

Regulatory Analysis Form

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(1) Agency

Insurance Department

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RECEIVED
REVIEW COMMISSION

Cocodrill

(2) I.D. Number (Governor's Office Use)

11-190

IRRC Number: 1989

(3) Short Title

Minimum Reserve Standards For Individual and Group Health and Accident Insurance Contracts

(4) PA Code Cite

31 Pa. Code, 84a, §§84a.1-84a.8

(5) Agency Contacts & Telephone Numbers

Primary Contact: Peter J. Salvatore, Regulatory Coordinator,
1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429
Secondary Contact:

(6) Type of Rulemaking (check one)

- Proposed Rulemaking
 Final Order Adopting Regulation
 Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

- No
 Yes: By the Attorney General
 Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

Chapter 84a currently establishes minimum standards for an insurer in calculating reserves for a health and accident insurance contract. The proposed amendments to Chapter 84a permit the use of termination rates that exceed mortality table rates in calculating contract reserves for all contracts. Also new termination rate standards are established for individual long-term care contracts and group certificates issued on and after January 1, 1999. The proposed rulemaking clarifies that the minimum standard requirements may be applied to a block of contracts, instead of on a per contract basis. Additionally, a minimum standard is established for contracts providing a nonforfeiture benefit. Finally, the proposed rulemaking clarifies the requirements of the rulemaking concerning contracts issued prior to the effective date of the chapter.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§66, 186, 144 and 412); and Sections 301.1 and 311.1 of The Insurance Department Act (40 P.S. §§71.1 and 93).

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(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

No

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

The minimum reserve standards set forth in the proposed rulemaking are part of the solvency requirements applied to insurers. The function of a reserve is to maintain sufficient funds to pay the future benefits that are guaranteed in an insurance contract. This provides protection to the policyholder in terms of the ability of the company to fulfill its contractual obligations. The proposed amendments update and clarify the minimum reserve standards.

(12) State the public health, safety, environmental or general welfare risks associated with nonregulation.

If an insurer was not required to maintain reserves, there would be a risk that the insurer would not have sufficient funds to pay future benefits to policyholders.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

Residents of this Commonwealth who purchase health and accident insurance contracts will benefit from the proposed rulemaking in that the amendments to Chapter 84a will strengthen the financial soundness of the insurance companies and the ability of the companies to fulfill their contractual obligations.

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(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

Any insurance company with reserves for business issued prior to the effective date of the chapter that do not comply with the minimum standards will be required to increase reserves.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

All life insurance companies, property and casualty insurance companies and fraternal benefit societies issuing health and accident insurance policies in the Commonwealth.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

In developing this rulemaking, the Department solicited comments from the Insurance Federation of Pennsylvania, Inc. Comments from this organization were taken into consideration in preparing the proposed amendments to Chapter 84a.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures that may be required.

Although each insurer may be affected differently, the effect of the proposed amendments on the total reserves held by the insurance industry is anticipated to be minimal. The proposed amendments to the minimum standards for long term care insurance apply to new business, not current business. There may be some expense incurred by an insurer in modifying the reserve calculation system to comply with the amended minimum reserve standards.

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(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures that may be required.

There are no additional costs or savings to local governments associated with this proposed rulemaking since it will impose no compliance requirements on them.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures that may be required.

There are no costs or savings to state government associated with this proposed rulemaking. The extent of the analysis performed by the Department in reviewing reserve calculations to ensure compliance with the minimum standards will not be changed by the proposed amendments to the rulemaking since it does not require additional reserve calculations by the insurance industry.

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years. N/A

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	\$	\$	\$	\$	\$	\$
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

N/A

Regulatory Analysis Form

(20b) Provide the past three-year expenditure history for programs affected by the regulation.

N/A

Program	FY -3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

No costs or adverse effects are anticipated as a result of the regulation.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

No other nonregulatory alternatives were considered. The amendment of Chapter 84a is necessary to Revise the minimum reserve requirements of the chapter.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No other regulatory schemes were considered. The amendment of Chapter 84a is necessary to revise the minimum reserve requirements of the chapter.

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(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

18 states have a regulation similar to Chapter 84a. Only a few of these states have adopted provisions similar to the proposed amendments to Chapter 84a. Chapter 84a has been in effect since 1993. During this time the regulation has not place Pennsylvania in a competitive disadvantage. The amendments pertain to the solvency requirements applied to insurance companies and will continue to ensure a financially stable insurance industry in the Commonwealth that benefits all insurers.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

The proposed rulemaking will not affect existing or proposed regulations of the Department or other state agencies.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No public hearings or informational meetings are anticipated.

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(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports that will be required as a result of implementation, if available.

The proposed rulemaking does not change existing reporting, record keeping or other paperwork requirements.

(29) Please list any special provisions that have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The proposed rulemaking will have no effect on the special needs of affected parties.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The proposed rulemaking will take effect upon final approval by the legislative standing committees, the Office of Attorney General and the Independent Regulatory Review Commission and upon final publication in the Pennsylvania Bulletin.

(31) Provide the schedule for continual review of the regulation.

The Department reviews each of its regulations for continued effectiveness on a triennial basis.

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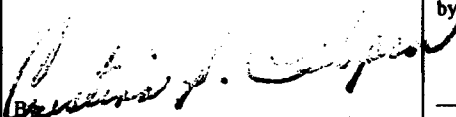
(Pursuant to Commonwealth Documents Law)

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HENRY BUILDING

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Copy below is hereby approved as to form and legality. Attorney General


(Deputy Attorney General)

Date of Approval

→ Check if applicable.
Copy not approved. Objections attached.

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

Insurance Department

(AGENCY)

DOCUMENT/FISCAL NOTE NO. 11-190

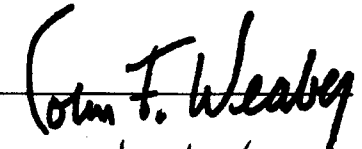
DATE OF ADOPTION:

BY: 

M. Diane Koken
Insurance Commissioner

TITLE:
(EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies

BY: 
9/17/98
DATE OF APPROVAL

(DEPUTY GENERAL COUNSEL)
(CHIEF COUNSEL, INDEPENDENT AGENCY)
(STRIKE INAPPLICABLE TITLE)

→ Check if applicable. No Attorney General approval or objection within 30 days after submission.

Insurance Department

Notice of Proposed Rulemaking

31 PA Code, Chapter 84a
§§84a.1-84a.8

**Minimum Reserve Standards for Individual and Group
Health and Accident Insurance Contracts**

PREAMBLE

The Insurance Department ("Department") proposes to amend Title 31 of the Pennsylvania Code, Chapter 84a, Minimum Reserve Standards for Individual and Group Health and Accident Insurance Contracts, as set forth in Annex A, under the authority of Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§66, 186, 411 and 412) and Sections 301.1 and 311.1 of The Insurance Department Act (40 P.S. §§71.1 and 93).

Purpose

The purpose of the proposed amendments to Chapter 84a of the Pennsylvania Code is to update the Chapter by clarifying and modifying the minimum standards for an insurance company in calculating financial reserves for a health and accident insurance contract. The proposed amendments also modify the minimum contract reserve standards for long-term care insurance.

A Pennsylvania Insurance Department notice, dated July 7, 1994 clarified the applicability of the requirements of Chapter 84a to contracts issued prior to the effective date of the chapter. The proposed rulemaking incorporates some minimum standards for reserves provided in the notice and also changes other requirements regarding minimum standards for reserves.

Most of the proposed amendments were patterned after the amendments to the National Association of Insurance Commissioners' (NAIC) Minimum Reserve Standards For Individual and Group Health Insurance Contracts Model Regulation adopted by the NAIC after the effective date of Chapter 84a.

In developing the proposed rulemaking, comments were solicited and received from the Insurance Federation of Pennsylvania, Inc (IFP). Comments from this organization were taken into consideration in preparing the proposed amendments to Chapter 84a.

Explanation of Regulatory Requirements

The following is a description of the significant features of the changes contained in the proposed rulemaking.

Section 84a.3 (definitions) was modified to add definitions of "operative date" and "rating block".

Section 84a.6 (relating to contract reserves) establishes minimum standards for contract reserves and defines the contracts that are subject to the minimum standards. Additionally, the proposed amendments to Chapter 84a permit the use of termination rates that exceed mortality table rates for all contracts. Also, new termination standards are established for individual long-term care contracts and group certificates issued on and after January 1, 1999. The proposed

rulemaking clarifies that the minimum standard requirements of Chapter 84a may be applied to a block of contracts, instead of on a per contract basis. Additionally, a minimum standard is established for contracts providing a nonforfeiture benefit. Finally, the proposed rulemaking clarifies the applicability of Chapter 84a to contracts issued prior to the effective date of the chapter.

Appendix A (relating to specific standards for morbidity, interest and mortality) establishes the minimum standards for morbidity, interest and mortality used in calculating claim, premium and contract reserves. The morbidity standards for group contract health and accident insurance benefits are being modified to clarify that the standards apply to group certificates instead of group policy contracts. The interest standards were modified to clearly identify the interest rate requirement in calculating minimum reserves. The Appendix is amended to clarify the mortality standards for individual contracts and group certificates issued prior to the effective date of Chapter 84a and to establish a new mortality standard for long term care individual contracts and group certificates issued on and after January 1, 1999.

Affected Parties

The proposed amendments to Chapter 84a will apply to life insurance companies, property and casualty insurance companies and fraternal benefit societies marketing health and accident insurance in this Commonwealth.

Fiscal Impact

State Government

There will be no increase in cost to the Department due to the adoption of the proposed modifications to Chapter 84a. As part of its solvency surveillance responsibilities the Department currently reviews the methodology used by an insurance company to calculate health and accident reserves to ensure that the reserves are adequate and comply with the minimum standard requirements. The proposed revisions and clarifications of the minimum standards will not create additional staff time to perform the analysis.

General Public

Since the proposed amendments to Chapter 84a concern the solvency requirements applied to insurance companies, the public will benefit from a financially sound insurance industry in the ability of insurers to fulfill their contractual obligations.

Political Subdivisions

The proposed amendments will not impose additional costs on political subdivisions. However, because the proposed rulemaking promotes stability in the insurance industry in this

Commonwealth, political subdivisions' tax revenues would benefit as a result of fewer insurer insolvencies. Fewer insolvencies would result in less unemployment and would increase incentives for insurers to market new insurance products in this Commonwealth.

Private Sector

The proposed amendments to Chapter 84a may have some fiscal impact on insurers. To the extent that reserves for business issued prior to the effective date of Chapter 84a do not comply with the minimum standard reserve requirements, an insurance company will need to increase the reserves. The proposed amendments to the minimum contract reserve standards that apply specifically to long-term care insurance will not affect current business. These amendments apply only to contracts issued after the effective date of this regulation. There may be some expense incurred by an insurance company in modifying the reserve calculation system to comply with amended minimum reserve standards.

Paperwork

The adoption of this proposed rulemaking will not impose additional paperwork on the Department or the insurance industry. The clarifications and new requirements of the amendments apply to the reserve calculations but will not result in additional paperwork.

Effective/Sunshine Date

The proposed rulemaking will become effective upon final adoption and publication in the Pennsylvania Bulletin as final rulemaking. No sunset date has been assigned.

Contact Person

Questions or comments concerning this proposed rulemaking may be addressed in writing to Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, within 30 days of the publication of this proposed rulemaking in the Pennsylvania Bulletin.

Regulatory Review

Under section 5(a) of the Regulatory Review Act, (71 P.S. §745.5(a)), the agency submitted a copy of this regulation on SEPTEMBER 23, 1998 to the Independent Regulatory Review Commission and to the Chairmen of the House Insurance Committee and the Senate Banking and Insurance Committee. In addition to the submitted regulation, the agency has provided the Commission and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the agency in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of that material is available to the public upon request.

If the Commission has any objections to any portion of the proposed amendments, it will notify the agency within 30 days after the close of the public comment period. The notification shall specify the regulatory review criteria, which have not been met by that portion. The Regulatory Review Act specifies detailed procedures for the agency, the Governor and the General Assembly to review these objections before final publication of the regulations.

**M. Diane Koken
Insurance Commissioner**

CONTINUATION SHEET FOR FILING DOCUMENTS
WITH THE LEHISLATIVE REFERENCE BUREAU
Pursuant to Commonwealth Documents Law

ANNEX A

TITLE 31. INSURANCE. PART VI. LIFE INSURANCE. CHAPTER 84a. MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH AND ACCIDENT INSURANCE CONTRACTS.

Sec.

- 84a.1. Purpose.
- 84a.2. Applicability and scope.
- 84a.3. Definitions,
- 84a.4. Claim reserves.
- 84a.5. Premium reserves.
- 84a.6. Contract reserves.
- 84a.7. Waiver of premium reserves.
- 84a.8. Reinsurance.

§84a.1. Purpose.

This chapter implements sections 301.1 and 311.1 of The Insurance Department Act of [one thousand nine hundred and twenty-one] 1921, as amended, (40 P.S. §§ 71.1 and 93) which authorize the Commissioner to promulgate regulations specifying appropriate reserve standards.

§84a.2. Applicability and scope.

- (a) This chapter shall take effect for annual statements for the year 1993.
- (b) The minimum reserve standards of this chapter apply to individual and group health and Accident insurance coverages, except credit insurance, written by life insurance companies and Casualty insurance companies.
- (c) When an insurer determines that adequacy of its health and accident insurance reserves requires reserves in excess of the minimum standards specified in this chapter, the increased reserves shall be held and shall be considered the minimum reserves for that insurer.
- (d) With respect to a block of contracts, or with respect to an insurer's health and accident business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

(e) The gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to a major block of contracts, or with respect to the insurer's health and accident business as a whole. If inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves, inclusive of claims, premium and contract reserves, if any, shall be held with respect to all contracts, regardless of whether contract reserves are required for the contracts under this chapter.

(f) Whenever minimum reserves, as defined in this chapter, exceed reserve requirements as [detrained] determined by a prospective gross premium valuation, the minimum reserves remain the minimum requirements under this chapter.

(g) Minimum standards for three categories of health and accident insurance reserves are established. These categories are claim reserves, premium reserves and contract reserves.

(h) Adequacy of an insurer's health and accident insurance reserves is to be determined on the basis of the three categories of subsection (g) combined. These minimum standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

§84a.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Annual claim cost – The net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a \$100 monthly disability benefit, for a maximum disability benefit period of 1 year, with an elimination period of 1 week, with respect to a male at age 35, in a certain occupation might be \$12, while the gross premium for this benefit might be \$18. The additional \$6 would cover expenses and profit or contingencies.

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

Claims reported – A claim that has been incurred on or prior to the valuation date is considered as a reported claim for annual statement purposes if the date the claim is reported to the insurer is on or prior to the valuation date.

Claims unaccrued – The portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be

rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made, which may or may not be discounted with interest, shall be established.

Claims unreported – A claim incurred on or prior to the valuation date is considered as an unreported claim for annual statement purposes if the insurer has not been informed of the claim on or before the valuation date.

Commissioner – The Insurance Commissioner of the Commonwealth.

Credit insurance – Insurance that falls within the regulatory scope of the Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance (40 P.S. §§1007.1-1007.15).

Date of disablement – The earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of an elimination period.

Elimination period – A specified number of days, weeks or months starting at the beginning of each period of loss, during which no benefits are payable.

Gross premium – The amount of premium charged by the insurer, which includes the net premium based on claim-cost for the risk, together with loading for expenses, profit or contingencies.

Group insurance – The term includes blanket insurance and other forms of group insurance.

Level premium – A premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. The annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case, the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

Long-term care insurance – An insurance contract advertised, marketed, offered or designed to provide coverage for at least 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for functionally necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes a policy or rider [which] that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term does not include an insurance contract which is offered

primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement[,] indemnity coverage, major medical expense coverage, disability income coverage, accident only coverage, specified disease coverage or specified accident coverage [or limited benefit health and accident coverage].

Modal premium – The premium paid on a contract based on a premium term [which] that could be annual, semiannual, quarterly, monthly or weekly. For example, if the annual premium is \$100 and if, instead, monthly premiums of \$9 are paid the modal premium is \$9.

Negative reserve – A terminal reserve which is a negative value.

Operative date – The effective date of the approval by the Commissioner for an insurer to use the 1980 CSO Mortality Table to calculate nonforfeiture values and reserves for life insurance contracts.

Preliminary term reserve method – A reserve method under which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium, or stream of changing valuation premiums, becomes applicable so that the present value of the net premiums is equal to the present value of the claims expected to be incurred following the end of the preliminary term period.

Present values of amounts not yet due on claims – The reserve for claims unaccrued, which may be discounted at interest.

Rating Block – A grouping of contracts based on common characteristics, such as a policy form or forms having similar benefit designs.

Reserve – The term used to include all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contract promises benefits which result in claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date and in claims which are expected to be incurred after the valuation date. For the incurred claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves. For the expected claims, the establishment of contract reserves and unearned premium reserves should provide for present liability of the insurer for these future claims.

Terminal reserve – The reserve at the end of a contract year. It is the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

Unearned premium reserve – The reserve that values that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date.

Thus if an annual premium of \$120 was paid on November 1, \$20 would be earned as of December 31 and the remaining \$100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

Valuation net modal premium – The modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on a contract to which contract reserves apply. For example, if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

§84a.4. Claim reserves.

(a) General requirements.

(1) Claim reserves are required for incurred but unpaid claims on health and accident insurance contracts.

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of incurred but unpaid claims.

(3) The reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of residual unpaid liability.

(b) Minimum standards for claim reserves of disability income benefits.

(1) The maximum interest rate for claim reserves is specified in Appendix A (relating to specific standards for morbidity, interest and mortality).

(2) Minimum standards with respect to morbidity are those specified in Appendix A; except that, at the option of the insurer:

(i) For claims with a duration from the date of disablement of less than 2 years, reserves may be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(ii) For group disability income claims with a duration from date of disablement of more than 2 years but less than 5 years, reserves may, with the approval of the Commissioner, be based upon the insurer's experience for which the insurer maintains underwriting and claim administration control if the experience is considered credible. For an insurer's experience to be considered credible, the insurer shall be able to provide claim termination patterns over no more than 6 years reflecting at least 5,000 claim terminations during the third through fifth claim durations on reasonably similar applicable policy forms. Reserve tables based on credible experience shall be adjusted regularly to maintain reasonable margins. [Demonstrations may be required by the Commissioner based on published literature.] The Commissioner, based on published literature, may require demonstrations. The request for approval of a plan of modification to the reserve basis shall include the following:

- (A) An analysis of the credibility of the experience.
- (B) A description of how the insurer's experience is proposed to be used in setting reserves.
- (C) A description and quantification of the margins to be included.
- (D) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement.
- (E) A copy of the approval of the proposed plan of modification by the Commissioner of the state of domicile.

(F) Other information deemed necessary by the Commissioner.

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

(c) Minimum standards for claim reserves of other benefits.

(1) The maximum interest rate for claim reserves is specified in Appendix A.

(2) Minimum standards with respect to morbidity and other contingencies shall be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(d) Claim reserve methods. [Generally accepted or] A reasonable actuarial method[s] or combination of methods may be used to estimate claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves shall be determined in the aggregate.

§84a.5. Premium reserves.

(a) General requirements.

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

(2) If premiums due and unpaid are carried as an asset, the premiums shall 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 shall be carried as an offsetting liability.

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

(b) Minimum standards for unearned premium reserves.

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

(i) The valuation net modal premium on the contract reserve basis applying to the contract.

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

(2) The sum of the unearned premium and contract reserves for contracts of the insurer subject to contract reserve requirements may not be less than the gross modal unearned premium reserve on the contracts, as of the date of valuation. The reserve shall never be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for in the claim reserves or contract reserves.

(c) Premium reserve methods. The insurer may employ suitable approximations and estimates, including groupings, averages and aggregate estimation, in computing premium reserves. The approximations or estimates shall be tested periodically to determine their continuing adequacy and reliability.

§84a.6. Contract reserves.

(a) General requirements.

(1) Contract reserves are required for the following:

(i) The individual and group contracts with which level premiums are used.

(ii) The individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and an actuary certifies the premium development. The actuary should state in the certification submitted to the Department with the reserve valuation data that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary shall also disclose the reasons for and magnitude of such recovery. The values specified in this subsection shall be determined on the basis specified in subsection (b).

[(2) Contract reserves are not required for the following:

(i) Contracts which cannot be continued after 1 year from issue.

(ii) Contracts already in force on October 23, 1993, for which no contract reserve was required under the standards in effect prior to October 23, 1993.]

[(3)] (2) The contract reserve is in addition to claim reserves and premium reserves.

[(4)] (3) The methods and procedures for contract reserves shall be consistent with those for claim reserves for a contract, or else appropriate adjustment shall be made when necessary to assure provision for the aggregate liability. The date of incurral shall be the same in determining both the contract reserves and the claim reserves.

(b) *Minimum standards for contract reserves.*

(1) *Morbidity or other contingency.*

(i) Minimum standards with respect to morbidity are those in Appendix A (relating to specific standards for morbidity, interest and mortality). Valuation net premiums used under each contract shall have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of the insured, contract duration and period for which gross premiums have been calculated.

(ii) Contracts for which tabular morbidity standards are not specified in Appendix A shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the Commissioner. The morbidity tables shall contain a pattern of incurred claim costs that reflect the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

(iii) If a morbidity standard specified in Appendix A is on an aggregate basis, the morbidity standard may be adjusted to a select and ultimate basis to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and be acceptable to the Commissioner.

(2) *Maximum interest rate.* The maximum interest rate is specified in Appendix A.

(3) *Termination rates.*

(i) Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in Appendix A except as noted in subparagraph (ii) and (iii).

(ii) [Under contracts for which premium rates are not guaranteed, and when the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits total] Total termination rates may be used at ages and durations when these exceed specified mortality table rates, but not in excess of

the lesser of 80% of the total termination rate used in the calculation of the gross premiums or 8%.

(iii) For long-term care individual contracts and group certificates issued on and after January 1, 1999, termination rates in addition to the specified mortality table rates may be used. The termination rates other than mortality must not exceed the following:

(A) For policy years one through four, the lesser of 80% of the voluntary lapse rate used in the calculation of gross premiums and 8 %.

(B) For policy years five and later, the lesser of 100% of the voluntary lapse rate used in the calculation of gross premiums and 4%.

(4) Reserve method.

(i) For health and accident insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the 2-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(ii) For long-term care insurance, the minimum reserve is the reserve calculated as follows: [on the 1-year full preliminary term method.]

(A) For individual contracts and group certificates issued before October 23, 1993, reserves calculated on the 2-year preliminary term method.

(B) For individual contracts and group certificates issued on or after October 23, 1993, reserves calculated on the 1-year preliminary term method.

(iii) For return of premium or other deferred cash benefits in individual contracts and group certificates issued prior to October 23, 1993, the minimum reserve is the reserve calculated on the 2-year preliminary term method. [as follows:

(A) On the 1-year preliminary term method if the benefits are provided at any time before the twentieth anniversary.

(B) On the 2-year preliminary term method if the benefits are only provided on or after the twentieth anniversary. Under the Insurance Department (Department) guidelines for the review of return of premium option, the return of premium benefit shall be available beginning by the tenth anniversary. The reference to benefits provided on or after the twentieth anniversary does not modify the referenced Department guideline as it pertains to form approval. This reference to a minimum reserve standard for benefits beginning on or after the twentieth anniversary is necessary only as it pertains to forms that are sold in other states.]

(iv) For return of premium or other deferred cash benefits in individual contracts and group certificates issued on or after October 23, 1993, the minimum reserve is the reserve calculated as follows:

(A) On the 1-year preliminary term method if the benefits are provided at any time before the twentieth anniversary.

(B) On the 2-year preliminary term method if the benefits are only provided on or after the twentieth anniversary. Under the Insurance Department (Department) guidelines for the review of return of premium option, the return of premium benefit shall be available beginning by the tenth anniversary. The reference to benefits provided on or after the twentieth anniversary does not modify the referenced Department guideline as it pertains to form approval. This reference to a minimum reserve standard for benefits beginning on or after the twentieth anniversary is necessary only as it pertains to forms that are sold in other states.

[(iv)] (v) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions -- for example, projected inflation rates -- or for other reasons, shall be applied immediately as of the effective date of adoption of the adjusted basis.

(5) *Negative reserves.* Negative reserves on a benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to benefits combined may not be less than zero.

(6) Nonforfeiture benefits. The contract reserve on a policy basis shall not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications.

(c) *Alternative valuation methods and assumptions.* If the contract reserve on contracts to which an alternative basis is applied is not less in the aggregate than the amount determined according to the standards of subsections (b)(1)-(3), an insurer may use reasonable assumptions as to interest rates, termination or mortality rates, or both, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated in subsection (b)(4) in determining a sound value of its liabilities under the contracts, including the following:

(1) The net level premium method.

(2) The 1-year full preliminary term method.

(3) Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses.

(4) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity and grouping of similar contract forms.

(5) The computation of the reserve for one contract benefit as a percentage of, or by other relation to the aggregate contract reserves exclusive of the benefit so valued.

(6) The use of a composite annual claim cost for all or a combination of the benefits included in the contracts valued.

(d) Tests for adequacy and reasonableness of contract reserves.

(1) Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate, subject to the minimum standards of subsection (b).

(2) If a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted [by contract] so that the future gross premiums reduced by expenses for administration, commissions and taxes will be insufficient to cover future claims, the company shall establish contract reserves for the shortfall in the aggregate.

§84a.7. Waiver of premium reserves.

Waiver of premium reserves involves several special considerations. The disability valuation tables promulgated by the National Association of Insurance Commissioners, or a successor thereto, are based on exposures that include contracts on premium waiver as in-force contracts. Therefore, contract reserves based on these tables are not reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT, 1985 CIDA and 1985 CIDB tables.

(1) Tabular reserves using one of these tables shall value reserves on the following basis:

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

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

(iii) Contract reserves shall include recognition of the waiver premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

(2) If an insurer is, instead, valuing reserves on what is truly an active life table, or if the specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, it may not be necessary to provide specifically for waiver of premium reserves. An insurer using a true "active life" basis shall carefully consider whether or not additional liability should

be recognized on account of premiums waived during periods of disability or during claim continuation.

§84a.8. Reinsurance.

Increase to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, shall be determined in a manner consistent with this chapter and with applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

APPENDIX A

**SPECIFIC STANDARDS FOR MORBIDITY, INTEREST
AND MORTALITY**

I. MORBIDITY

(a) Minimum morbidity standards for valuation of specified individual contract health and accident insurance benefits are as follows:

(1) Disability income benefits due to accident or sickness.

(i) *Contract reserves.*

(A) Contracts issued on or after January 1, 1965, and prior to January 1, 1986: The 1964 Commissioners Disability Table (64 CDT).

(B) Contracts issued on or after January 1, 1993: The 1985 Commissioners Individual Disability Tables A (85 CIDA) or The 1985 Commissioners Individual Disability Tables B (85 CIDB).

(C) Contracts issued on or after January 1, 1986, and prior to January 1, 1993: Optional use of either the 1964 Table or the 1985 Tables.

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

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

(2) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(i) *Contract reserves.*

(A) Contracts issued on or after January 1, 1955, and before January 1, 1982: The 1956 Intercompany Hospital-Surgical Tables.

(B) Contracts issued on or after January 1, 1982: The 1974 Medical Expense Tables, Table A, Transaction of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this 1974 table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(ii) *Claim reserves.* Claim reserves are to be determined as provided in § 84a.4(c)(2) (relating to claim reserves).

(3) Cancer expense benefits (scheduled benefits or fixed time period benefits only).

(i) *Contract reserves.* Contracts issued on or after January 1, 1986: The 1985 NAIC Cancer Claim Cost Tables.

(ii) *Claim reserves.* Claim reserves are to be determined as provided in § 84a.4(c)(2).

(4) Accidental death benefits.

(i) *Contract reserves.* Contracts issued on or after January 1, 1965: The 1959 Accidental Death Benefits Table.

(ii) *Claim reserves.* Actual amount incurred.

(5) Other individual contract benefits.

(i) *Contract reserves.* For other individual contract benefits, morbidity assumptions are to be determined as provided in § 84a.6(b)(1)(ii) (relating to contract reserves).

(ii) *Claim reserves.* For benefits other than disability, claim reserves are to be determined as provided in § 84a.4(c)(2).

(b) Minimum morbidity standards for valuation of specified group contract health and accident insurance benefits are as follows:

(1) Disability income benefits due to accident or sickness.

(i) *Contract reserves.*

(A) [Contracts] Certificates issued prior to January 1, 1993: The same basis, if any, as that employed by the insurer as of January 1, 1993.

(B) [Contracts] Certificates issued on or after January 1, 1993: The 1987 Commissioners Group Disability Income Table (87CGDT).

(ii) *Claim reserves.*

(A) For claims incurred on or after January 1, 1993: The 1987 Commissioners Group Disability Income Table (87CGDT).

(B) For claims incurred prior to January 1, [1933] 1993: [Use of the 87CGDT is optional.] Claim reserves are to be determined as provided in §84a.4(c)(2).

(2) Other group contract benefits.

(i) *Contract reserves.* For other group contract benefits, morbidity assumptions are to be determined as provided in [the reserve standards] §84a.6(b)(1)(ii).

(ii) *Claim reserves.* For benefits other than disability, claim reserves are to be determined as provided in [the standards] §84a.4(c)(2).

II. INTEREST

(a) *Contract reserves.*

(1) The maximum interest rate is the maximum rate permitted by Section 301 of The Insurance Department Act (40 P.S. §71) in the valuation of whole life insurance issued on the same date as the health and accident insurance contract and with a guarantee duration of more than 20 years.

(b) *Claim reserves.*

(1) For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by Section 301 of The Insurance Department Act (40 P.S. §71) in the valuation of whole life insurance issued on the same date as the claim incurral date and with a guarantee duration equal to the maximum benefit period.

(2) For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by Section 301 of The Insurance Department Act (40 P.S. §71) in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by 100 basis points.

III. MORTALITY

(a) For individual contracts and group certificates issued prior to the insurer's operative date, the mortality basis used shall be according to a table permitted by law for the valuation of whole life insurance issued on the same date as the health and accident insurance individual contract or group certificate.

(b) For individual contracts and group certificates issued on or after the insurer's operative date and prior to January 1, 1989, the mortality basis shall be according to either the 1958 CSO

Mortality Table or the 1980 CSO Male and Female Mortality Tables, but without use of selection factors.

[(a)](c) [Except as provided in] Unless subsection [(b)](d) applies, the mortality basis used for individual contracts and group certificates issued on or after January 1, 1989, except long-term care individual contracts and group certificates issued on or after January 1, 1999, shall be according to a table, but without use of selection factors, permitted by law for the valuation of whole life insurance issued on the same date as the health and accident insurance contract. For long-term care individual contracts and group certificates issued on or after January 1, 1999, the mortality basis used shall be the 1983 Group Annuity Mortality Table without projection.

[(b)](d) Other mortality tables adopted by the National Association of Insurance Commissioners (NAIC) and promulgated by the Commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the Commissioner. The request for approval shall include the proposed mortality table and the reason that the standard specified in subsection [(a)] (c) is inappropriate.



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**OFFICE OF SPECIAL PROJECTS
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September 23, 1998

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

**Re: Insurance Department Proposed
Regulation No. 11-190, Minimum
Reserve Standards for Individual &
Group Health & Accident Insurance
Contracts**

Dear Mr. Nyce:

Pursuant to Section 5(a) of the Regulatory Review Act, enclosed for your information and review is proposed regulation 31 Pa. Code, Chapter 84a, Minimum Reserve Standards for Individual & Group Health & Accident Insurance Contracts.

The purpose of the proposed amendments to Chapter 84a is to update the Chapter by clarifying and modifying the minimum standards for an insurance company in calculating financial reserves for a health and accident insurance contract. The proposed amendments also modify the minimum contract reserve standards for long-term care insurance. A Pennsylvania Insurance Department notice, dated July 7, 1994 clarified the applicability of the requirements of Chapter 84a to contracts issued prior to the effective date of the chapter. The proposed rulemaking incorporates some minimum standards for reserves provided in the notice and also changes other requirements regarding minimum standards for reserves.

Most of the proposed amendments were patterned after the amendments to the National Association of Insurance Commissioners' (NAIC) Minimum Reserve Standards For Individual and Group Health Insurance Contracts Model Regulation adopted by the NAIC after the effective date of Chapter 84a.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore
Peter J. Salvatore
Regulatory Coordinator

**TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE
REGULATORY REVIEW ACT**

REG-2018-0014

30 SEP 20 09 14:13

REGULATORY REVIEW COMMISSION

I.D. NUMBER: 11-190

SUBJECT: Minimum Reserve Standards for Individual & Group Health & Accident Insurance Contracts

AGENCY: Department of Insurance

TYPE OF REGULATION

- X Proposed Regulation
- Final Regulation
- Final Regulation with Notice of Proposed Rulemaking Omitted
- 120-day Emergency Certification of the Attorney General
- 120-day Emergency Certification of the Governor
- Delivery of Tolled Regulation
 - a. With Revisions
 - b. Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
<u>9-23-98</u>	<u>B. Draphagen</u>	HOUSE COMMITTEE ON INSURANCE
<u>9/23/98</u>	<u>Senise Patton</u>	SENATE COMMITTEE ON BANKING & INSURANCE
<u>9/23/98</u>	<u>Kim C. Garne</u>	INDEPENDENT REGULATORY REVIEW COMMISSION
_____	_____	ATTORNEY GENERAL
<u>9/23/98</u>	<u>Cynthia J. ...</u>	LEGISLATIVE REFERENCE BUREAU

September 22, 1998