

Regulatory Analysis Form

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 INDEPENDENT REGULATORY
 REVIEW COMMISSION

(1) Agency

Insurance Department

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

11-228

IRRC Number: 2518

(3) Short Title

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

(4) PA Code Cite

31 Pa. Code, Chapter 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 establishes minimum standards for an insurer in the calculation of reserves for health and accident insurance contracts. The proposed rulemaking: (1) modifies the morbidity standard in calculating minimum claim reserves for individual disability income benefits; (2) establishes reserve standards for single premium credit health and accident insurance; and (3) modifies the standards in calculating minimum contract reserves for long term care insurance.

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

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 ("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 purpose of the minimum reserve standards is to ensure that insurers 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 insurer's ability to fulfill its contractual obligations. The proposed rulemaking updates 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 adequate reserves, there would be the 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 rulemaking. The amendment to Chapter 84a will strengthen the financial soundness of insurers, and the ability of the insurers to fulfill 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.)

The amendment to the minimum morbidity standards will not affect claims incurred prior to the effective date of this rulemaking. The reserves for claims incurred on policies issued on or after the effective date of this rulemaking could exceed the insurer's reserves if this rulemaking is not adopted.

(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.

Comments were not solicited from the industry in the drafting of the proposed regulation.

(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 which may be required.

The amendment to the minimum morbidity standards will have no impact on costs associated with current claims since the amendment does not apply to claims incurred on policies issued prior to the effective date of this rulemaking. There may be some expense incurred by an insurer in modifying the reserve calculation system to comply with the amended minimum 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 which may be required.

There are no costs or savings to local governments associated with this rulemaking.

(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 which may be required.

There are no costs or savings associated to state government associated with this rulemaking. This rulemaking does not affect the extent of the analysis performed by the Department, but instead modifies the existing standards for calculation reserves.

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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 this 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 because the standards are currently established by regulation. Therefore, amendment of Chapter 84a is necessary to revise the minimum reserve standards of the chapter and nonregulatory alternatives are not feasible.

(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 standards of the chapter.

Regulatory Analysis Form

(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?

The rulemaking will not put Pennsylvania at a competitive disadvantage with other states.

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

No.

(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 which will be required as a result of implementation, if available.

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

(29) Please list any special provisions which 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 rulemaking will have no effect on 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 rulemaking will undergo a 30-day public comment period and will take effect upon approval of the final form regulation by the Legislative Standing Committees, the Independent Regulatory Review Commission, the Office of the Attorney General, and upon final publication in the *Pennsylvania Bulletin* with an effective date of January 1, 2007.

(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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INDEPENDENT REGULATORY
REVIEW COMMISSION

#2518

DO NOT WRITE IN THIS SPACE

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

By *Amy M. Elliott*
(Deputy Attorney General)

JAN 06 2006

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. 11-228

DATE OF ADOPTION: _____

BY: *M. Diane Koken*
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 *Richard C. Clark*
RICHARD C. CLARK

DEC 12 2005

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.

NOTICE OF PROPOSED RULEMAKING

INSURANCE DEPARTMENT

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 (“Act”)(40 P.S. §§71.1 and 93).

Purpose

The purpose of the proposed rulemaking is to: (1) modify the morbidity standards in calculating minimum claim reserves for individual disability income benefits; (2) establish reserve standards for single premium credit health and accident insurance; and (3) modify the standards for calculating minimum contract reserves for long term care insurance.

The proposed rulemaking is patterned after amendments to the Health Insurance Reserves Model Regulation adopted by the National Association of Insurance Commissioners (“NAIC”) in June 2001, December 2003 and March 2004. A copy of the copyrighted model regulations were provided to the Legislative Standing Committees, the Independent Regulatory Review Commission (“IRRC”), the Governor’s Office of Policy, the Governor’s Office of General Counsel and the Attorney General to aid in their analysis of this propose regulation.

Explanation of Regulatory Requirements

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

Section 84a.2 (relating to applicability and scope) is modified to include single premium credit health and accident insurance while differentiating that monthly premium credit health and accident insurance is not subject to this regulation. Rather, monthly premium credit health and accident insurance is regulated pursuant to Chapter 73 of the Department’s regulations (31 Pa. Code Ch. 73) (relating to credit life insurance and credit accident and health insurance). Amendments to Chapter 73 are being submitted simultaneously with these amendments for review.

Section 84a.3 (relating to definitions) will be amended with regard to the definition of *Group long-term care insurance*.

Section 84a.4 (relating to claim reserves) is being amended to describe the minimum standards and methods used in calculating claim reserves. An insurer may use the insurer’s experience as the minimum morbidity standard in calculating claim reserves of disability income benefits for claims with a duration from date of disablement of less than two years for individual insurance or less than five years for group insurance. The proposed amendment clarifies that the standard based on the insurer’s experience applies to the determination of the claim termination rates during the initial two or five year periods commencing from the date of disablement.

Section 84a.5 (relating to premium reserves) will now exempt single premium credit health and accident insurance from the regulation.

Section 84a.6. (relating to contract reserves) will be amended to augment the minimum standards and methods used in calculating contract reserves. This proposal adds a requirement that the contract reserve shall incorporate a provision for moderately adverse deviations. The proposed amendment also adds a requirement that a morbidity improvement assumption shall not be used in calculating contract reserves for contracts issued on or after January 1, 2007, as well as modifies the termination rate standards used in calculating contract reserves for long term care insurance contracts issued on or after January 1, 2007.

Appendix A (relating to specific standards for morbidity, interest and mortality) will be amended to modify the morbidity standard in calculating minimum claim reserves for individual disability income benefits by adding adjustment factors that are multiplied by the termination rates in the 1985 Commissioners Individual Disability Tables A (85 CIDA) in calculating minimum claim reserves for individual disability income benefits. The adjusted termination rates will then apply to claims incurred on or after the effective date of the rulemaking or, at the option of the insurer, to all claims.

Appendix A is also being modified to add the minimum standards in the calculation of contract and claim reserves for single premium credit health and accident insurance, and to amend the mortality standard in the calculation of contract reserves for long term care insurance contracts issued on or after January 1, 2007.

Affected Parties

The proposed rulemaking will apply to life insurance companies, property and casualty insurance companies and fraternal benefit societies marketing health and accident insurance contracts.

Fiscal Impact

State Government

There will be no increase in cost to the Department as a result of the adoption of the proposed amendment to Chapter 84a. As part of its solvency monitoring responsibilities the Department currently reviews the methodology used by an insurer to calculate health and accident reserves to ensure that the reserves are adequate and comply with the minimum standard requirements. The proposed rulemaking will not require additional staff time or resources to perform the analysis.

General Public

Since the proposed rulemaking concerns the solvency requirements applied to insurance companies, the public will benefit from a financially sound insurance industry and the ability of insurers to fulfill their contractual obligations under accident and health contracts.

Political Subdivisions

The proposed rulemaking will not impose additional costs on political subdivisions. However, because the proposed rulemaking promotes stability in the Commonwealth's insurance industry, political subdivisions' tax revenues should 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 amendment does not apply to claims incurred prior to the adoption of the proposed rulemaking unless elected on an optional basis by the insurance company. There may be some expense incurred by an insurance company in modifying the claim reserve calculation system to comply with amended minimum claim reserve standards.

Paperwork

The adoption of this proposed rulemaking would not impose additional paperwork on the Department or the insurance industry. The proposed amendment to the reserve minimum standards applies to the claim reserve calculation, but will not result in additional paperwork.

Effectiveness/Sunset Date

The proposed rulemaking will become effective January 1, 2007. The Department continues to monitor the effectiveness of regulations on a triennial basis; therefore, no sunset date has been assigned.

Contact Person

Questions or comments regarding the proposed rulemaking may be addressed in writing to Peter J. Salvatore, Regulatory Coordinator, Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120, within 30 days following the publication of this notice in the *Pennsylvania Bulletin*. Questions and comments may also be e-mailed to psalvatore@state.pa.us or faxed to (717) 772-1969.

Pursuant to the Regulatory Review Act (71 P.S. §745 et seq.), the Department is required to write to all commentators, requesting whether or not they wish to receive a copy of the final form regulation. In order to better serve our stakeholders, the Department has made a determination that all commentators will receive a copy of the final form rulemaking when it is made available to the IRRC and the Legislative Standing Committees.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. §745.5(a)), on January 13, 2006, the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Banking and Insurance Committee and the House Insurance Committee. In addition to the submitted proposed rulemaking, the

Department has, as required by the Regulatory Review Act, provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department. A copy of that material is available to the public upon request.

The IRRC will notify the Department of any objections to any portion of the proposed rulemaking within 30 days of the close of the public comment period. The notification shall specify the regulatory review criteria that have not been met by that portion. The Regulatory Review Act specifies detailed procedures for the Department, 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 LEGISLATIVE
REFERENCE BUREAU Pursuant to Commonwealth Documents Law

ANNEX A

**TITLE 31, INSURANCE. PART IV. 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 1921 (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, including single premium credit health and accident insurance [except credit insurance], written by life insurance companies and casualty insurance companies. Monthly premium credit health and accident insurance is not subject to this chapter, but instead is subject to the reserve standards in 31 Pa. Code § 73 (relating to Credit Life and Credit Accident and Health Insurance).

(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 claim, 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 determined by a prospective gross premium valuation, the minimum reserves remain the minimum requirement 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 which 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.

Department—The Insurance Department of the Commonwealth.

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.

Group long-term care insurance – A long-term care insurance policy that is delivered or issued for delivery in this Commonwealth and issued to 1 or more employers or labor organizations, or to a trust or to the trustees of a fund established by 1 or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations.

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:

(i) The term includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(ii) 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.

Modal premium—The premium paid on a contract based on a premium term 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 value 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, present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

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, excluding single premium credit health and accident insurance.*

(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 incurred on or after January 1, 2007, assumptions regarding claim termination rates for the period less than 2 years [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 incurred on or after January 1, 2007, assumptions regarding claim termination rates for the period of 2 or more years but less than 5 years [with a duration] from the 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 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.

(iii) For claims incurred prior to January 1, 2007, each insurer may elect one of the following as the minimum standard.

(A) 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. For group disability income claims with a duration from the 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 request for approval of a plan of modification to the reserve basis shall include the following:

(I) An analysis of the credibility of the experience.

(II) A description of how the insurer's experience is proposed to be used in setting reserves.

(III) A description and quantification of the margins to be included.

(IV) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement.

(V) A copy of the approval of the proposed plan of modification by the Commissioner of the state of domicile.

(VI) Other information deemed necessary by the Commissioner.

(B) The standards as defined in (b)(2)(i) and (b)(2)(ii) applied to all open claims.

If reserves are calculated on the standards defined in (b)(2)(i) and (b)(2)(ii), all future calculations must be on that basis.

(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, including single premium credit health and accident insurance.

(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. A reasonable actuarial method 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, except single premium credit health and accident insurance 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 reserve with respect to a contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the premium determined on the basis of 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 requirement 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 prior years, the actuary shall also disclose the reasons for and magnitude of the recovery. The values specified in this subsection shall be determined on the basis specified in subsection (b).

(2) Contract reserves are not required for individual contracts and group certificates already in force on October 23, 1993, that are not guaranteed renewable or noncancellable as set forth in the contract or certificate or as prescribed under the Health Insurance Portability and Accountability Act (Pub. L. 104-191, 110 Stat. 1936).

(3) If this section requires contract reserves for individual contracts or group certificates already in force on October 23, 1993, for which contract reserves were not held as of December 31, 1998, the additional reserves may be phased in over a 3-year period with 1/3 of the required reserve at December 31, 1999, 2/3 of the required reserves at December 31, 2000, and 100% of the required reserve at December 31, 2001, and after.

(4) The contract reserve is in addition to claim reserves and premium reserves.

(5) 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.

(6) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

(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 may 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.

(iv) In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement for contracts issued on or after January 1, 2007. Morbidity improvement is a change in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred from the current morbidity tables or experience that will result in a reduction to reserves. The actuary can reflect the morbidity impact for a specific known event that has occurred and can be evaluated and quantified.

(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 subparagraphs (ii) [and], (iii), (iv) and (v).

(ii) 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 may not exceed the following:

(A) For policy years 1 through 4, the lesser of 80% of the voluntary lapse rate used in the calculation of gross premiums and 8%.

(B) For policy years 5 and later, the lesser of 100% of the voluntary lapse rate used in the calculation of gross premiums and 4%.

(iv) For long term care individual contracts and group certificates issued on and after January 1, 2007, the following termination rates in addition to the mortality table rates specified in Appendix A may be used.

(A) For policy year 1, the lesser of 80% of the voluntary lapse rate used in the calculation of gross premiums and 6%.

(B) For policy years 2 through 4, the lesser of 80% of the voluntary lapse rate used in the calculation of gross premiums and 4%.

(C) For policy years 5 and later, the lesser of 100% of the voluntary lapse rate used in the calculation of gross premiums and 2%, except for group long-term care insurance where the 2% shall be 3%.

(v) For single premium credit disability insurance, no termination rates shall be used.

(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:

(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.

(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.

(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 may 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 specifications listed in this section.

(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 subsection (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 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 of 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.

Increases 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.]

(A) Claims incurred on or after January 1, 2007: The 1985 Commissioners Individual Disability Table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

Duration

Adjustment

Factor

Week 1

0.366

2

0.366

3

0.366

4

0.366

5

0.365

6

0.365

7

0.365

8

0.365

9

0.370

10

0.370

11

0.370

12

0.370

13

0.370

Month 4

0.391

5

0.371

6

0.435

7

0.500

<u>8</u>	<u>0.564</u>
<u>9</u>	<u>0.613</u>
<u>10</u>	<u>0.633</u>
<u>11</u>	<u>0.712</u>
<u>12</u>	<u>0.756</u>
<u>13</u>	<u>0.800</u>
<u>14</u>	<u>0.844</u>
<u>15</u>	<u>0.888</u>
<u>16</u>	<u>0.932</u>
<u>17</u>	<u>0.976</u>
<u>18</u>	<u>1.020</u>
<u>19</u>	<u>1.049</u>

Duration

Adjustment

Factor

<u>20</u>	<u>1.078</u>
<u>21</u>	<u>1.107</u>
<u>22</u>	<u>1.136</u>
<u>23</u>	<u>1.165</u>
<u>24</u>	<u>1.195</u>

<u>Year 3</u>	<u>1.369</u>
<u>4</u>	<u>1.204</u>
<u>5</u>	<u>1.199</u>
<u>6 and later</u>	<u>1.000</u>

The 85 CIDA so adjusted for the computation of claim reserves shall be known as The 1985 Commissioners Individual Disability Table C (85 CIDC).

(B) Claims incurred prior January 1, 2007: Optional use of either the minimum morbidity standard in effect for contract reserves on contracts issued on the same date the claim is incurred, or 85 CIDC, applied to all claims.

(C) If reserves for all claims are calculated on 85 CIDC, all future calculations must be on 85 CIDC.

(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) Single Premium Credit Health and Accident Insurance

(i) Contract Reserves:

(A) Contracts issued on or after January 1, 2007:

(I) Plans having less than a 30 day elimination period: The 85 CIDA with claim incidence rates increased by 12%.

(II) Plans having a 30 day and greater elimination period: The 85 CIDA for a 14 day elimination period with claim incidence rates increased by 12%.

(B) Contracts issued prior to January 1, 2007:

(I) Optional use of either:

(a) The mean of the amounts of unearned premium calculated from gross premiums in force on the pro rata basis and the Rule of 78 basis.

(b) The standard as defined in I(a)(5)(i)(A) of APPENDIX A, applied to all contracts.

(II) If reserves are calculated on the standard defined in I(a)(5)(i)(A) of APPENDIX A, all future calculations must be on that basis.

(ii) Claim Reserves: Claim reserves are to be determined as defined in § 84a.4(c)(2).

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

(B) 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, 1993: Claim reserves are to be determined as provided in § 84a.4(c)(2) (relating to claim reserves).

(2) Single Premium Credit Health and Accident Insurance

(i) Contract Reserves

(A) Contracts issued on or after January 1, 2007:

(I) Plans having less than a 30 day elimination period: The 85CIDA with claim incidence rates increased by 12%.

(II) Plans having a 30 day and greater elimination period: The 85CIDA for a 14 day elimination period with claim incidence rates increased by 12%.

(B) Contracts issued prior to January 1, 2007:

(I) Optional use of either:

(a) The mean of the amounts of unearned premium calculated from gross premiums in force on the pro rata basis and the Rule of 78 basis.

(b) The standard as defined in I(a)(5)(i)(A) of APPENDIX A, applied to all contracts.

(II) If reserves are calculated on the standard defined in I(a)(5)(i)(A) of APPENDIX A, all future calculations must be on that basis.

(ii) Claim Reserves: Claim reserves are to be determined as defined in § 4a.4(c)(2).

[(2) 3) Other group contract benefits.

(i) *Contract reserves.* For other group 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).

II. INTEREST

(a) Contract reserves.

(1) The maximum interest rate is the maximum rate permitted by section 301 of The Insurance Department Act of 1921 (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 of 1921, 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 of 1921 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.

(c) Unless subsection (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. For long-term care insurance individual policies and group certificates issued on or after January 1, 2007, the mortality basis used shall be the 1994 Group Annuity Mortality Static Table.

(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 (c) is inappropriate.

HEALTH INSURANCE RESERVES MODEL REGULATION

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Section 1. Introduction

A. Purpose and Scope

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Standard Valuation Law].

These standards apply to all individual and group health [accident and sickness] insurance coverages including single premium credit disability insurance. All other credit insurance is not subject to this regulation.

When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a 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: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

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

Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

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B. Categories of Reserves

The following sections set forth minimum standards for three categories of health insurance reserves:

- Section 2. Claim Reserves
- Section 3. Premium Reserves
- Section 4. Contract Reserves

Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

C. Appendices

These standards contain two appendices which are an integral part of the standards, and one additional "supplementary" appendix which is not part of the standards as such, but is included for explanatory and illustrative purposes only.

Appendix A. Specific minimum standards with respect to morbidity, mortality and interest, which apply to claim reserves according to year of incurral and to contract reserves according to year of issue.

Appendix B. Glossary of Technical Terms used.

Appendix C. (Supplementary) Waiver of Premium Reserves.

Section 2. Claim Reserves

A. General

- (1) Claim reserves are required for all incurred but unpaid claims on all health insurance policies.
- (2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.
- (3) All such 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 any residual unpaid liability.

B. Minimum Standards for Claim Reserves

- (1) Disability Income
 - (a) Interest. The maximum interest rate for claim reserves is specified in Appendix A.
 - (b) Morbidity. Minimum standards with respect to morbidity are those specified in Appendix A, except that, at the option of the insurer:

- (i) For individual disability income claims incurred on or after [January 1, 2005], assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.
- (ii) For group disability income claims incurred on or after [January 1, 2005]:
 - (I) Assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement 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) Assumptions regarding claim termination rates for the period two (2) or more years but less than five (5) years from the date of disablement may, with the approval of the commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:
 - An analysis of the credibility of the experience;
 - A description of how all of the insurer's experience is proposed to be used in setting reserves;
 - A description and quantification of the margins to be included;
 - A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;
 - A copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and
 - Any other information deemed necessary by the commissioner.
- (iii) For disability income claims incurred prior to [January 1, 2005] each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

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- (I) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or
- (II) The standards as defined in Items (i) and (ii), applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in Items (i) and (ii), all future valuations must be on that basis.

Drafting Note: It is recommended that these amended standards apply to claims incurred on or after January 1, 2005, however, the state should insert the date on which these standards will apply to newly incurred claims in its jurisdiction.

Drafting Note: For experience to be considered credible for purposes of Item (ii), the company should be able to provide claim termination patterns over no more than six (6) years reflecting at least 5,000 claims terminations during the third through fifth claims durations on reasonably similar applicable policy forms.

For claim reserves to reflect "sound values" and reasonable margins, reserve tables based on credible experience should be adjusted regularly to maintain reasonable margins. Demonstrations may be required by the commissioner of the state of domicile based on published literature (e.g., Goldman, TSA XLII).

- (c) **Duration of Disablement.** For contracts with an elimination period, the duration of disablement should be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(2) All Other Benefits

- (a) **Interest.** The maximum interest rate for claim reserves is specified in Appendix A.
- (b) **Morbidity or Other Contingency.** The reserve should 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.

C. Claim Reserve Methods Generally

A generally accepted actuarial reserving method or other reasonable method, if, after a public hearing, the method is approved by the commissioner prior to the statement date, or a combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

Section 3. Premium Reserves

A. General

- (1) Except as noted in Paragraph (2), unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.
- (2) Single premium credit disability insurance, both individual and group, is excluded from unearned premium reserve requirements of this Section 3.

- (3) If premiums due and unpaid are carried as an asset, the premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes and the cost of collection associated with due and unpaid premiums shall be carried as an offsetting liability.
- (4) 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 reserve with respect to a contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the premium determined on the basis of:
 - (a) The valuation net modal premium on the contract reserve basis applying to the contract; or
 - (b) The gross modal premium for the contract if no contract reserve applies.
- (2) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. The reserve 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.

Drafting Note: States should be aware that while single premium credit disability insurance is excluded from unearned premium reserve requirements, there may be requirements elsewhere in statutory accounting to test reserves against the premium refund net liability.

C. Premium Reserve Methods Generally

The insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

Section 4. Contract Reserves

A. General

- (1) Contract reserves are required, unless otherwise specified in Section 4A(2) for:
 - (a) All individual and group contracts with which level premiums are used; or

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

Drafting Note: Language permitting a rating block test was added because a concern arose that the existing minimum reserve standards could be interpreted as requiring contract reserves on a per contract basis for products that are community rated or that use other rating methodology based on cross-subsidies among contracts within the block. If rates are determined such that each year's premium is intended to cover that year's cost, the rating block approach results in no contract reserves unless required by Subsection D. If rates are designed to prefund future years' costs, contract reserves will be required.

- (2) Contracts not requiring a contract reserve are:
 - (a) Contracts that cannot be continued after one year from issue; or
 - (b) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.
- (3) The contract reserve is in addition to claim reserves and premium reserves.
- (4) 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 definition of the date of incurral shall be the same in both determinations.
- (5) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

B. Minimum Standards for Contract Reserves

- (1) Basis
 - (a) Morbidity or Other Contingency. Minimum standards with respect to morbidity are those set forth in Appendix A. 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 the advancing age of insured, contract duration and period for which gross premiums have been calculated. Contracts for which tabular morbidity standards are not specified in 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 claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

Drafting Note: Section 4B(1)(a) only applies to the premium structure applicable to each contract. The relationship among gross premiums for different contracts (e.g., variations by age) has no bearing on the net premium structure. If for a policy form there is no gross premium variation by age, the valuation net premiums will nonetheless vary based on age at issue for each contract since at issue the present value of valuation net premiums for a contract must equal the present value of tabular claim costs.

- (i) In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and that is able to be evaluated and quantified.

Drafting Note: The last sentence is intended to provide allowances for a known event, such as a new drug release, but at the time of this writing, there are no specific examples that could be pointed to in the recent past that would have met this standard. This is intended to be an extremely rare event.

- (ii) Business in force as of the effective date of Section 4B(1)(c)(iii) may be permitted to retain the original reserve basis which may not meet the provisions of Item (i) above, subject to the acceptability to the commissioner.

Drafting Note: The consistency between the gross premium structure and the valuation net premium is required only at issue, because the impact on such consistency after issue of regulatory restrictions on premium rate increases is still under study.

- (b) Interest. The maximum interest rate is specified in Appendix A.
- (c) Termination Rates. 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 the following items:
 - (i) Under contracts for which premium rates are not guaranteed, and where 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 termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:
 - (I) Eighty percent of the total termination rate used in the calculation of the gross premiums, or
 - (II) Eight percent;

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- (ii) For long-term care individual policies or group certificates issued after January 1, [1997], the contract reserve may be established on a basis of separate:
- (I) Mortality (as specified in Appendix A); and
 - (II) Terminations other than mortality, where the terminations are not to exceed:
 - For policy years one through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and eight percent (8%);
 - For policy years five (5) and later, the lesser of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%).
- (iii) For long-term care individual policies or group certificates issued on or after January 1, [2005], the contract reserve shall be established on the basis of:
- (I) Mortality (as specified in Appendix A); and
 - (II) Terminations other than mortality, where the terminations are not to exceed:
 - For policy year one, the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and six percent (6%);
 - For policy years two (2) through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%); and
 - For policy years five (5) and later, the lesser of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums and two percent (2%), except for group insurance as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act, i.e., employer groups] where the 2% shall be three percent (3%).
- (iv) Where a morbidity standard specified in Appendix A is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the commissioner.

- (2) Reserve Method.
- (a) For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.
 - (b) For long-term care insurance, the minimum reserve is the reserve calculated as follows:
 - (i) For individual policies and group certificates issued on or before December 31, [1991], reserves calculated on the two-year full preliminary term method;
 - (ii) For individual policies and group certificates issued on or after January 1, [1992], reserves calculated on the one-year full preliminary term method.
 - (c) (i) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:
 - (I) On the one year preliminary term method if the benefits are provided at any time before the twentieth anniversary;
 - (II) On the two year preliminary term method if the benefits are only provided on or after the twentieth anniversary.
 - (ii) 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 (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.
- (3) Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.
- (4) Nonforfeiture Benefits for Long-Term Care Insurance. 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.

Drafting Note: While the above consideration for nonforfeiture benefits is specific to long-term care insurance, it should not be interpreted to mean that similar consideration may not be applicable for other lines of business.

C. Alternative Valuation Methods and Assumptions Generally

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable

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assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; 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 or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

D. Tests For Adequacy and Reasonableness of Contract Reserves

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 such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of Section 4B.

In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such 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 such shortfall in the aggregate.

Section 5. Reinsurance

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

Section 6. Effective Date

The regulation shall be effective on [insert date].

APPENDIX A. SPECIFIC STANDARDS FOR MORBIDITY, INTEREST AND MORTALITY

I. MORBIDITY

A. Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued on or after January 1, 1965 and prior to January 1, [YEAR]:

The 1964 Commissioners Disability Table (64 CDT).

Contracts issued on or after January 1, [YEAR]:

The 1985 Commissioners Individual Disability Tables A (85CIDA); or

The 1985 Commissioners Individual Disability Tables B (85CIDB).

Contracts issued during [YEAR or YEARS]:

Optional use of either the 1964 Table or the 1985 Tables.

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, however, elect to use the other tables with respect to any subsequent statement year.

(b) Claim Reserves:

(i) For claims incurred on or after [effective date of this amendment]:

The 1985 Commissioners Individual Disability Table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

Duration	Adjustment Factor	Adjusted Termination Rates*
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344

(cont.)

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Duration	Adjustment Factor	Adjusted Termination Rates*
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448
17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

* The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (*Transactions of the Society of Actuaries* (TSA) XXXVII, pp. 457-463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

** Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pp. 462-463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (The 1985 Commissioners Individual Disability Table C).

- (ii) For claims incurred prior to [effective date of this amendment]:

Each insurer may elect which of the following to use as the minimum standard for claims incurred prior to [effective date of this amendment]:

- (I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred, or
- (II) The standard as defined in Item (i), applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in Item (i), all future valuations must be on that basis.

- (2) Hospital Benefits, Surgical Benefits and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

- (a) Contract Reserves:

Contracts issued on or after January 1, 1955, and before January 1, 1982:

The 1956 Intercompany Hospital-Surgical Tables.

Contracts issued on or after January 1, 1982:

The 1974 Medical Expense Tables, Table A, *Transactions of the Society of Actuaries*, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this 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.

- (b) Claim Reserves:

No specific standard. See (6).

- (3) Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

- (a) Contract Reserves:

Contracts issued on or after January 1, 1986:

The 1985 NAIC Cancer Claim Cost Tables.

- (b) Claim Reserves:

No specific standard. See (6).

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- (4) Accidental Death Benefits.
 - (a) Contract Reserves:

Contracts issued on or after January 1, 1965:
The 1959 Accidental Death Benefits Table.
 - (b) Claim Reserves:

Actual amount incurred.
- (5) Single Premium Credit Disability.
 - (a) Contract Reserves:
 - (i) For contracts issued on or after [effective date of this amendment]:
 - (I) For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).
 - (II) For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in Item (I).
 - (ii) For contracts issued prior to [effective date of this amendment], each insurer may elect either Item (I) or (II) to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Item (i), all future valuations must be on that basis.
 - (I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or
 - (II) The standard as defined in Item (i), applied to all contracts.
 - (b) Claim Reserves:

Claim reserves are to be determined as provided in Subsection 2C.
- (6) Other Individual Contract Benefits.
 - (a) Contract Reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

Drafting Note: If the state does not have a minimum morbidity standard in effect for contract reserves on currently issued contracts, the state shall accept the methodology approved by the commissioner in the state of domicile.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

B. Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued prior to January 1, [YEAR]:

The same basis, if any, as that employed by the insurer as of January 1, [SAME YEAR];

Contracts issued on or after January 1, [YEAR]:

The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim Reserves:

For claims incurred on or after January 1, [YEAR]:

The 1987 Commissioners Group Disability Income Table (87CGDT);

For claims incurred prior to January 1, [YEAR]:

Use of the 87CGDT is optional.

(2) Single Premium Credit Disability

(a) Contract Reserves:

(i) For contracts issued on or after [effective date of this amendment]:

(I) For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).

(II) For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in item (I).

(ii) For contracts issued prior to [effective date of this amendment], each insurer may elect either Item (I) or (II) to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Item (i), all future valuations must be on that basis.

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(I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or

(II) The standard as defined in Item (i), applied to all contracts.

(b) Claim Reserves:

Claim reserves are to be determined as provided in Subsection 2C.

(3) Other Group Contract Benefits.

(a) Contract Reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

II. INTEREST

A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

B. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

C. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

III. MORTALITY

A. Unless Subsection B or C applies, the mortality basis used for all policies except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued before [January 1, 1997 or the effective date set in state regulations, whichever is later] 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 insurance contract. For long-term care insurance individual policies or group certificates issued on or after [January 1, 1997 or the effective date set in state regulations, whichever is later], the mortality basis used shall be the 1983 Group Annuity Mortality Table without projection. For long-term care insurance individual policies or group certificates issued on or after the effective date of Section 4B(1)(c)(iii), the mortality basis used shall be the 1994 Group Annuity Mortality Static Table.

- B. Other mortality tables adopted by the 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 is inappropriate.
- C. For single premium credit insurance using the 85CIDA table, no separate mortality shall be assumed.

APPENDIX B. GLOSSARY OF TECHNICAL TERMS USED

As used in this valuation standard, the following terms have the following meaning:

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 one year, with an elimination period of one 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. That 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, must be established.

CLAIMS REPORTED. When an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

CLAIMS UNACCRUED. That 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), must be established.

CLAIMS UNREPORTED. When an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

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 any 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. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

GROUP INSURANCE. The term group insurance includes blanket insurance and franchise insurance and any 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.

Generally, 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. Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more 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. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy 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 or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

MODAL PREMIUM. This refers to the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is \$100 and if, instead, monthly premiums of \$9 are paid then the modal premium is \$9.

NEGATIVE RESERVE. Normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

PRELIMINARY TERM RESERVE METHOD. Under this method of valuation 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 such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

PRESENT VALUE OF AMOUNTS NOT YET DUE ON CLAIMS. The reserve for “claims unaccrued” (see definition), which may be discounted at interest.

RATING BLOCK. “Rating block” means a grouping of contracts determined by the valuation actuary based on common characteristics filed with the commissioner, such as a policy form or forms having similar benefit designs.

RESERVE. The term “reserve” is 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 contracts promises benefits which result in:

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- (a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these 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; or
- (b) Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

TERMINAL RESERVE. This is the reserve at the end of a contract year, and is defined as 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. This reserve 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. This is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

**APPENDIX C. RESERVES FOR WAIVER OF PREMIUM
(Supplementary explanatory material)**

Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in-force contracts. Hence, 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 and for both the “1985 CIDA and CIDB tables.

Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

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

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

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

If an insurer is, instead, valuing reserves on what is truly an active life table, or if a 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, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true “active life” basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

Legislative History (all references are to the Proceedings of the NAIC).

1989 Proc. I 9, 23-25, 651-658, 705 (adopted new model).
1989 Proc. II 13, 23-24, 467, 875 (adopted technical amendment).
1991 Proc. II 25, 58, 719, 1257-1264 (amended and reprinted).
1993 Proc. I 8, 136, 820, 1460-1462 (amended).
1993 Proc. 1st Quarter 3, 34, 266, 438-446 (amended and reprinted).
1996 Proc. 2nd Quarter 10, 30, 732, 960, 961-964 (amended).
1997 Proc. 4th Quarter 1175-1188 (model adopted later is printed here).
1998 Proc. 1st Quarter 15, 17, 770, 1000, 1056-1057 (amended).
2000 Proc. 2nd Quarter 21, 22, 163-164, 166-168, 1098, 1112 (amended).
2001 Proc. 2nd Quarter 12, 14, 112-113, 991, 1130, 1132-1137 (amended).
2003 Proc. 3rd Quarter (amended).
2003 Proc. 4th Quarter (amended).

The following has been superseded by the model above:

Reserve Standards for Individual Health Insurance Policies

1941 Proc. 160-162 (adopted).
1957 Proc. I 75, 77, 78-85, 107 (amended).
1959 Proc. I 90 (reaffirmed).
1965 Proc. I 71, 73-86, 88 (adopted 1964 Commissioners Disability Table).
1981 Proc. II 27, 35, 558, 561, 778, 781, 823-826 (amended).
1985 Proc. II 11, 23, 564, 567-569, 609-612 (cancer tables added).
1986 Proc. I 601-605 (Contains amendments adopted in June 1985 but omitted from that Proceedings).
1986 Proc. I 9, 23, 547, 557-558, 666 (Appendix A amended).

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The date in parentheses is the effective date of the legislation or regulation, with latest amendments. See KEY at end of listing for explanation of numbers in brackets.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA. INS. DEPT. REG. NO. 84 (1988) [1]	ALA. CODE § 27-36-1 to 27-36-5 (1971).
Alaska	ALASKA STAT. §§ 21.18.082 to 21.18.084 (1997) (Similar to model).	
Arizona	NO ACTION TO DATE	
Arkansas	ARK. INS. RULE & REG. 22 (1976/1999) [2]	
California	CAL. ADMIN. CODE tit. 10 §§ 2310 to 2315 (1994) [2]	CAL. INS. CODE § 997 (1959/1984).
Colorado	COLO. ADMIN. INS. REG. 3-1-9 (1993) [2]	
Connecticut	CONN. ADMIN. CODE tit. 38a §§ 78-11 to 78-16 (1993/1998) [2]	
Delaware		DEL. CODE ANN. tit. 18 § 1108 (1953).
District of Columbia	NO ACTION TO DATE	
Florida	FLA. ADMIN. CODE §§ 690-154.201 to 690-154.210 (1999).	
Georgia		GA. CODE ANN. § 33-10-8 (1960/1985).
Guam	NO ACTION TO DATE	
Hawaii		HAWAII REV. STAT. § 431:5-303 (1955/1987).
Idaho	IDAHO INS. REGS 68 [IDAPA 18.01.68] (1993) [2]	
Illinois	ILL. ADMIN. REG. tit. 50 §§ 2004.15 to 2004.20 (1965/2002)[1]	

HEALTH INSURANCE RESERVES MODEL REGULATION

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Indiana		IND. ADMIN. tit. 760 R-1-9-1 to 1-9-4 (1964) (Adopts some of NAIC explanations from 1957 model by reference) [1]
Iowa	NO ACTION TO DATE	
Kansas	KAN. ADMIN. REG. § 40-4-21 (1968/1986)(Model adopted by reference) [1]	
Kentucky		KY. REV. STAT. § 304.6-070 (1970).
Louisiana		LA. REV. STAT. ANN. §§ 22:891, 22:893 (1968/1975).
Maine	ME. INS. REG. ch. 130 (1991) [2]	
Maryland		MD. ANN. CODE. INS. § 5-203 (1963/1997).
Massachusetts	NO ACTION TO DATE	
Michigan	MICH. COMP. LAWS §§ 500.701 to 500.737 (1994) [2]	
Minnesota	MINN. STAT. §§ 60A.70 to 60A.78 (2004)[2]	
Mississippi		MISS. CODE ANN. § 83-9-106 (1992) (Authority to adopt regulation).
Missouri	MO. ADMIN. CODE tit. 20 § 200-1.140(2)(A), (D) (1969/2001) [1]	
Montana		MONT. CODE ANN. § 33-2-514 (1959/1995).
Nebraska		NEB. REV. STAT. § 44-409 (1913/1985).
Nevada		NEV. REV. STAT. § 681B.080 (1971).
New Hampshire	NO ACTION TO DATE	

HEALTH INSURANCE RESERVES MODEL REGULATION

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
New Jersey	N.J. ADMIN. CODE §§ 11:4-6.1 to 11:4-6.8 (1965/2003) [1]	
New Mexico	N.M. ADMIN. CODE §§ 13.10.14.1 to 13.10.14.26 (1997/2003) [2]	
New York	N.Y. ADMIN. CODE tit. 11 §§ 94.1 to 94.12 (1971/2004) (Regulation 56) [1]	
North Carolina	N.C. ADMIN. CODE tit. 11 ch. 11F.0201 to 11F.0208 (1994/2004) [2]	
North Dakota	NO ACTION TO DATE	
Northern Marianas	NO ACTION TO DATE	
Ohio	OHIO ADMIN. CODE § 3901-3-13 (1996/2003) [2]	
Oklahoma		OKLA. STAT. tit. 36 § 1508 (1957).
Oregon	OR. ADMIN. R. 836-031-0200 to 836-031-0300 (1995) [2]	OR. REV. STAT. § 733.080 (1967/1971).
Pennsylvania	PA. ADMIN. CODE tit. 31 §§ 84a.1 to 84a.8 (1993/1999) [2]	
Puerto Rico		P.R. LAWS ANN. tit. 26 § 507 (1966).
Rhode Island	R.I. REGS. R27-86-001 to 27-86-007 (1996) [2]	
South Carolina	S.C. INS. R 69-7 (1991/1997) [2]	
South Dakota		S.D. CODIFIED LAWS ANN. § 58-26-30 (1966).
Tennessee	TENN. ADMIN. COMP. ch. 0780-1-69 (1998).	
Texas	28 TEX. ADMIN. CODE §§ 3.7001 to 3.7010 (1992/2003) [2]	
Utah	NO ACTION TO DATE	
Vermont	NO ACTION TO DATE	

HEALTH INSURANCE RESERVES MODEL REGULATION

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Virgin Islands	NO ACTION TO DATE	
Virginia	14 VA. ADMIN. CODE 5-320-10 to 5-320-70 (1979/1994) [2]	
Washington	WASH. ADMIN. CODE R. §§ 284-16-400 to 284-16-540 (1992) [2]	
West Virginia	W. VA. REGS. §§ 114-44-1 to 114-44-10 (1996) [2].	W. VA. CODE § 33-7-7 (1957/1969).
Wisconsin	WIS. ADMIN. CODE § INS. 3.17 (1989/1992) [2]	
Wyoming		WYO. STAT. § 26-6-107 (1967/1993).

KEY

- [1] Old NAIC model, applying only to individual policies and first adopted in 1941; amended numerous times.
- [2] Newer NAIC model adopted December 1988 and subsequently revised; shown on previous pages.



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

SPECIAL PROJECTS OFFICE
1326 Strawberry Square
Harrisburg, PA 17120

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E-mail: psalvatore@state.pa.us

January 13, 2006

Mr. Kim Kaufman
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17101

Re: Insurance Department Proposed Regulation No. 11-228, Chapter 84a, Minimum Reserve Standards for Individual and Group Health and Accident Insurance Contracts

Dear Mr. Kaufman:

Pursuant to Section 5(a) of the Regulatory Review Act, enclosed for your information and review is proposed regulation 31 Pa. Code, Chapter 84a.

The purpose of the proposed rulemaking is to modify the morbidity standards in calculating minimum claim reserves for individual disability income benefits, establish reserve standards for single premium credit health and accident insurance and modify the standards for calculating minimum contract reserves for long term care insurance. The proposed rulemaking is patterned after amendments to the Health Insurance Reserves Model Regulation adopted by the National Association of Insurance Commissioners ("NAIC") in June 2001, December 2003 and March 2004. A copy of the copyrighted model regulations is being provided to you to help in your analysis of this propose regulation.

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

Sincerely yours,

A handwritten signature in blue ink that reads "Peter J. Salvatore".

Peter J. Salvatore
Regulatory Coordinator

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

I.D. NUMBER: #11-228

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

AGENCY: DEPARTMENT OF INSURANCE

#2518

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

RECEIVED
2006 JAN 13 PM 1:45
INDEPENDENT REGULATORY
REVIEW COMMISSION

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
1-13-06	<i>Shirley Kubat</i>	HOUSE COMMITTEE ON INSURANCE
	<i>[Signature]</i> 1/13/06	
	<i>Amber Datska</i> 1-13-06	SENATE COMMITTEE ON BANKING & INSURANCE
	<i>Cheryl Schell</i> 1-13-06	
1/13/06	<i>Steph. F. Hoff</i>	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL (for Final Omitted only)
1/13/06	<i>C. Lee</i>	LEGISLATIVE REFERENCE BUREAU (for Proposed only)