, "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." Furthermore, "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."

There are two competing interpretations of this language. Some argue that for claims with duration less than two or five years for individual and group policies respectively that the model allows the claim reserve to be based entirely on the company's morbidity experience. Others maintain that company morbidity experience may only be used in setting that portion of claim reserve for benefits payable in the first two or five durations from date of disablement with tabular morbidity rates as specified in the model to be used to set the portion of claim reserve for benefits payable beyond duration two or five from date of disablement.

The first interpretation can produce a substantial increase in the claim reserve following duration two or five if the insurer's own morbidity assumption was used to set the entire reserve and that assumption varies to a great extent from the tabular morbidity assumption required to be used to set the reserve once the duration from date of disablement is beyond durations two or five. In an effort to promote consistency of interpretation and to eliminate substantial reserve increases, an amendment to the model language reflecting the second interpretation has been proposed.

States That Participated in Drafting the Amendment to the Model

Member states of the Accident and Health Working Group of the Life and Health Actuarial Task Force are New Mexico (Chair), Alaska, Arkansas, Connecticut, Florida, Illinois, Maine, Minnesota, Nebraska, New York, Oklahoma, Texas and Vermont.

Procedure Followed in Drafting the Amendment to the Model Including Efforts Made to Assure All Interested Parties Were Provided An Opportunity to Comment During the Drafting Process

A subgroup of the working group was formed in March 2002 to gather and review additional information on this issue. In addition to conducting a survey of the reserving methods used by major disability income carriers and a survey of state regulators as to how the model is interpreted in their state, several conference calls were also conducted by the subgroup. Industry representatives were invited to participate in the conference calls and the subgroup received a number of verbal and written comments. This matter was included as a specific agenda item at each quarterly meeting of the working group from March 2002 through September 2003, and correspondence was included in numerous mailings of the *Life and Health Actuarial Subscription* over that time period.

At the 2003 Summer National Meeting, the working group reviewed language to amend the model. Following discussion, the working group recommended the proposed language be released for comment. The June 2003 draft was posted on the NAIC website and was included in the June mailing of the *Life and Health Actuarial Subscription*. A conference call of the working group was held in August 2003 to discuss comments received on the draft.

Significant Issues Raised During the Due Process and Group's Response

Initial comments from the industry noted a concern with clarity and potential for continued varying interpretations of the language originally considered as the proposed revision to the model. Industry also suggested a survey be taken of the methods being used to develop disability claim reserves during the initial two- or five-year period. In response the subgroup surveyed, with industry input on survey development, major disability income insurance writers on methods used to calculate claim reserves. A survey was also made of state regulators on their interpretation of current model language. During its

review, the subgroup considered alternative solutions for addressing the issue including taking no action to amend the model and revising the *Health Reserve Guidance Manual* to indicate the need for asset adequacy analysis to consider this issue. The working group agreed amending the model to be the best course of action.

Another issue was the effective date of the amendment and whether it was to be prospective only. The subgroup proposed a January 1, 2005, effective date that allows reasonable time for states to enact the amendment. In addition, the date will be bracketed so states can choose an alternative date to accommodate timing issues. They also agreed the revisions shall apply only to claims incurred on or after the effective date in recognition of the fact the change could have significant impact on carriers that used a varying interpretation of the current model language. However, the language allows carriers to select the amended method for all prior claims if they so desire.

Some comments received during the comment period pertained to portions of Section 2 – Claim Reserves other than those to which amendments are being proposed. The working group noted that these comments deserve consideration and discussion, however, since they broaden the scope of this particular issue, a decision was made to defer such consideration to such time a more thorough review of the model is undertaken.

Over the course of due process, the draft language was revised on multiple occasions in an effort to better reflect the intent of the proposed amendment and remove potential ambiguity. Ultimately, industry representatives offered their support to the final draft language.

At the 2003 Fall National Meeting the working group recommended adoption, without change, of the draft language released for exposure, and the Life and Health Actuarial Task Force also recommended adoption of the amendment to the model.

Implications of this Project for Accreditation and Codification

This change has no impact on accreditation.

Appendix A- Volume I of the *Accounting Practices and Procedures Manual* contains document No. A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, which is referenced by several Statements of Statutory Accounting Principles. No. A-010 is a virtual copy of the Health Insurance Reserves Model Regulation to which this amendment applies.

PROJECT HISTORY - 2001

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)

Project Description: Review recommendations from the Society of Actuaries (SOA) relative to revisions concerning current minimum morbidity valuation standards for single premium credit disability insurance, and if appropriate, propose revisions.

Drafting group: Accident and Health Working Group (A&HWG) of the Life and Health Actuarial Task Force member states are: Minnesota, Chair, Alaska, Arkansas, Connecticut, Florida, Illinois, Kansas, Maine, Michigan, New Hampshire, Nebraska, New Mexico, Oklahoma, South Carolina, Texas.

Charge authorizing project: 2000 Charge for the Life and Health Actuarial Task Force: Continue discussions on the recommendations from the Society of Actuaries regarding revisions to the Health Insurance Reserves Model Regulation concerning single premium credit disability income valuation tables. Report recommendations as to whether changes to the model regulation should be made no later than the Winter National Meeting

Drafting process: Proposed revisions to the model were drafted by the A&HWG and revised based on comments from working group members and interested parties.

Due process:

National Meeting Date	Description of Activity
May, 2000	As agreed upon at the 2000 Spring National Meeting, the working group sent a letter to the Society of Actuaries (SOA) requesting that they review current minimum morbidity valuation standards for single premium credit disability insurance, and to recommend, as appropriate, valuation morbidity tables. The Society of Actuaries (SOA) established the Task Force to Recommend Morbidity Standards for Valuation of Credit Disability Benefits.
Nov., 2000	The A&HWG received the final report of the SOA's Task Force at the 2000 Winter National Meeting.
March, 2001	At the 2001 Spring National Meeting, the working group discussed a draft of the Health Insurance Reserves Model Regulation that incorporated the SOA recommendations. Immediately following the national meeting, a March 28, 2000 draft was exposed that incorporated revisions based upon all of the comments from regulators and interested parties that had been received to-date.
June, 2001	At the Summer National Meeting, the A&HWG, the Life and Health Actuarial Task Force, and the Health Insurance and Managed Care (B) Committee adopted the March 28, 2000 draft of the model with two revisions for clarification, and forward it to the Executive (EX) Committee with a recommendation for adoption.

Significant issues:
States have historically required unearned premium reserves as the standard method for determining policy reserves. The adoption of this model could cause an estimated overall reduction in policy reserves for single premium credit disability insurance of 25% to 30%.