

Statutory Issue Paper No. 54

Individual and Group Accident and Health Contracts

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SUMMARY OF ISSUE

1. Current statutory accounting guidance on income recognition and policy reserves for individual and group accident and health contracts, as defined in *Issue Paper No. 50—Classifications and Definitions of Insurance or Managed Care Contracts In Force* (Issue Paper No. 50), is addressed in Chapter 13, Aggregate Reserves for Accident and Health Policies and Chapter 18, Premium Income, in the Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies (Life/A&H Accounting Practices and Procedures Manual). That guidance addresses income recognition and policy reserves related to individual and group accident and health contracts. Under current statutory accounting, premiums are recorded on a gross basis when due from policyholders and policy and claim reserves are computed based upon specific contract provisions and the methods described in the NAIC Model Law, Minimum Reserve Standards for Individual and Group Health Insurance Contracts (Individual and Group Health Model Law), the Long-Term Care Insurance Model Regulation, and the Actuarial Standards of Practice promulgated by the American Academy of Actuaries. Further, policy and claim reserves must, in the aggregate, place a sound value on both present and future liabilities.

2. GAAP requires insurance contracts to be classified as short-duration or long-duration contracts. Long-duration contracts are those contracts expected to remain in force for an extended period and include certain noncancelable and guaranteed renewable accident and health contracts. All other insurance contracts are considered short-duration contracts and include most property and liability insurance contracts. Premiums from short-duration contracts ordinarily are recognized as revenue over the period of the contract in proportion to the amount of insurance protection provided. Claim costs, including estimates of costs for claims relating to insured events that have occurred but have not been reported to the reporting entity, are recognized when insured events occur. GAAP guidance requires policy reserves for individual and group accident and health classified as long-duration to be established using actuarial assumptions applicable at the time the insurance contracts are made, or for short-duration contracts, using an unearned premium reserve.

3. The purpose of this issue paper is to establish statutory accounting principles for policy and claim reserves for all individual and group accident and health contracts consistent with the Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy (Statement of Concepts). Credit accident and health insurance contracts are discussed in *Issue Paper No. 59—Credit Life and Accident and Health Insurance Contracts*.

SUMMARY CONCLUSION

Income Recognition

4. Premiums shall be recognized as income on the gross basis (amount charged to the policyholder or subscriber exclusive of copayments or other charges related to the receipt of healthcare services) when due from policyholders or subscribers, but no earlier than the effective date of coverage under the terms of the contract. Due and uncollected premiums shall follow the guidance in *Issue Paper No. 10—*

Uncollected Premium Balances (Issue Paper No. 10), to determine the admissibility of premiums and related receivables. Premiums waived by the reporting entity under disability provisions contained in its policies and contracts, and reported in operations as a disability benefit, are included in premium income.

5. Premium income shall exclude premiums that have been received by the reporting entity on or prior to the valuation date but which are due after the valuation date (i.e., advance premiums as discussed below).

6. Premium income shall be reduced for premiums returned and allowances to industrial policyholders for the direct payment of premiums.

7. Premium income shall be increased by reinsurance premiums assumed and reduced by reinsurance premiums ceded. Reinsurance premiums assumed and ceded shall be defined and addressed in *Issue Paper No. 74—Life, Deposit-Type and Accident and Health Reinsurance*.

8. Advance premiums are those premiums that have been received by the reporting entity prior to or on the valuation date but which are due after the valuation date. The total amount of such advance premiums is reported as a liability in the statutory financial statement and is not considered premium income until due. The gross premium, not the net valuation premium, is recorded as the advance premium in recognition of the company's liability to refund such premiums in the event the policy is terminated.

9. As discussed in *Issue Paper No. 47—Uninsured Plans*, amounts received on behalf of uninsured plans or the uninsured portion of partially insured plans shall not be reported as premium income. Administrative fees for servicing the uninsured plans shall be deducted from general insurance expenses. Conversely, income relating to the insured portion of any plan shall be reported as premium income.

Reserve Requirements

10. The aggregate reserve for individual and group accident and health contracts generally consists of a policy reserve and a claim reserve as well as certain other miscellaneous reserves discussed in paragraphs 26 and 27. The aggregate reserve reflects the future liabilities arising under accident and health insurance policies. Policy reserves have traditionally been referred to as active life reserves and include unearned premium reserves. Policy reserves reflect that premiums cover future liabilities in addition to current claim costs and expenses. Claim reserves, sometimes referred to as disabled life reserves, are required on claims which involve continuing loss. The reserve in this case is a measure of the present value of future benefits or amounts not yet due as of the statement date (the unaccrued portion) which are expected to arise under claims which have been incurred as of the statement date. The aggregate reserve for individual and group accident and health contracts does not include claim liabilities which are the amounts payable at the reporting date (the accrued portion) and reflect the reporting entity's liability for benefits due as of the statement date. Claim liabilities are further discussed in *Issue Paper No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*.

11. Policy reserves for individual and group accident and health contracts shall include an unearned premium reserve and, as applicable, an additional or contract reserve where constant or level premiums are assumed for certain noncancelable or guaranteed renewable contracts. The claim reserve shall consist of a reserve for the present value of amounts not yet due.

12. Statutory policy reserves shall be established for all unmatured contractual obligations of the reporting entity arising out of the provisions of the contract. Where separate benefits are included in a contract, a reserve for each benefit shall be established as required in Appendix A-820. A prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Statutory reserves meet the definition of liabilities as defined in *Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets* (Issue Paper No. 5). The actuarial methodologies referred to in the following paragraph meet the criteria required for reasonable estimates in Issue Paper No. 5.

13. The reserving methodologies and assumptions used in calculating individual and group accident and health reserves shall meet the provisions of Appendices A-010, A-641, A-820 and A-822 and the actuarial guidelines found in Part 9 of the NAIC Financial Examiners Handbook. Further, policy reserves shall be in compliance with those Actuarial Standards of Practice promulgated by the Actuarial Standards Board.

Policy Reserves

14. Unearned premium reserves shall be required for all accident and health contracts for which premiums have been reported for a period beyond the date of valuation other than premiums paid in advance. The minimum unearned premium reserve that applies to the premium period beyond the valuation date shall be based on the valuation net modal premium if contract reserves are required and the gross modal unearned premium reserve if contract reserves are not required. If premiums due and unpaid are carried as an asset, such 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. In no event, however, shall the aggregate policy reserve for all contracts be less than the unearned gross premium under such contracts. Additionally, the reserve shall never be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for elsewhere.

15. Contract or additional reserves on accident and health contracts shall be recorded when premiums and benefits are not earned or incurred at the same incidence over the policy period (e.g., contracts having premiums determined on an issue-age basis where premiums and related morbidity, risk of loss, and the cost of coverage are not evenly matched). 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 (e.g., community-rated contracts). The additional reserves shall be set aside from the early years' level premiums to pay the claims that experience indicates will be incurred as the policy continues in force. The fact that the reporting entity may have the right to increase premiums or to decline renewal of the policies for certain reasons has no bearing on whether or not a contract or additional reserve should be held. These reserves shall apply to regardless of whether or not benefits are currently being received, and are in addition to unearned premium reserves discussed in paragraph 14.

16. Contract or additional reserves shall also be recorded where, due to the gross premium structure, the future benefits exceed the future net premiums (e.g., group conversion policies) or where the contract provides for the extension of benefits after the termination of the coverage (e.g., deferred maternity and other similar benefits).

17. A terminal reserve for accident and health contracts is the policy reserve at the end of a policy year to cover the assumed difference between future benefits and future net premiums. The components used to compute a terminal reserve shall consist of an interest rate, a mortality and/or morbidity table, and a valuation method (e.g., net level, one-year full preliminary term, and two-year full preliminary term) and where allowed, other assumptions. A terminal reserve is based on the assumption that all net premiums have been received, all interest earned, and all benefits paid to the end of the policy year.

18. Since terminal reserves are computed as of the end of a policy year and not the reporting date, the terminal reserve as of policy anniversaries immediately prior to and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date. This is generally accomplished using either the mean reserve method or the mid-terminal method as described in paragraph 22 of *Issue Paper No. 51—Life Contracts* (Issue Paper No. 51). Other appropriate methods, including an exact reserve valuation, may also be used.

19. For individual accident and health contracts, negative reserves on any benefit shall be offset against positive reserves for other benefits in the same policy but the mean reserve on any policy shall

never be taken as less than one-half the valuation net premium. The majority of group accident and health policies are written in conjunction with group life or other policies. If these policies are an experience rated package, positive or favorable margins on one of the contracts can offset the need to establish additional reserves on the other contracts.

Additional Reserves

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

Claim Reserves

21. Claim reserves shall be accrued for estimated cost of future health care services to be rendered that the reporting entity is currently obligated to provide as a result of premiums earned to date and that would be payable after the reporting date under the terms of arrangements, regulatory requirements or other requirements if the insured's or subscriber's illness or disability were to continue. It shall include a reserve for disability benefits covered under premium waiver provisions. For individual and group disability claims with a duration of less than two years, reserves may be based on the reporting entity's experience, if credible, or other methods, as appropriate. Generally, reserves for disability income claims with durations of greater than two years shall be determined based on a tabular method using the age of the insured at the date of disablement, the number of months the insured already has been disabled, and the number of months remaining in the benefit period.

Reserve Recognition

22. The difference between the aggregate reserve for accident and health contracts at the beginning and end of the reporting period shall be reflected in the summary of operations, except for any difference due to a change in valuation basis.

Change In Valuation Basis

23. A change in valuation basis shall be defined as a change in the interest rate, mortality or morbidity assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in *Issue Paper No. 3—Accounting Changes* (Issue Paper No. 3). Consistent with Issue Paper No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus rather than as a part of the reserve change recognized in the summary of operations. The impact on surplus is based on the difference between the reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless an actuarial guideline adopted by the NAIC prescribes a new method and a specific transition that allows for grading.

Supplemental Benefits

24. In addition to the basic policy benefit, the contract may provide supplemental benefits. Supplemental benefits include, but are not limited to, accidental death benefits, dental and waiver of premium benefits. If the terms of the contract provide for these benefits, appropriate reserves shall be established in accordance with the applicable standards within this Codification.

Reserve Adequacy

25. As discussed in Appendix A-010, a prospective gross premium valuation is the ultimate test of the adequacy of a reporting entity's accident and health reserves as of a given valuation date and shall be

determined on the basis of unearned premium reserves, contract or additional reserves, claim reserves (including claim liabilities), and miscellaneous reserves combined; however, each component shall be computed separately.

Additional Reserves Not Included Elsewhere

26. Reserve for experience-rating refunds or the dividend liability in group policies are discussed in *Issue Paper No. 66—Accounting for Retrospectively Rated Contracts*.

27. Additional actuarial or other liabilities are commonly held for such items as:

- a. Surrender values in excess of reserves otherwise required or carried;
- b. Additional reserves required based on cash flow testing and/or asset/liability matching requirements; and
- c. Additional reserves for policies which contain conversion privileges or future contingent benefits.

Contracts Subject to Redetermination

28. This statement also applies to other contracts which are subject to redetermination such as Federal (and State) Groups – subject to rate adjustments through audits by the Office of Personnel Management (“OPM”). Reporting entities are required to give Federal Groups the lowest rates that are being charged to similar groups.

29. Amounts due from insureds or subscribers and amounts due to insureds or subscribers under contracts subject to redetermination meet the definitions of assets and liabilities as set forth in *Issue Paper No. 4—Definition of Assets and Nonadmitted Assets* and *Issue Paper No. 5*, respectively.

30. Contract redeterminations shall be estimated based on the experience to date. The method used to estimate the liability shall be reasonable based on the reporting entity’s procedures, and consistent among reporting periods. An examination of contract requirements in relation to the rates being charged and the current status of applicable audits (e.g., OPM, Health Care Finance Administration and other Federal, state or government department) is a common method used to estimate such contract redeterminations.

31. Premium adjustments for contracts subject to redetermination are estimated for the portion of the policy period that has expired and shall be considered an immediate adjustment to premium. Accrued premium adjustments shall be recorded as a write-in for other-than-invested assets, with a corresponding entry to premiums; accrued return premium adjustments shall be recorded as a liability with a corresponding entry to premiums.

32. If, in accordance with *Issue Paper No. 5*, it is probable that the additional premium adjustment is uncollectible, any uncollectible premium shall be written off against operations in the period the determination is made and the disclosure requirements outlined in *Issue Paper No. 5* shall be made.

33. Premium adjustments for contracts subject to redetermination shall be determined and billed or refunded in accordance with the policy provisions or contract provisions. If such premiums are not billed in accordance with the policy provisions or contract provisions, or the policy provisions or contract provisions do not address the due date of such premiums, the accrual shall be nonadmitted. This is consistent with the guidance for audit premiums established in *Issue Paper No. 10*.

Disclosures

34. Disclose the aggregate amount of direct premiums written through managing general agents or third party administrators. For purposes of this disclosure, a managing general agent means the same as in

Appendix A-225. If this amount is equal to or greater than 5% of surplus, provide the following information for each managing general agent and third party administrator:

- a. Name and address of managing general agent or third party administrator;
- b. Federal Employer Identification Number;
- c. Whether such person holds an exclusive contract;
- d. Types of business written;
- e. Type of authority granted (i.e., underwriting, claims payment, etc.);
- f. Total premium written.

35. If a premium deficiency reserve is established in accordance with paragraph 20, disclose the amount of that reserve.

DISCUSSION

36. This issue paper adopts the current statutory accounting guidance for premiums, policy reserves, and claim reserves associated with accident and health contracts. However, paragraph 20 of this issue paper expands the current requirements for reserving for contracts where due to the gross premium structure, future benefits exceed future premiums.

37. The statutory accounting principles outlined in the conclusion above are consistent with the conservatism, consistency and recognition concepts in the Statement of Concepts which state:

Conservatism

Financial reporting by insurance enterprises requires the use of substantial judgments and estimates by management. Such estimates may vary from the actual amounts for numerous reasons. To the extent that factors or events result in adverse variation from management's accounting estimates, the ability to meet policyholder obligations may be lessened. In order to provide a margin of protection for policyholders, the concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory reporting.

Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency. Valuation procedures should, to the extent possible, prevent sharp fluctuations in surplus.

Consistency

The regulators' need for meaningful, comparable financial information to determine an insurer's financial condition requires consistency in the development and application of statutory accounting principles. Because the marketplace, the economic and business environment, and insurance industry products and practices are constantly changing, regulatory concerns are also changing. An effective statutory accounting model must be responsive to these changes and address emerging accounting issues. Precedent or historically accepted practice alone should not be sufficient justifications for continuing to follow a particular accounting principle or practice which may not coincide with the objectives of regulators.

Recognition

Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., excess of statutory reserves over statement reserves, interest maintenance reserves, asset valuation reserves, and others).

Claim Reserves - Indemnity and Managed Care Contracts

38. As discussed in paragraph 21, claim reserves shall be accrued for estimated amounts that would be payable after the reporting date if the insured's illness or disability were to continue. For health maintenance organizations claims reserves shall be provided if the benefits for the event extend beyond the contract period. For claims with a duration of less than two years, there are a variety of acceptable methods for calculation. Some of them are: (a) use of the disabled life table—either a published table or one based on the insurer's experience; (b) use of an estimate made by the insurer's claim department for each policy (the individual judgment approach); or (c) other appropriate estimation techniques.

39. The method used to compute the claim reserve must be appropriate in the circumstances. Historical development might provide information as to the appropriateness of the method used by developing statistics to show that its method would (or actually did) produce adequate reserves for prior valuation periods. If the loss-of-time policy provides a waiver of premium benefit, the reserve for policies that are having their premiums waived should be included with the disabled life reserves.

Level Premiums - Indemnity Contracts

40. As discussed in paragraph 15 of this issue paper, contract or additional reserves on accident and health contracts shall be recorded when premiums and benefits are not earned or incurred at the same incidence over the policy period. The Life/A&H Accounting Practices and Procedures Manual requires contract reserves on individual accident and health policies but does not specifically extend this requirement to group policies. This issue paper clarifies current SAP to require contract reserves on group accident and health policies, including those group accident and health contracts that are individually underwritten.

Future Contingent Benefits - Indemnity Contracts

41. A reporting entity shall establish a reserve for future contingent benefits which extend beyond the termination of the policy, subject to specific contract provisions. Such provisions which accrue and are payable at some future date, are predicated on a condition or actual disability which existed at the termination of the contract and which is usually not known to the reporting entity at the time of the termination (e.g., deferred maternity benefits). In situations where the actual disability is not known to the reporting entity at the time of the termination, the reserve shall be computed based on relevant pricing, periodic, or industry studies of similar benefits on terminated policies. Reporting entities shall separately compute a reserve for deferred maternity benefits and any other extended benefits under group contracts.

Extension of Benefits - Indemnity Contracts

42. An additional reserve shall be required for group accident and health contracts which contain a conversion privilege. The minimum additional reserve shall equal the excess morbidity costs assumed in the premium payable on the terminated coverages. If future guaranteed rates are inadequate to meet future obligations, then additional reserves shall be established. A reserve shall be established to cover the expected benefit payments for any policy having a conversion privilege or other similar extension of benefits when the policy is terminated with no additional premiums due but the benefits extend beyond the termination date. However, for cases where the experience of the case or the experience of a block of cases is reflected back to the policyholder, the dividend liability or provision for experience rating refunds is a direct offset to the need to establish an additional reserve.

GAAP Literature

43. Consistent with Issue Papers Nos. 50 and 51, *FASB Statement No. 60, Accounting and Reporting by Insurance Enterprises (FAS 60)*, relating to individual and group accident and health contracts is rejected for the reasons set forth in those issue papers. However, some of the elements regarding income recognition have been used in this issue paper.

Drafting Notes/Comments

- Issue Paper No. 50 addresses Classifications and Definitions of Insurance or Managed Care Contracts In Force.
- Issue Paper No. 51 addresses Life Contracts.
- Issue Paper No. 52 addresses Deposit-Type Contracts.
- Issue Paper No. 55 addresses Unpaid Claims, Losses and Loss Adjustment Expenses.
- Issue Paper No. 59 addresses Credit Life and Accident and Health Insurance Contracts.
- Issue Paper No. 66 addresses Accounting for Retrospectively Rated Contracts.
- Issue Paper No. 74 addresses Life, Deposit-Type and Accident and Health Reinsurance.

RELEVANT STATUTORY ACCOUNTING AND GAAP GUIDANCE (only pertinent excerpts are included below)**Statutory Accounting**

44. Chapter 13, Aggregate Reserves For Accident and Health Policies, of the Life/A&H Accounting Practices and Procedures Manual provides the following guidance on individual and group accident and health reserves:

Accident and health insurance provides protection against economic losses resulting from accident and/or sickness. This insurance may be provided under individual policies, under group or franchise policies, or it may be provided under certain special types of policies which bear unique titles such as credit insurance. The economic losses which accident and health insurance policies cover, or the types of benefits provided, will vary with different policies. For example, reimbursement for hospital, surgical, or medical expenses may be provided under a hospital expense policy, while under other policies, a more comprehensive form of coverage, known as major medical insurance, may be offered. Similarly, policies may provide monthly benefits for loss of income from disability, either on a short term or a long term basis, or only for disabilities due to accident. Loss of life from accident may be covered under accidental death policies, while under certain limited accident policies, only accidental death from air travel may be covered. Therefore, accident and health policies may be categorized by the form of policy through which the coverage is provided; it may be categorized according to the benefits provided by the policy; or it may be categorized by the contingencies insured against. These variations in types of policies and the benefits provided must be considered in discussing the reserves for accident and health insurance policies.

Accident and health policies are offered by life companies, casualty companies, fraternal benefits societies, and certain specialty companies. While the coverage originated with casualty companies, it is now the life insurance companies which provide the majority of accident and health insurance. The history of the business is important because many of the concepts currently used originated from casualty insurance practices and use casualty terminology. Since the life insurance companies began writing this insurance, the form of the policies and the concept of coverages have changed, which also produced changes in reserving practices.

At one time, all reporting of accident and health insurance was on the miscellaneous blank, which was originally designed for the casualty companies. The policies then offered were referred to as commercial policies under which the insurer had the right to cancel or fail to renew coverage. Some noncancellable accident and health insurance was written with specific reserve requirements for those policies. The premium rates for commercial policies were often on a uniform rate basis, with the same premium applying to a broad range of ages. Under the casualty concept, the reserves for these commercial policies consisted primarily of an unearned premium

reserve and claim reserve. The unearned premium reserve was intended to recognize that portion of a premium which covered a policy period extending beyond the valuation date. Claim reserves were required to recognize the liability of the company for claims which had not been paid or were being processed. The titles assigned to the various claim reserves were intended to reflect their payment status; however, over the years, procedures have changed and certain of the reserves are calculated differently but still bear the same titles. Reserves in the statutory financial statement required for accident and health insurance are measures of the value of liability for future obligations of an insurer. Two basic types of reserves are required to value the future liabilities arising under accident and health insurance policies. "Policy reserves" have traditionally been referred to as active life reserves and unearned premium reserves and are a recognition that premiums cover future liabilities in addition to current claim costs and expenses. "Claim reserves," sometimes referred to as disabled life reserves, are required on claims which involve continuing loss. The reserve in this case is a measure of the present value of future benefits or amounts not yet due as of the statement date which are expected to arise under claims which have been incurred as of the statement date. "Claim liabilities," to be discussed in a later chapter, are a measure of an insurer's liability for benefits due as of the statement date.

In many respects, the reporting of accident and health insurance is similar to that used for life insurance but the reserving of accident and health insurance differs significantly from that used for life insurance. The separation of the claim reserve is an example of unique accident and health reserving and will be discussed later. This chapter will analyze accident and health reserves from a general standpoint and reference will be made to the numerous regulations on accident and health reserves which have been recommended by the NAIC and which have been promulgated at various times by the different states. It is not intended that those reserve recommendations be restated in this chapter but comments will be made to enhance their understanding.

Individual Accident and Health Policies

Individual accident and health policies, other than credit insurance, are separated for reserve reporting purposes in the statutory financial statement into six classifications. The definitions are included in the instructions for the statutory financial statement and are based principally on the renewal agreement of the policy. There is some variation in the reserve requirements which apply to the different renewal classifications of policies but most reserve requirements apply to all individual policies.

Legal Requirements for Reserves

For life insurance, the standard valuation law defines the minimum standard which a company's aggregate reserves must meet. However, for accident and health insurance, the statutes of most states provide that the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under its accident and health policies and be not less than the reserve according to the appropriate standards set forth in regulations issued by the insurance department. In other states which have not adopted specific reserve requirements for accident and health insurance, the requirement for reserves may be based on more general statutory requirements or on the instructions to the statutory financial statement. Those instructions provide that a reserve must be carried for any policy which provides guarantee of renewability, and the standards adopted by the NAIC in December 1964, are indicated to be an acceptable basis for such additional reserves. The report of the Industry Advisory Committee on Reserves for Individual Accident and Health Policies, approved by the NAIC in December 1964 has served as the basis for the reserve regulations promulgated by many insurance departments. Revisions in the regulations may change the reserve requirements, as well as provide for new morbidity tables, without a change in the reserve law of a state as is true for life insurance.

Unearned Premium Reserves

These reserves are established for all accident and health policies and are equivalent to the amount of the gross premium for that portion of the premium period which extends beyond the

valuation date. The unearned portion may be computed on a pro rata basis using the actual due dates, or it may be computed on the “monthly pro rata method,” which assumes that all premiums are collected evenly throughout the month. Special consideration should be given to the method used if there is a high concentration of premiums due on a given date because of company practices in the dating of policies. Care must be taken to insure consistency between unearned premium reserves and premiums reported as due and unpaid. For example, if a company is taking a due and unpaid premium for a policy as an asset, the appropriate portion of that premium should be included in the unearned premiums just as if the premium had actually been paid.

Active Life or Additional Reserves

These reserves arise as a consequence of the rating concept for the policy where a constant or “level premium” is assumed over a specified period of years during which the cost of insurance increases with the increasing age of the insured lives. This is similar in concept to the reserves provided for term life insurance policies, but again, there are distinct differences. The active life reserve is required of all in-force policies, which would include policies on those lives which are currently disabled and receiving benefits, and is in addition to any reserves required on those lives in connection with the claim. Active life reserves are necessary because the level premiums, as with life insurance, will likely prove to be inadequate to meet future claim costs as the policies mature. The additional reserves are, therefore, set aside from the early years’ level premiums to pay the claims that experience indicates will be incurred as the policy continues in force. The fact that the insurer may have the right to increase premiums or to decline renewal of the policies for certain reasons has no bearing on the calculation of the active life reserves. These additional reserves are not required of policies with certain renewal agreements.

Specific morbidity tables, valuation methods and interest rates have been included in the NAIC recommendations as minimum standards. The policy reserves established and maintained by a company should place a sound value on both present and future liabilities under those policies and should not be less than the minimum values determined by the methods and bases described therein.

The morbidity tables specified in the NAIC recommendations should be viewed as minimum standards. While these morbidity tables have been developed from industry experience data, it has not been possible to recognize all the variations in policy benefits or underwriting philosophies of all companies. Appropriate modifications should be made to reflect the actual benefits provided in the policy. Similarly, recommended morbidity tables do not exist for certain benefits so there is a need to develop reserves based on the insurer’s recent morbidity experience, or on recognized published morbidity experience, such that a sound value is placed on the liabilities under that benefit.

The NAIC recommendations permit alternative valuation procedures and assumptions. Often the great variety of benefits and options in accident and health policies make it impractical to precisely value each variation. Approximations such as those involving age groupings, groupings of several years of issue, or average amounts of indemnities are among those mentioned. Others include the computations of the reserve for a policy benefit as a percentage of some other policy benefit or the use of composite annual claim costs for all or any combination of the benefits included in the policies.

The insurer may employ the use of either the level premium, the one-year preliminary term, or the two-year preliminary term valuation methods. The reserves may be shown as mean reserves diminished by appropriate credit for valuation net deferred premiums or as mid-terminal reserves plus the gross or net unearned premium reserves. In no event, however, may the aggregate reserve for all policies be less than the unearned gross premium under such policies. For statement purposes, the net reserve liability may be shown as the excess of the mean reserve over the amount of net unpaid and deferred premiums or, regardless of the underlying method of calculation, it may be divided between the unearned gross premium reserve and a balancing item for the “additional reserve” which is generally based on the mid-terminal reserves. The insurer is

required to attach to the statutory financial statement a description of the valuation standards used in calculating the reserves, and to specify the reserve basis, interest rates, and methods.

Because of the aggregate and average nature of policy reserves, deficiency reserves are normally not required for accident and health insurance. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same policy but the mean reserve on any policy should never be taken as less than one-half the valuation net premium.

Reserves for cash value, return of premium, or other nonforfeiture benefits should be calculated using interest, mortality, and morbidity, provided the value of benefits payable upon death is included in the calculation; otherwise, reserves should be calculated on a sinking fund basis using interest and morbidity only. The aggregate policy reserves established for these, over and above any policy reserve required for other policy benefits, should not be less than the aggregate of any withdrawal benefits then payable. Where cash value or return of premium benefits are payable periodically, reserves should be calculated on a recurring term period basis, consistent with the payment cycle.

Group Policies

All organizations that qualify to purchase group life insurance may also, by most state laws, purchase accident and health insurance. In many states, the definition of what constitutes an eligible group for accident and health insurance is entirely left up to any set of good underwriting practices established by the insurance company.

Some insurers may act as administrators of accident and health plans under which the plans bear the risk of claims. Such plans are commonly terms “administrative services only” plans and are described in this manual as “uninsured plans.” For additional discussion see Chapter 8—Other Admitted Assets.

The insurer’s aggregate reserves should not include any amounts arising from uninsured accident and health plans or the uninsured portion of partially insured plans. The insured portion of any partially insured plan should be treated as any other insured plan with appropriate reserves established.

Legal Requirements for Reserves

The minimum reserve for active lives is the gross unearned premium. Unlike life insurance, where due and outstanding premium is a net valuation premium and reserves are also net valuation premium reserves, group accident and health due and outstanding premium and unearned premium reserves are reported on a gross basis. There is, therefore, no need to calculate loading or establish the excess of the cost of collection over loading for group accident and health policies. The liabilities established on due and outstanding premiums are discussed elsewhere in this manual.

Unearned Premium Reserves

The methods of computing group unearned premium reserves may vary between companies and even within a company, depending upon the premium due dates of the policies involved. The monthly pro rata gross unearned premium is a common method used. The assumption of uniform issuance is applied in the monthly pro rata method. At the end of the month in which the premium is due, one-half of the premium is considered to be earned and one-half is considered to be unearned.

Unearned premium reserves also may be based on the actual due date of the premium; this has been referred to as the “daily pro rata” method. It is the most precise basis. Sometimes a combination of the two methods is used. An unearned premium reserve of zero is established for all policies with monthly premium due dates of the first day of the month. For all other monthly policies, a uniform distribution is assumed. Most group accident and health policies are billed on

a monthly basis but, in a few cases, quarterly, semiannual, and even triannual modes are encountered. Premium modes other than monthly can be handled in similar fashion.

Additional Reserves

Some states may require an additional reserve for policies which contain a conversion privilege. The minimum reserve should be the excess of the morbidity costs assumed in the premium to be payable on the terminated coverages. If the rates guaranteed into the future are inadequate to meet future obligations, then additional reserves should be established. However, for cases where the experience of the case or the experience of a block of cases is reflected back to the policyholder, the dividend liability or provision for experience rating refunds is a direct offset to the need to establish an additional reserve. Also, it should be noted that the vast majority of group accident and health policies are written in conjunction with a group life policy. In the case of an experience rated package of group life and group accident and health, policyholder margins available from the group life contract may also reduce the need to establish an additional reserve. A detailed discussion of the group dividend liability and experience rating refunds may be found below.

Reserve For Future Contingent Benefits

In addition to the unearned premium reserves for all group accident and health policies, a company may be required to establish a reserve for future contingent benefits. The most common of these is for deferred maternity benefits.

Employer groups frequently have female employees leaving for maternity reasons. These employees usually leave at some time before giving birth and are not members of the group at the time their hospitalization claim is presented. For this reason, most group policies are written to insure conception rather than birth. The requirement, therefore, is that the female employee be a member of the group at the time of conception for her to receive benefits upon giving birth.

One other contingent benefit that may be set up is a special reserve for major medical policies that have a high front-end deductible, such as \$5,000 to \$10,000. A claim reserve may not have been established since the insureds have not used up the deductible but future contingent benefits may be in the process of building as the deductibles are satisfied.

According to the NAIC instructions, any policy having similar extension of benefits must have such a reserve. It is intended that this reserve should be set up on the assumption that all insurance under policies containing an extension of benefits will terminate on the statement date.

Other Reserve Considerations

Claim Reserves

The treatment of active life reserves for accident and health policies has been discussed in three categories — individual, group, and credit. The requirements for each category were sufficiently unique to warrant separate consideration. The standards and practices employed in the computation of claim reserves, however, are for the most part the same for individual, group, and credit and will apply jointly unless specific reference is made to one line of business.

Claim reserves are reported as accident and health reserves. Estimated amounts that would be payable after the statement date if the insured's liability were to continue represent the unaccrued benefits which make up the claim reserve. The accrued benefit, i.e., the amount payable on the balance sheet date, is reported as the claim liability in the balance sheet. Separating accrued and unaccrued portions of claims provision often is difficult because many methods of computing claim reserves generate one total amount based upon the company's past experience.

Disabled Life Reserves For Loss-Of-Time Policies

The calculation of disabled life reserves for claims with a duration of more than two years is straightforward. The disabled life factors are based upon the age of the insured at the date of

disablement, the number of months the insured already has been disabled, and the number of months remaining in the benefit period.

For claims with a duration of less than two years, there is a variety of acceptable methods for calculation. Some of them are: (a) use of the disabled life table—either a published table or one based on the insurer's experience; (b) use of an estimate made by the insurer's claim department for each policy (the individual judgment approach); (c) use of a "rule of thumb," such as setting the reserve equal to the prospective claim payments for 3 1/2 times the elapsed period of disability; or (d) a combination of the first three methods.

For any method it uses, the insurer should have statistics to show that its method would (or actually did) produce adequate reserves for prior valuation periods. If the loss-of-time policy provides a waiver of premium benefit, the reserve for policies that are having their premiums waived should be included with the disabled life reserves. A portion of the liability for incurred but not unreported loss-of-time claims may be unaccrued.

A shortage in the statutorily-determined reserves for loss-of-time claims may develop, since the experience of these claims is consolidated for those of more than and less than a duration of two years. Because of the legal requirement, claims of more than two years' duration must have tabular reserves in accordance with statutory requirements. The minimum reserves for these claims are set, therefore, and at least that amount should be reported. Consolidated experience may indicate, because of earlier terminations of payments and lump sum settlements, that these reserves are redundant. In any case, the reserve for the initial two years of incurrence must be sufficient in its own right and must not be reduced to offset a redundancy in the reserve for claims beyond two years' duration.

Claim Reserves For Other Than Loss-Of-Time Policies

The incurred claim reserve for various hospital and medical expense coverages may have an unaccrued portion. For example, if an insured has been hospitalized for 20 days as of a given valuation date, and it was estimated that he would be hospitalized for another 10 days for the same sickness, then the reserve for the 10 days of benefits should be established as a claim reserve. In practice, a total reserve for a given claim generally will be established and then divided by some predetermined means between claim reserves and claim liability. Due to the great latitude given the insurer in determining reserves for other than loss-of-time policies, the insurer is required to provide statistics that support the adequacy of the reserves for each major line of business.

The emergence of discount and the existence of certain minimum-premium policies and excess risk reinsurance may distort the above-mentioned tests. The adequacy of reserves is also affected by other factors, such as the existence of contractual premium clauses under which the insurer can require an additional premium to be paid under certain stipulated conditions.

45. The Life/A&H Accounting Practices and Procedures Manual provides the following guidance on individual and group accident and health premiums:

CHAPTER 18 PREMIUM INCOME

Accident and Health Policies

Accident and health insurance policies typically provide a grace period after the due date for the premium to be received before the policy is terminated. If the company is relatively assured of collecting the late premium, and has established an appropriate unearned premium reserve, it is permitted to record such due and uncollected premium as an admitted asset.

On accident and health policies, other than group, with premiums payable more frequently than quarterly, all due and unpaid premiums are not admitted if more than one period premium is overdue. Group premiums more than 90 days overdue also are disallowed as an admitted asset.

If gross accident and health uncollected premiums are recorded as income and as an asset, commissions on uncollected premiums are included in the liability for unpaid commissions.

The method used for determining the amount of uncollected premiums should be the same for group as for individual policies. This usually is done by preparing an inventory of premiums billed, due prior to the statement date but uncollected. If the company pays a different rate of commission on first-year premiums than on renewals, the premiums should be grouped to facilitate the calculation of the unpaid commissions.

Because the policyholder can terminate the policy at any time simply by not paying the premium, the company should consider its lapse experience in determining the amount it records as uncollected premiums. Recording older due premiums (although not more than 90 days past due), which have little or no unearned premium reserve, may overstate the company's financial condition. Direct mail mail-order insurance is a good example of business having high lapse rates. Many companies record no uncollected premiums on these policies.

Some insurers may act as administrators of accident and health plans under which the plans bear the risk of claims. Such plans are commonly termed "administrative services only" plans and are described in this manual as "uninsured plans." For additional discussion see Chapter 8—Other Admitted Assets.

Amounts related to uninsured plans or the uninsured portion of partially insured plans must not be reported in premiums. Conversely income relating to the insured portion of any plan must be reported as premiums.

Generally Accepted Accounting Principles

46. The *AICPA Audit and Accounting Guide: Health Care Organizations* provides the following guidance:

Revenue

10.04 Revenue usually is recorded when coverage is provided to an enrollee or the service is provided to a patient or resident. Revenue is classified based on the type of service rendered or contracted to be rendered. Examples of revenue include—

- Patient service revenue, which is derived from fees charged for patient care. This may be based on diagnosis related group (DRG) payments, resource-based relative value scales (RBRVS) payments, per diems, discounts, or other fee-for-service arrangements.
- Premium revenue, which is derived from capitation arrangements.
- Resident service revenue, which may be related to maintenance fees, rental fees, or amortization of advance fees.

Accounting for Loss Contracts

13.05 A prepaid health care provider enters into contracts to provide members with specified health care services for specified periods in return for fixed periodic premiums. The premium revenue is expected to cover health care costs and other costs over the terms of the contracts. Only in unusual circumstances would a provider be able to increase premiums on contracts in force to cover expected losses. A provider may be able to control or reduce future health care delivery costs to avoid anticipated losses, but the ability to avoid losses under existing contracts may be difficult to measure and to demonstrate. Associated entities such as hospitals, medical groups, and individual practice associations (IPAs) may enter into similar contracts with prepaid health care providers in which they agree to deliver identified health care services to the providers' members for specified periods in return for fixed fees.

13.06 *FASB Statement No. 5, Accounting for Contingencies*, states that a loss should be accrued in financial statements when it is probable that a loss has been incurred and the amount of the loss can be reasonably estimated. Accordingly, losses should be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts. For purposes of determining whether a loss exists, the expected future health care costs include all costs other than general and administrative, selling, maintenance, marketing and interest. The term maintenance costs refers to costs associated with maintaining announcement records and processing premium collections and payments. The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable, direct, and allocable indirect costs. Contracts should be grouped in a manner consistent with the provider's method of establishing premium rates, for example, by community rating practices, geographical area, or statutory requirements, to determine whether a loss has been incurred.

RELEVANT LITERATURE

Statutory Accounting

- Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy
- Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies, Chapter 13, Aggregate Reserves for Accident and Health Policies, and Chapter 18, Premium Income
- *Issue Paper No. 3—Accounting Changes*
- *Issue Paper No. 4—Definition of Assets and Nonadmitted Assets*
- *Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets*
- *Issue Paper No. 10—Uncollected Premium Balances*
- *Issue Paper No. 47—Uninsured Plans*
- *Issue Paper No. 50—Classifications and Definitions of Insurance or Managed Care Contracts In Force*
- *Issue Paper No. 51—Life Contracts*
- *Issue Paper No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*
- *Issue Paper No. 59—Credit Life and Accident and Health Insurance Contracts*
- *Issue Paper No. 66—Accounting for Retrospectively Rated Contracts*
- *Issue Paper No. 74—Life, Deposit-Type and Accident and Health Reinsurance*

Generally Accepted Accounting Principles

- *AICPA Audit and Accounting Guide: Health Care Organizations*

State Regulations

- No additional guidance obtained from state statutes or regulations.