CALIFORNIA CODE OF REGULATIONS

TITLE 10. INVESTMENT
CHAPTER 5. INSURANCE COMMISSIONER
SUBCHAPTER 2. POLICY FORMS AND OTHER DOCUMENTS
ARTICLE 1.9. STANDARDS FOR DETERMINING WHETHER BENEFITS OF AN INDIVIDUAL
HOSPITAL, MEDICAL OR SURGICAL POLICY ARE UNREASONABLE IN RELATION TO THE
PREMIUM CHARGED PURSUANT TO SUBDIVISION (C) OF SECTION 10293

§ 2222.10. Applicability.

This article is adopted pursuant to and in implementation of Section 10293(a) of the Insurance Code, is applicable to individual disability policies providing hospital, medical or surgical insurance coverages as defined in Section 2222.11 herein, and mass-marketed policies as defined in Insurance Code section 10293(c)(1), ~~delivered or issued for delivery to any person in this State on or after July 1, 1962~~ that are either (1) delivered or issued for delivery to any person in this State on or after July 1, 2007, or (2) delivered or issued for delivery to any person in this State on or after July 1, 1962 and subject to any rate revision effective on or after July 1, 2007.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

§ 2222.11. Definitions.

(a) The term "hospital, medical or surgical policy" as used in this article means any disability insurance contract (whether composed solely of a policy or of a policy and one or more riders, endorsements, or amendments attached thereto) designed, constructed, advertised or sold as having as its dominant purpose the provision of benefits contingent upon the rendition of hospital, medical or surgical services. This definition includes a policy of “health insurance,” as described in Insurance Code section 106(b), as well as a “mass-marketed policy,” as described in Insurance Code section 10293. For purposes of this article, the phrase "dominant purpose" means any disability insurance contract (whether composed solely of a policy, or of a policy and one or more riders, endorsements, or amendments attached thereto) upon which at least 50 percent of the initial premium or of any renewal premium is or may be, under the underwriting rules or practices of the insurer, allocated or apportioned or should reasonably be allocated or apportioned to the hospital, medical or surgical benefits provided therein. In case of a "hospital, medical or surgical policy" which contains, in addition to benefits contingent upon the rendition of hospital, medical or surgical services, other benefits which are not subject to this article, the insurer may segregate the earned premiums and the incurred losses for those benefits which are subject to the provision of this article, and the commissioner may require such segregation if substantial benefits not subject to this article are provided. If there is no such segregation, the experience of the policy will be

considered as a unit. This definition shall not be construed to include: (1) policies which provide a benefit expressed as an increase of a loss of time benefit during hospital confinement, which is not advertised or sold as a hospital benefit, or (2) a single premium nonrenewable transportation ticket policy having as its dominant feature the protection of the insured from a transportation hazard.

(b) The term "individual policy" as used in this article means a disability policy purporting to insure only one person, except that included within this definition shall be a family policy or family expense policy defined in Section 10320(c) of the Insurance Code.

(c) Policies "issued on a mass underwriting basis" as used in this article shall mean individual hospital, medical, or surgical policies (1) conforming to all of the underwriting and renewal conditions set forth in Section 10270.97 of the Insurance Code, relating to selected group disability insurance; or (2) issued without individual underwriting pursuant to the exercise of a conversion privilege in a group policy; or (3) issued at lower than the individual policy rates otherwise charged predicated on the expectation of substantial savings in operating expenses to members of a group of individuals (such as members of a professional association), under a plan or arrangement entered into between the insurer and the association; or issued on a mass enrollment basis to members of a defined group of individuals (such as residents over age 65 in one state) under a plan whereby the insurer will not discontinue, or modify rates of, any policy, unless it simultaneously discontinues or similarly modifies all other policies in the same group; or (4) at the discretion of the commissioner, any similar policy predicated upon substantial savings in operating expense arising from mass enrollment.

(d) The terms "premiums earned" and "losses incurred" as used in this article shall be developed by a method consistent with that method used for developing such items in Schedule H of the life and accident and health annual statement blank, unless otherwise specifically indicated in this article.

(e) References to specified portions of annual statement blanks shall apply to all amendments and additions or successor provisions hereafter made.

(f) "Rate revision" means a change in premium rates that applies to existing policies.

(g) "Lifetime anticipated loss ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of accumulated value of past incurred claims since the inception of policy and the present value of future anticipated claims, and (ii) is the sum of accumulated value of past earned premiums and the present value of future anticipated premium earnings.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

§ 2222.12. ~~Standards of Reasonability~~. Minimum Loss Ratio Standards

~~The standards of the reasonableness of the relation of the benefits of hospital, medical and surgical policies to the premium charged therefor shall be that each policy form should develop a ratio of losses incurred to premiums earned in the aggregate, based upon the assumption of the payment of premiums annually in advance, of not less than: (i) 50 percent if the premium is at a rate in excess of $7.50 per person annually, or (iii) 35 percent if the premium is at a lesser rate or (ii) 60 percent if the policy is designed to supplement Medicare.~~

The authority of the commissioner under Insurance Code Section 10293 being to withdraw approval of policy forms the benefits of which are not reasonable in relation to the premium charged, whether the approval of any form of an insurer should be withdrawn pursuant to said section shall be determined by an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop. Some of such factors which will be considered by the commissioner are hereinafter in this article set forth, but their listing does not preclude an insurer from urging any other factors which it considers relevant to the issue involved.

(a) Benefits provided by a hospital, medical or surgical policy shall be deemed to be reasonable in relation to premiums if (1) the lifetime anticipated loss ratio is not less than 70%, and (2) in the case of a rate revision, the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage is also not less than 70%.

(b) Benefits provided by a hospital, medical or surgical policy designed to supplement Medicare, as defined in subdivision (l) of Insurance Code section 10192.4, must meet the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

~~§ 2222.13. Preliminary Screening Procedure.~~

~~In view of the fact that appropriate procedures relative to a determination of whether an individual hospital, medical or surgical policy conforms to the standards set out in Section 2222.12 have not heretofore been established, the preliminary screening procedure outlined hereinafter is hereby adopted on a trial basis, and is subject to appropriate modification by the Insurance Commissioner whenever he may deem such to be advisable or necessary in order to properly effectuate the purposes of this article.~~

~~Nothing hereinafter contained in this section shall preclude the commissioner from reviewing any policy subject to this article for compliance therewith at any time that he determines such review to be advisable or necessary.~~

In reviewing the experience developed by individual hospital, medical or surgical policies health insurance policies of an admitted insurer, the commissioner will utilize the data contained in the most recent annual statement and supplements thereto on file at his office as a basis for a preliminary screening of the experience of such policies pursuant to the technique hereinafter outlined.

(1) The commissioner will make a review of the total countrywide direct experience of an insurer on individual hospital, medical and surgical policies exclusive, however, of policies issued on a mass underwriting basis, as developed from the accident and health policy experience exhibit of the annual statement blank promulgated by the National Association of Insurance Commissioners. He may assume that further study is currently unnecessary with respect to the question of the reasonableness of the benefits provided in relation to the premiums charged on the policies issued by the insurer, if the review discloses that for the total of all such policy forms the reported experience does not establish that the losses incurred are less than 70 percent of premium earned on the policies reviewed. If the policies reviewed include (a) policies with a premium at a rate of $7.50 or less per person annually, or (b) policies issued on the industrial debit basis, in lieu of such 50 percent total test the commissioner may employ such alternative percentage test as may be appropriate to the standards established in this article for each category of policies, and the portion of the total premiums earned allocable to each such category.

(2) If pursuant to footnote (5) of the accident and health policy experience exhibit, an insurer segregates the first year business and renewal business on each policy form subject to this article, the commissioner shall make an alternative review on the basis outlined in paragraph (1) above, modified so that it is limited to review of the experience on renewal business only. In such case, he may assume that further study is currently unnecessary with respect to the question of the reasonableness of the benefits provided in relation to the premiums charged on the policies issued by the insurer, if the review discloses that for the total of all such policy forms, on renewal business only, the reported experience does not establish that the ratio of losses incurred to premiums earned is less than the ration which would otherwise be considered adequate in accordance with paragraph (1) above.

(3) In the event that the procedure outlined in paragraphs (1) and (2) above discloses that the commissioner is unable to make the assumption that further review is currently unnecessary, the commissioner shall conduct a preliminary screening as to experience on each policy form subject to this article by utilizing the information contained in the accident and health policy experience exhibit. Each individual hospital, medical or surgical policy listed on such exhibit on which the loss ratio currently emerging appears to be less than the applicable standard for the category of policy to which it belongs established by this article may be subject to thorough detailed investigation by the commissioner. However, in such a preliminary determination as to whether the loss ratio under a specific policy appears to fall below such standards, the commissioner may, in his discretion, consider the experience developed for a period in excess of one calendar year and ending with the year of review, may combine the experiences developed under

~~several policies, and may give effect to the credibility of the experience based on information as to experience prevailing in the industry on policies providing similar coverage or application of appropriate credibility factors consistent with Section 2222.14 hereof, according to volume of premium earned during the experience period.~~

~~NOTE: Authority cited: Insurance Code section 10293.~~
~~Reference: Insurance Code section 10293(a).~~

§ 2222.14. Credibility Factors.

~~The credibility factors used in review of experience shall be those set forth in the following schedule unless the commissioner, in his discretion, deems that a modification thereof is indicated because of the attributes of a particular policy or the nature of the experience under review.~~

~~TABLE OF CREDIBILITY FACTORS Maximum downward deviation from a 50-percent loss ratio considered consistent with chance variation~~

~~Premium volume for experience period~~	~~Approximate maximum deviation (as a percentage of premiums)~~
~~$1,250,000 or more.....~~	~~None~~
~~683,000 to $1,250,000.....~~	~~2%~~
~~413,000 to 683,000.....~~	~~4%~~
~~277,000 to 413,000.....~~	~~5%~~
~~198,000 to 277,000.....~~	~~6%~~
~~149,000 to 198,000.....~~	~~7%~~
~~116,000 to 149,000.....~~	~~8%~~
~~93,000 to 116,000.....~~	~~9%~~
~~76,000 to 93,000.....~~	~~10%~~

~~When premium volume is less than $76,000, the applicable credibility factor consistent with the above table is derived from the formula given below: 0.01 ($8,357,000 divided by premium volume)<<super>>1/2~~

~~However, premium volume less than $76,000 may require special consideration because of the low frequency of losses incurred.~~

The commissioner may consider the use of credibility factors consistent with sound actuarial principles in the review of experience to recognize deviations from the loss ratio standard that may be due to chance variation.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

§ 2222.15. Communication to Insurer.

Prior to taking any action under Section 2222.17, the commissioner will communicate with the insurer in writing, identifying those policies for which any preliminary review does not establish an inference that the benefits provided therein are reasonable in relation to the premium charged. Such communication shall be deemed confidential, and shall advise the insurer that it should inform the commissioner as to any factors applicable to the consideration of the policy under review which it considers relevant to the reasonableness of the relationship of benefits to premiums. The insurer may, from time to time, submit supplementary material which it deems to be relevant to the study of the loss ratios generated by a specific policy; and the commissioner may request such additional information as he may deem necessary to complete his consideration of such policy.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

§ 2222.16. Consideration of Relevant Factors.

In reviewing any specific policy the commissioner shall consider all factors as are relevant to a determination as to whether the benefits are unreasonable in relation to the premium charged therefor. Relevant factors and the weight to be given thereto depend upon the attributes of such particular policy, as determined by the commissioner in accordance with the provisions of this article. The following is a list of relevant factors which are generally applicable to policies subject to this statute:

(a) Policy experience generated over the period of the one preceding calendar year (ending with the beginning of the year of review) in addition to the year of review may be considered as relevant in case of any policy form. Experience generated over a still longer period (ending with the year of review) may be considered in case of any policy as to which there are substantial reasons to believe, insofar as loss experience is relevant to the issue to be determined, that the experience statistics for the shorter period do not give a fair indication of the actual loss experience of the policy under review. Experience over such extended periods can be considered only if relevant experience figures are made available to the commissioner.

(b) Adjustment of experience statistics to conform to assumption of payment of premiums annually in advance. The adjustment will be that the annual premium shall be deemed to be an amount which is:

(1) 96 percent of the sum of semiannual premiums;

(2) 94 percent of the sum of quarterly premiums; or

(3) 92 1/2 percent of the sum of monthly premiums~~; or~~ .

~~(4) 80 percent of the sum of the premiums collected upon industrial insurance as defined in Section 2220.2 of Subchapter 2, Chapter 5, Title 10, California Administrative Code, herein called "industrial debit basis."~~

If the insurer desires consideration of the increase in handling expenses arising from fractional premium payments, the insurer must furnish for the experience period (i) the distribution of earned premiums according to mode of premium payment during the year, and (ii) adjusted experience statistics based upon conforming earned premiums related to premiums collected semiannually, quarterly, monthly, and upon a weekly and monthly debit basis to the earned premiums developed from the corresponding pro rata annual premium.

(c) Effect of any premium rate changes made during the experience period under review. In order that the commissioner may properly evaluate this factor, the insurer must furnish complete data thereon, including adjusted experience statistics in which earned premiums are adjusted to conform with the current rate basis.

(d) The effect of any experience refunds or dividends paid to policyholders. Insurers desiring consideration of this factor should furnish particulars with respect to such amount accrued for the period of review together with adjusted experience statistics in which such refunds or dividends are considered as a reduction of premiums earned.

(e) With respect to a policy not subject to the reserve requirements of Insurance Code Section 997(b), the loss ratio experienced and reasonably anticipated by policy year; and, where appropriate, the aggregate loss ratio excluding the first policy year. In order that the commissioner may properly evaluate these factors, the insurer must furnish in conjunction therewith data as to the persistency experienced and reasonably anticipated on the policy under review, together with a weighted average loss ratio computed over a reasonable period of time giving effect to these factors. Such weighted average should be based on the experience reasonably to be anticipated in the light of persistency actually experienced and other circumstances likely to affect future persistency. The insurer may also furnish other data relating to actuarial assumptions relevant to the experience to be expected on the policy.

(f) With respect to a policy subject to the reserve requirements of Insurance Code Section 997(b), the insurer should submit for consideration an adjusted loss ratio for the experience period based on the formula given in the footnote to Schedule H in the Life and Accident and Health Annual Statement blank relating to the development of a supplemental loss ratio for individual noncancelable accident and health policies which takes into account the reserves held pursuant to Section 997. If such adjusted loss ratio, after giving effect to such other factors as may be relevant, does not establish the reasonableness of benefits to premiums, the insurer must furnish an analysis of the relation of actuarial net annual premium rates for the policy to the corresponding gross annual premium rates established by the insurer. Such net premiums may be determined on a basis consistent with the minimum valuation standards set forth in Section 997(b) or on an appropriate alternate basis permitted by Section 997 provided details of the

actuarial assumptions used are furnished the commissioner. In order that the commissioner may properly evaluate this factor, the insurer may also be required to submit an actuarial analysis of the relation of the actual morbidity experience under the policy to the assumptions used in determining the net premium rates, with an estimate of the extent of the change in the net premium rates indicated by such actual experience, with due allowance for reserves held pursuant to Section 997.

(g) Experience in any areas where different rate levels were in effect as compared with the countrywide experience on such policy of the insurer in any case in which it can be shown that such experience differs significantly from such countrywide experience.

(h) The likelihood of fluctuation in experience under the policy because of infrequency of loss occurrence or catastrophic nature of hazard covered. Insurers requesting consideration of this factor should furnish appropriate data as requested.

(i) Establishment of credibility of loss ratio experienced on policy under review, based upon available data to be furnished by the insurer for the experience period as to volume of premiums earned, average premium paid per person insured for one year's coverage, average amount of loss per claim incurred, and distribution of claims incurred by size of claim.

(j) With respect to any policy under review the commissioner may on his own initiative or at the request of the insurer consider experience and other factors on other policy forms to the extent they are relevant to determination of the reasonableness of benefits to premium; in particular, such aggregate or averages as may serve to show the reasonableness of benefits to premiums on a class of business as a whole of which the policy under review is a part.

(k) When in connection with the consideration of any policy it is established that there is a trend upward or downward in the loss experience for the type of benefits provided therein, consideration may be given to the probable effect of such trend factor on the loss experience reasonably to be anticipated under such policy.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

§ 2222.17. Notice to Insurer.

If after consideration of all relevant factors the commissioner believes that the benefits provided under an individual hospital, medical or surgical policy are not reasonable in relation to the premium charged, ~~he~~ the commissioner shall so inform the insurer in writing. Such notification shall be deemed a confidential communication~~. He shall further advise the insurer that unless within 31 days from the date thereof the insurer has committed itself in writing to the commissioner that it will, within 90 days thereafter, voluntarily either cease further issuance of the policy form or increase benefits under the policy in relation to premiums charged therefor sufficiently that they are reasonable in~~

~~relation to such premiums, then the commissioner will thereafter, at his discretion, commence proceedings for the withdrawal of authorization of the form after notice and hearing as provided by law.~~ The commissioner shall also advise the insurer that the commissioner will, at the commissioner's discretion, commence proceedings for withdrawal of authorization of the form after notice and hearing as provided by law unless, within 31 days from the date of the notification, the insurer commits itself in writing to the commissioner that it will, within 90 days, voluntarily either (1) cease further issuance of the policy form or (2) increase benefits under the policy in relation to the premiums charged in an amount sufficient to bring the policy into compliance with the minimum loss ratio standards provided for in section 2222.12. ~~At any time after expiration of said 31 days so specified, and if the insurer has not so committed itself~~ If the insurer does not commit itself, within 31 days from the date of the notification, to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings at any time as provided by law for withdrawal of the authorization of the policy form.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

§ 2222.19. Filing Experience Data.

As a supplement or as a part of the annual statement of financial condition required to be filed pursuant to Section 900 of the Insurance Code, each insurer issuing policies subject to this article shall annually file the data required by the accident and health policy experience exhibit for the calendar year when completed to designate those individual policy forms providing hospital, medical or surgical benefits which are subject to the provisions of this article, in each instance showing the ratio of losses incurred to premiums earned thereon, classified in subdivisions as follows:

(1) A schedule showing the experience on each such policy form, exclusive of the experience on policies issued on a mass underwriting basis~~, on the industrial debit basis, and policies with premiums at a rate of $7.50 or less per person annually,~~ and the total for all such policies of premiums earned and losses incurred and resultant total loss ratio. If an insurer~~, pursuant to footnote (5) of the accident and health policy experience exhibit,~~ segregates first year business and renewal business on each policy form, it shall report the total for all such policies of premiums earned and losses incurred and resultant total loss ratio, separately for first year business and renewal business.

~~(2) A schedule similarly showing the experience on policies with premiums at a rate of $7.50 or less per person annually, by policy form.~~

~~(3) A schedule similarly showing the experience on policies issued on the industrial debit basis, by policy form.~~

~~(4)~~ (2) A schedule similarly showing the experience on policies issued on a mass underwriting basis, by policy form.

~~(5)~~ (3) Policies designed to supplement Medicare shall be identified as such.

NOTE: Authority cited: Insurance Code sections 10293, 10293(a) and 10608. Reference: Insurance Code section 10293(a).