Regulatory Analysis Form

(Completed by Promulgating Agency)

(All Comments submitted on this regulation will appear on IRRC's website)

INDEPENDENT REGULATORY REVIEW COMMISSION

(1) Agency

Insurance Department

(2) Agency Number: 11

Identification Number: 259

IRRC Number: 3269

(3) PA Code Cite:

31 Pa. Code Chapter 84a

(4) Short Title:

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

(5) Agency Contacts (List Telephone Number and Email Address):

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(6) Type of Rulemaking (check applicable box):	
☐ Proposed Regulation ☒ Final Regulation ☐ Final Omitted Regulation	☐ Emergency Certification Regulation; ☐ Certification by the Governor ☐ Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

Chapter 84a sets forth minimum reserving standards for claims reserves, contract reserves, and premium reserves. Reserves are held by insurers for incurred but unpaid claims, expected future claims, and for unearned premium to ensure that a health insurer has the financial wherewithal to uphold its contractual obligations. This final-form rulemaking incorporates updates to the National Association of Insurance Commissioners ("NAIC") Model Regulation #10 and accomplishes three primary goals. First, the amendments clarify that the regulation applies to individual and group health and accident insurance policies that were issued prior to January 1, 2017. Second, the amendments indicate that the claim reserve requirements for all claims incurred on or after January 1, 2017, are as described in the NAIC Valuation Manual. And third, the amendments specify the use of new valuation tables for certain individual disability and group disability policies and claims. Reserve methodologies in the Actuarial Guidelines would be required for policies and claims valued with the new valuation tables.

(8) State the statutory authority for the regulation. Include specific statutory citation.

Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412), regarding the general rulemaking authority of the Pennsylvania Insurance Department ("Department"); paragraphs (c)(1) and (2) of section 7124 of the act of June 30, 2016 (P.L. 399, No. 59) (40 Pa.C.S. § 7124(c)(1)-(2)), regarding minimum reserve standards for accident and health insurance contracts. For additional reference, the operative date of the Valuation Manual referred to in the statutory provision granting the Department's authority to promulgate the regulation was January 1, 2017 (*see* 46 Pa. B. 5867).

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

These amendments are not mandated by any federal or state law or court order or federal regulation. There are no relevant state or federal court decisions.

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The Department's adoption of the new standards will help to ensure the solvency of health insurance companies by requiring adequate and accurate reserves based on the most recent industry standards as described in the Valuation Manual. Additionally, it would make consistent the reserve standards

applicable to policies issued both before and after January 1, 2017. Since the rulemaking concerns the solvency requirements applied to health insurers, the public will benefit to the extent the rulemaking promotes a financially sound insurance industry that is subject to consistent standards and that has the ability to fulfill its contractual obligations under insurance policies.

(11) 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 regulations.

There are no federal standards applicable to the substance of these amendments.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

Forty-two (42) states have adopted the NAIC's model law concerning health insurance reserve standards. The adoption of the amendments will allow the Commonwealth to adopt the most up-to-date reserving standards, along with Connecticut, New York, and Oregon, who have already adopted the amendments in this rulemaking.

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

These amendments will not affect other regulations of the Department or other state agencies.

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

The Department circulated an exposure draft of the regulation to the Insurance Federation of Pennsylvania, Inc., the American Council of Life Insurers, America's Health Insurance Plans, and Life Insurance Company of North America. Comments received were carefully considered in developing the proposed rulemaking.

Notice of proposed rulemaking was published at 50 Pa. B. 5260 (September 26, 2020), with a 30-day public comment period. Stateside Associates and the Insurance Federation of Pennsylvania (IFP) submitted comments during the public comment period. All comments were taken into consideration.

Madison Hetzner, a senior regulatory associate with Stateside Associates, submitted a comment noting that the regulation is located in the life insurance part of the insurance regulations and inquiring whether the rulemaking would affect health insurers. This final-form rulemaking applies to all entities with the authority to issue individual and group health and accident insurance coverages, including single premium credit health and accident insurance coverage. The entities include licensed insurers as defined in section 201-A of the Insurance Department Act of 1921 (40 P.S. § 65.1-A) and entities doing the business of insurance pursuant to the Insurance Company Law of 1921 (40 P.S. §§ 341-999.2707).

The IFP expressed support for the proposed rulemaking without any additional comments.

The Independent Regulatory Review Commission had no objections, comments, or recommendations. However, IRRC did separately note that there was a transcription error in the Annex in Appendix A, Section (I)(a)(1)(ii) under Month 10. The adjustment factor included in the proposed rulemaking, which was unchanged from the current provision in 31 Pa. Code § 84a Appendix A, was 0.633. The same adjustment factor in the NAIC Model Regulation #10 is 0.663. The Legislative Reference Bureau will be correcting this transcription error upon publication of the final-form rulemaking so that the correct adjustment factor of 0.663 will appear in 31 Pa. Code § 84a, Appendix A. As such, this non-substantive edit has not been noted in the Annex.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

This final-form rulemaking will affect consumers who purchase a policy subject to this regulation in that it will allow the Department to ensure the companies issuing the policies remain financially solvent, which will promote market stability. Additionally, this final-form rulemaking will affect foreign and domestic life, property, and casualty insurers, including fraternal benefit societies, that hold a certificate of authority to write life insurance contracts and/or accident and health insurance contracts in the Commonwealth. The Department has identified approximately 1,003 licensees that fall within this definition. Of these licensees, 24 domestic licensees qualify as small businesses. The definition of small business in this context is a life and health insurer who earns less than $38.5 million in direct written premium annually. For property and casualty insurers, the threshold for being considered a small business is having less than 1,500 employees.

(16) List the persons, groups or entities, including small businesses, that will be required to comply with the regulation. Approximate the number that will be required to comply.

This final-form rulemaking will affect foreign and domestic life, property, and casualty insurers, including fraternal benefit societies, that hold a certificate of authority to write life insurance contracts and/or accident and health insurance contracts in the Commonwealth. The Department has identified approximately 1,003 licensees that fall within this definition. Of these licensees, 24 domestic licensees qualify as small businesses. The definition of small business in this context is a life and health insurer who earns less than $38.5 million in direct written premium annually. For property and casualty insurers, the threshold for being considered a small business is having less than 1,500 employees.

(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

Although it is not possible to quantify the exact cost that would be incurred by an insurer implementing the standards in the updates to the regulation, the final-form rulemaking may have some adverse fiscal impact on insurance companies marketing individual and group health and accident and single premium

credit health and accident policies. Specifically, insurers may be required to expend the time and resources necessary to ensure that policies issued prior to January 1, 2017, are compliant with the updates to the regulation, that claim reserves are calculated according to the Valuation Manual for claims incurred after January 1, 2017, and that the appropriate valuation tables are used for certain individual disability and group disability policies. To the extent that an insurer's current practices do not comply with the regulation, an insurance company would need to put procedures in place to effect compliance. Moreover, insurers may incur costs to upgrade their technological and actuarial services. Costs of compliance with the amendments will vary by insurer.

The amendments will strengthen insurer solvency by providing for more consistent and updated reserve standards for all applicable policies. Specifically, the final-form rulemaking will benefit consumers by ensuring that insurers will be financially able to pay benefits on individual and group health and accident policies as well as single premium credit health and accident policies. Consumers are engaging with healthcare services at a steadily increasing rate. Commensurate with this pattern and the expected lifespan of individuals, health insurers will need to maintain the ability to pay claims more frequently and for a longer duration of time. By using the most current standards and creating a more consistent standard of review, the final-form rulemaking will promote health insurers' ability to meet their long-term contractual obligations.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

Any costs incurred by insurers in complying with this rulemaking would be outweighed by the benefit to consumers of holding policies from, and submitting claims to, a more financially solvent and stable insurer. Additionally, insurers are already familiar with the standards in the regulation and the Valuation Manual, which should mitigate the costs of any necessary adjustments to procedures.

(19) 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. Explain how the dollar estimates were derived.

Because costs of compliance with the rulemaking will vary from insurer to insurer, it is not feasible for the Department to quantify the exact cost that would be incurred by an insurer implementing the new requirements. Costs will vary based upon the insurer's existing reserving practices, as well as the insurer's necessity to update current systems to accommodate the new requirements.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

This rulemaking will not impose any costs and/or savings to local governments.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

This rulemaking will not impose any costs and/or savings to state government.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

This rulemaking does not impose any additional reporting, recordkeeping or paperwork upon the regulated community. It is possible that actuarial services may be required for implementation of the new requirements, but it is not possible to quantify the extent to which they may be required. These requirements will be minimized by the current applicability and familiarity with the underlying standards in the regulation as well as the standards in the Valuation Manual.

(22a) Are forms required for implementation of the regulation?

There are no forms required for implementation of the regulation.

(22b) If forms are required for implementation of the regulation, **attach copies of the forms here.** If your agency uses electronic forms, provide links to each form or a detailed description of the information required to be reported. **Failure to attach forms, provide links, or provide a detailed description of the information to be reported will constitute a faulty delivery of the regulation.**

There are no forms required for the implementation of this regulation.

(23) 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.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community**	0	0	0	0	0	0
Local Government*	0	0	0	0	0	0
State Government*	0	0	0	0	0	0
Total Savings	0	0	0	0	0	0
COSTS:	0	0	0	0	0	0
Regulated Community**	0	0	0	0	0	0
Local Government*	0	0	0	0	0	0

State Government*	0	0	0	0	0	0
Total Costs	0	0	0	0	0	0
REVENUE LOSSES:	0	0	0	0	0	0
Regulated Community **	0	0	0	0	0	0
Local Government*	0	0	0	0	0	0
State Government*	0	0	0	0	0	0
Total Revenue Losses	0	0	0	0	0	0

*As explained above, there are no expected costs, savings, or revenue losses that would be incurred by local or state government as a result of these amendments.

** As explained above, because costs of compliance with the rulemaking will vary from insurer to insurer, it is not feasible for the Department to quantify the exact cost that would be incurred by an insurer implementing the new requirements. Costs will vary based upon the insurer's existing reserving practices, as well as the insurer's necessity to update current systems to accommodate the new requirements. It is not expected that this rulemaking will result in any loss of revenue to the regulated community.

(23a) Provide the past three-year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY
N/A***	N/A***	N/A***	N/A***	N/A***

***There is no "program" operated by the Department that will be affected by this regulation. Rather, the regulatory activities that are necessary to ensure compliance with this regulation are dispersed throughout the Department and the Department's Office of Insurance Product Regulation and Administration.

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

(a) An identification and estimate of the number of small businesses subject to the regulation.
(b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.
(c) A statement of probable effect on impacted small businesses.
(d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Identification and Estimate of Small Business Subject to the Regulation

The Department reviewed standards set forth by 13 CFR § 121.201 and the U.S. Small Business Administration Table of Small Business Size Standards Matched to North American Industry Classification System (NAICS) Codes to determine the applicability of this rulemaking to Pennsylvania small businesses. The standards for small business classification vary by type of business written as follows:

Subsector 524 – Insurance Carriers and Related Activities

NAICS Codes	NAICS Industry Description	Size Standards in millions of dollars / Size Standards in number of employees
524113	Direct Life Insurance Carriers	$38.5
524114	Direct Health and Medical Insurance Carriers	$38.5
524126	Direct Property and Casualty Insurance Carriers	1,500 employees
524127	Direct Title Insurance Carriers	$38.5
524128	Other Direct Insurance (except Life, Health and Medical) Carriers	$38.5
524130	Reinsurance Carriers	$38.5
524210	Insurance Agencies and Brokerages	$7.5
524291	Claims Adjusting	$20.5
524292	Third Party Administration of Insurance and Pension Funds	$32.5

524298	All Other Insurance Related Activities	$15.0

Based upon the limited information available to the Department, the Department has identified the following numbers of domestic companies that may meet the definition of "small business:" 15 Fraternal Benefit Societies and 9 Direct Life Insurance Carriers.

Projected costs of compliance and probable effect on impacted small businesses

The rulemaking does not impose any reporting or recordkeeping requirements on the regulated community. An insurer may incur administrative cost in attaining compliance with the final-form rulemaking and may need to employ actuarial services as necessary to determine to what extent reserving processes may need to be adjusted. However, because insurers utilize actuarial services in the normal course of business, it is not possible to quantify the extent of additional services required, if any. Additionally, the rulemaking is not anticipated to have an effect on small businesses.

Alternative methods

The Department is unaware of any less intrusive or less costly alternative methods for achieving the purpose of the amendments, which is to provide updated and consistent requirements for the minimum reserves that insurers must maintain for health and accident insurance policies and claims.

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

Because the Department is not aware of any alternative methods for achieving the purpose of the amendments, no provisions were developed to meet the particular needs for minorities, the elderly, small businesses, or farmers.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

No alternative regulatory provisions were considered. There is no less burdensome acceptable alternative to the adoption of new reserving standards for use in determining the minimum reserves that insurers must maintain for health and accident insurance policies and claims.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

a) The establishment of less stringent compliance or reporting requirements for small businesses;
b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;
c) The consolidation or simplification of compliance or reporting requirements for small businesses;
d) The establishment of performance standards for small businesses to replace design or operational standards required in the regulation; and
e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

The Department did not consider regulatory methods to minimize adverse impact on small businesses. The reserving standards required by the amendments are necessary to ensure financial solvency and wherewithal to pay claims regardless of the size of the insurer issuing the policy. Consumers that purchase health and accident policies from smaller insurers should be provided the same assurances that their benefits be paid as those who contract with larger insurers. Also, it should be noted that the Department does not have the statutory authority to grant an exemption of small businesses from all or any part of the requirements of the amendments.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

Data is not the basis for this final-form regulation.

(29) Include a schedule for review of the regulation including:

A. The length of the public comment period: 30 days

B. The date or dates on which any public meetings or hearings will be held: None

C. The expected date of delivery of the final-form regulation: Spring 2021

D. The expected effective date of the final-form regulation: Upon publication as final-form in the *Pennsylvania Bulletin*

E. The expected date by which compliance with the final-form regulation will be required: Upon publication as final-form in the *Pennsylvania Bulletin*

F. The expected date by which required permits, licenses or other approvals must be obtained: N/A

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulations after its implementation. The Department reviews each of its regulations for continued effectiveness on a triennial basis.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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Independent Regulatory Review Commission

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Copy below is hereby approved as to form and legality. Attorney General	Copy below is here by certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to form and legality. Executive or Independent Agencies.
BY: _____ (DEPUTY ATTORNEY GENERAL)	Insurance Department (AGENCY)	BY: Marisa H. Z. Lehr
_____ DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 11-259	June 22, 2021 DATE OF APPROVAL
☐ Check if applicable Copy not approved. Objections attached.	DATE OF ADOPTION _____ BY: Jessica Altman Jessica K. Altman Insurance Commissioner TITLE (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	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 FINAL RULEMAKING
INSURANCE DEPARTMENT

31 Pa. Code Chapter 84a

MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH AND ACCIDENT INSURANCE CONTRACTS

RULES AND REGULATIONS

TITLE 31 - INSURANCE

INSURANCE DEPARTMENT

31 Pa. CODE CH. 84a

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

[___ Pa.B._____]
[Saturday, _____, 202_]

Preamble

The Insurance Department (Department) amends Chapter 84a (relating to minimum reserve standards for individual and group health and accident insurance contracts) of Title 31 (relating to insurance) of the *Pennsylvania Code* to read as set forth in Annex A. This final-form rulemaking is made under the Department's general rulemaking authority as set forth in sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412) and the Insurance Commissioner's (Commissioner) authority to set forth minimum valuation and reserve standards in paragraphs (c)(1) and (2) of section 7124 of the act of June 30, 2016 (P.L. 399, No. 59), known as the Standard Valuation Law (40 Pa.C.S. § 7124(c)(1)-(2)).

Purpose

Chapter 84a of Title 31 of the *Pennsylvania Code* governs the minimum reserve standards to which insurers issuing individual and group health and accident insurance contracts must adhere. Among other standards, the regulation establishes standards for claim reserves, contract reserves, and premium reserves. These standards are in place to ensure that insurers maintain sufficient financial wherewithal to support long-term solvency. Chapter 84a, originally adopted in 1993, is based on the National Association of Insurance Commissioners (NAIC) Health Insurance Reserves Model Regulation (#10).

The purpose of this final-form rulemaking is to update Pennsylvania's standards to align with the most recent updates to the NAIC Health Insurance Reserves Model Regulation, which were incorporated in 2017. These updates clarify that the minimum reserve standards contained in Chapter 84a apply to individual and group health and accident insurance coverages, including single premium credit health and accident insurance, issued prior to January 1, 2017. The amendments specify the use of new valuation tables for certain individual disability and group disability policies and claims. By incorporating these standards for coverages issued prior to January 1, 2017, the Department promotes the continuity of applicable reserving standards for those older coverages issued prior to the operative date of the NAIC Valuation Manual. Moreover, the amendments indicate that the claim reserve requirements for all claims incurred on or after January 1, 2017, are as described in the NAIC Valuation Manual. As indicated in Department

Notice 2016-10 entitled "Principle-Based Reserving Operative Date" published at 46 Pa. B. 5867 (September 10, 2016), the operative date of the NAIC Valuation Manual was January 1, 2017.

Comments and Responses

Notice of proposed rulemaking was published at 50 Pa. B. 5260 (September 26, 2020), with a 30-day public comment period. Stateside Associates and the Insurance Federation of Pennsylvania (IFP) submitted comments during the public comment period. All comments were taken into consideration.

Madison Hetzner, a senior regulatory associate with Stateside Associates, submitted a comment, noting that the regulation is located in the life insurance part of the insurance regulations and inquiring whether the rulemaking would affect health insurers. This final-form rulemaking applies to all entities with the authority to issue individual and group health and accident insurance coverages, including single premium credit health and accident insurance coverage. The entities include licensed insurers as defined in section 201-A of the Insurance Department Act of 1921 (40 P.S. § 65.1-A) and entities doing the business of insurance pursuant to the Insurance Company Law of 1921 (40 P.S. §§ 341-999.2707).

The IFP expressed support for the proposed rulemaking without any additional comments.

The Independent Regulatory Review Commission (IRRC) had no objections, comments, or recommendations. However, IRRC did separately note that there was a transcription error in the Annex in Appendix A, Section (I)(a)(1)(ii) under Month 10. The adjustment factor included in the proposed rulemaking, which was unchanged from the current provision in 31 Pa. Code § 84a Appendix A, was 0.633. The same adjustment factor in the NAIC Model Regulation #10 is 0.663. The Legislative Reference Bureau will be correcting this transcription error upon publication of the final-form rulemaking so that the correct adjustment factor of 0.663 will appear in 31 Pa. Code § 84a, Appendix A. As such, this non-substantive edit has not been noted in the Annex.

Affected Parties

This final-form rulemaking applies to all entities with the authority to issue individual and group health and accident insurance coverages, including single premium credit health and accident insurance coverage.The entities include licensed insurers as defined in section 201-A of the Insurance Department Act of 1921 (40 P.S. § 65.1-A) and entities doing the business of insurance pursuant to the Insurance Company Law of 1921 (40 P.S. §§ 341-999.2707).

Fiscal Impact

State Government

There will not be any fiscal impact to the Department as a result of this rulemaking.

General Public

The final-form rulemaking will have no fiscal impact upon the general public.

Political Subdivisions

The final-form rulemaking will have no fiscal impact upon political subdivisions.

Private Sector

The final-form rulemaking will have no fiscal impact upon the private sector, except for a possible minimal impact to the regulated entities affected.

Paperwork

The final-form rulemaking would not impose additional paperwork on the Department or the regulated community because no additional filing is required to be made by insurers that must comply with this proposed rulemaking.

Effectiveness/Sunset Date

The final-form rulemaking will become effective immediately upon publication in the *Pennsylvania Bulletin*. 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 Richard L. Hendrickson, Department Counsel, Insurance Department, 1341 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 rlhendrick@pa.gov or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on September 10, 2020 , the Department submitted a copy of the notice of proposed rulemaking, published at 50 Pa. B. 5260 (September 26, 2020), to IRRC and to the Chairpersons of the House Insurance Committee and the Senate Banking and Insurance Committee for review and comment.

Under section 5(c) of the Regulatory Review Act, (71 P.S. § 745.5(c)), IRRC and the House and Senate Committees were provided copies of comments received as well as other documents when requested. In preparing the final-form rulemaking, the Department has considered all comments from IRRC and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P.S. § 745.5a(j.2)), on _____ this final-form rulemaking was deemed approved by the House and Senate Committees. Under

section 5.1(e) of the Regulatory Review Act (71 P.S. § 745.5a(e)), IRRC met on _____ and approved the final-form rulemaking.

Findings

The Commissioner finds that:

(1) Public notice of proposed rulemaking was given under sections 201 and 202 of the Act of July 31, 1968 (P.L. 769, No. 240) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) This final-form rulemaking does not enlarge the purpose of the proposed rulemaking published at 50 Pa. B. 5260.

(4) This final-form rulemaking adopted by this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Commissioner, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 31 Pa. Code Chapter 84a, are amended to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Department shall submit this final-form rulemaking to IRRC and the House and Senate Committees as required by law.

(c) The Department shall submit this final-form rulemaking to the Office of General Counsel and Office of Attorney General for approval as to legality and form as required by law.

(d) The Department shall certify this final-form rulemaking, as approved for legality and form, and deposit them with the Legislative Reference Bureau, as required by law.

(e) This final-form rulemaking shall take effect immediately upon publication of the Pennsylvania Bulletin.

Jessica K. Altman
Insurance Commissioner

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 84A. MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH AND ACCIDENT INSURANCE CONTRACTS

§ 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 authorizes the Commissioner to promulgate regulations specifying appropriate reserve standards.] **The purpose of this chapter is to set forth the minimum standards of valuation required by 40 Pa.C.S. § 7124(c)(1) and (2) (relating to minimum standard for accident and health insurance contracts).**

§ 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, **[written]** **issued prior to January 1, 2017,** by life insurance companies **[and]**, **property insurance companies,** casualty insurance companies **and fraternal benefit societies**. Monthly premium credit health and accident insurance is not subject to this chapter, but instead is subject to the reserve standards in Chapter 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 one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one 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.

***Group long-term disability income contract*—A group contract providing group disability income coverage with a maximum benefit duration longer than 2 years that is based on a group pricing structure. The term does not include any of the following:**

(i) Group short-term disability (coverage with benefit periods of 2 years or less in maximum duration).

(ii) Voluntary group disability income coverage that is priced on an individual risk structure and generally sold in the workplace.

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.

***Worksite disability policies*—Individual short-term disability policies that are sold at the worksite through employer-sponsored enrollment, that cover normal pregnancy, and that have benefit periods up to 24 months. The term does not include any of the following:**

(i) Personal disability policies sold to an individual and not associated with employer-sponsored enrollment.

(ii) Business overhead expense, disability buyout, or key person policies, in whatever manner those policies are sold.

§ 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 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) 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 from the date of disablement 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 must 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 must 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 subparagraph (i) and (ii) applied to all open claims. If reserves are calculated on the standards defined in subparagraph (i) and (ii), 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.]**

(a) ***General requirements.***

(1) Claim reserves are required for incurred but unpaid claims on health and accident insurance contracts. When reserving for contracts with an elimination period, the duration of disablement commences on the date that benefits would have begun to accrue had there been no elimination period.

(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.

(4) For claim reserves on policies that require contract reserves, the claim incurral date constitutes the "issue date" for determining the table and interest rate for claim reserves.

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

(6) The requirements for claims reserves on all claims incurred on or after January 1, 2017 will be as described in the Valuation Manual based on the incurred date of the claim.

(b) *Minimum morbidity standards for claim reserves of individual disability income benefits, excluding single premium credit health and accident insurance.*

(1) For claims incurred prior to January 1, 2007, each insurer may elect any of the following standards to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred.

(ii) The standards as defined in paragraphs (2) or (3) applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in either paragraph (2) or (3), all future valuations must be on that basis.

(2) For claims incurred on or after January 1, 2007, and prior to the effective date for the company as determined in paragraph (5), the minimum standards with respect to morbidity are those specified in Appendix A, except that, at the option of the insurer, assumptions regarding claim termination rates for the period less than 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.

(3) For claims incurred on or after January 1, 2020, the minimum standards with respect to morbidity are those specified in Appendix A, including all of the following (as derived in accordance with Actuarial Guideline L):

(i) The use of the insurer's own experience.

(ii) An adjustment to include an own experience measurement margin.

(iii) The application of a credibility factor.

(4) In determining the minimum reserves in accordance with paragraph (3), the provisions in subparagraphs (i), (ii) and (iii) of paragraph (3) are not applicable to any of the following circumstances:

(i) Where the insurer meets the Own Experience Measurement Exemption provided in Actuarial Guideline L.

(ii) Where, for worksite disability policies with benefit periods of up to 2 years, the insurer chooses to base its disabled life reserves on the insurer's experience, if such experience is considered credible, or on other assumptions and methods designed to place a sound value on the liabilities.

(5) An insurer may begin to use the minimum reserve standards in paragraph (3) at a date earlier than January 1, 2020, but not prior to January 1, 2017.

(6) An insurer may, within 3 years of January 1, 2020, or an earlier date the insurer elects under paragraph (5), apply the new standards in paragraph (3) to all open claims incurred prior to the effective date for paragraph (3) for the insurer. Once an insurer elects to calculate reserves for all open claims based on paragraph (3), all future valuations must be on that basis.

(c) *Minimum morbidity standards for claim reserves of group disability income benefits, excluding single premium credit health and accident insurance.*

(1) For claims incurred prior to January 1, 2007, each insurer may elect any of the following standards to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred.

(ii) After the effective date selected by the company in paragraph (2), the standards as defined in paragraph (2), applied to all open group long term disability income claims. Once an insurer elects to calculate reserves for all open claims on a more recent standard, all future valuations must be based on that more recent standard.

(iii) The standards as defined in paragraph (3), applied to all open group disability income claims. Once an insurer elects to calculate reserves for all open claims on a more recent standard, all future valuations must be based on that more recent standard.

(2) For group long-term disability income claims incurred on or after January 1, 2007, but before the effective date selected by the company in paragraph (4), and group disability income claims incurred on or after January 1, 2007, that are not group long-term disability income, the minimum standards with respect to morbidity are those specified in Appendix A except that, at the option of the insurer:

(i) Assumptions regarding claim termination rates for the period less than 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 2 or more years but less than 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:

(A) An analysis of the credibility of experience.

(B) A description of how all of 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) Any other information the Commissioner deems necessary to review the plan of modification.

(iii) Each insurer may elect any of the following standards to use as the minimum morbidity standard for group long term disability income claim reserves:

(A) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred.

(B) The standards as defined in paragraph (3), applied to all open claims. Once an insurer elects to calculate reserves for all open claims on a more recent standard, all future valuations must be on that basis.

(3) For group long-term disability income claims incurred on or after January 1, 2017, the minimum standards with respect to morbidity must be based on the 2012 GLTD termination table or subsequent table with consideration of all of the following:

(i) The insurer's own experience computed in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual.*

(ii) An adjustment to include an own experience measurement margin derived in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual.*

(iii) A credibility factor derived in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual.*

(4) An insurer may begin to use the minimum reserve standards in paragraph (3) for dates earlier than January 1, 2017, but not prior to October 1, 2014. The date the insurer selects between January 1, 2017, and October 1, 2014, to begin to use the minimum reserve standards in paragraph (3) will be considered the effective date.

(5) An insurer may apply the standards in paragraph (3) to all open claims incurred prior to the effective date of paragraph (3) for the insurer. Once an insurer elects to calculate reserves for all open claims based on paragraph (3), all future valuations must be on that basis.

(d) *Minimum morbidity standards for other health insurance claim reserves, including single premium credit health and accident insurance.* The minimum standards with respect to morbidity and other contingencies must 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.

(e) *Claim reserve methods.* An insurer may use a generally accepted actuarial reserving method or combination of methods to estimate claim liabilities.

(1) Methods used for estimating liabilities generally may be aggregate methods or various reserve items may be separately valued.

(2) Approximations may be based on groupings and averages.

(3) 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 **all** 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.

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§ 84a.6. Contract reserves.

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(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 may 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), (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, termination rates may not be used.

(4) ***[Reserved]*** ***Reserve*** *methods.*

(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.

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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**, and before January 1, 2020**: 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.

(E) Contracts issued on or after January 1, 2020: The 2013 IDI Valuation Table with modifiers as described in Actuarial Guideline L.

(F) An insurer may begin to use the 2013 IDI Valuation Table with modifiers at a date earlier than January 1, 2020, but not prior to January 1, 2017.

(G) Within 3 years of 2020 or the earlier date an insurer begins to use the 2013 IDI Valuation Table, the insurer may elect to apply that morbidity standard for all policies issued subject to other valuation tables. This may be done if the following conditions are met:

(I) The insurer applies the morbidity standard to all inforce policies and incurred claims.

(II) The insurer elects or has elected to apply the 2013 IDI Valuation Table to all claims incurred regardless of incurral date.

(III) The insurer maintains adequate policy records on policies issued prior to 2020 that allow the insurer to apply the 2013 IDI Valuation Table appropriately.

(IV) Once an insurer elects to calculate reserves for all inforce policies based on the current morbidity standard, all future valuations must be on that basis.

(ii) *Claim reserves.*

(A) Claims incurred on or after January 1, 2007**, and prior to January 1, 2020**: 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
8	0.564
9	0.613
10	0.633
11	0.712
12	0.756
13	0.800
14	0.844
15	0.888
16	0.932
17	0.976
18	1.020
19	1.049
20	1.078
21	1.107
22	1.136
23	1.165
24	1.195
Year 3	1.369
4	1.204

5 1.199

6 and later 1.000

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 to 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, future calculations must be on 85 CIDC.]

(B) For claims incurred on or after January 1, 2020, the 2013 IDI Valuation Table with modifiers and adjustments for company experience as prescribed in the Actuarial Guideline L, except for worksite disability policies with benefit periods of 24 months or less.

(C) For worksite disability policies, claim reserves may be calculated using claim run-out analysis or claim triangles or other methods that place a sound value on the reserves that are appropriate for the business and risks involved.

(D) For claims incurred prior to January 1, 2020, each insurer may elect any of the following standards to use as the minimum standard for claims incurred:

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

(II) The standard as defined in Clause (A) or (B) applied to all open non-worksite claims, if the insurer maintains adequate claim records to allow the insurer to apply the standard defined in Clause (A) or (B) appropriately. Once an insurer elects to calculate reserves for all open claims on the standard defined in Clause (A) or (B), all future valuations must be on that basis. This option, with respect to Clause (B), may be selected only if the insurer maintains adequate claims records for all claims incurred to use the 2013 IDI Valuation Table appropriately.

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

(i) *Contract reserves.*

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

(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:

* * * * *

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

(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)]** **§ 84a.4(d)**.

(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) Where the regulation references this Appendix.

[(i)] **(A)** *Contract reserves.*

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

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

[(ii)] **(B)** *Claim reserves.*

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

[(B)] **(II)** For claims incurred prior to January 1, 1993: Claim reserves are to be determined as provided in **[§ 84a.4(c)(2)]** **§ 84a.4(d)** (relating to claim reserves).

(ii) Where the regulation does not reference this Appendix, the minimum morbidity standards are set forth in Actuarial Guideline XLVII.

(2) Single Premium Credit Health and Accident Insurance.

* * * * *

(ii) *Claim reserves.* Claim reserves are to be determined as defined in **[§ 84a.4(c)(2)]** **§ 84a.4(d)**.

(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)]** **§ 84a.4(d)**.

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)]** **40 Pa.C.S. §§ 7111—7127 (relating to valuation of reserves for contracts and policies)** 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 (40 P.S. § 71)]** **40 Pa.C.S. §§ 7111—7127** 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.]

(2) For claim reserves on policies not requiring contract reserves, the maximum interest rate (*I*) shall be the calendar year statutory valuation interest rates as defined by:

$$I = .02 + .8 * (R - .03)$$

Where *R* is the average, over a period of 12 months, ending June 30 of the calendar year of the claim incurral date, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc. and the results rounded to the nearer 1/4 of 1%.

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.

* * * * *

(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.

(e) For single premium credit insurance using the 85CIDA table, no separate mortality shall be assumed.

Stephen Hoffman

From: Humma, Jonathan <jhumma@pasen.gov>
Sent: Friday, July 9, 2021 9:57 AM
To: Hendrickson, Richard
Cc: Sheaffer, Kimberly; Frantz, Jodi (Insurance)
Subject: RE: Delivery of Insurance Department final-form regulation 11-259

Good morning Richard. I'm confirming receipt of this email and attachment. Thank you for advising the committee of this final-form rulemaking.

Sincerely,

Jonathan Humma, Executive Director
Senate Banking & Insurance Committee
Chairman John DiSanto, District 15
168 Main Capitol, Harrisburg, PA 17120
717-787-6801, www.SenatorDiSanto.com

From: Hendrickson, Richard <rihendrick@pa.gov>
Sent: Friday, July 9, 2021 9:46 AM
To: Humma, Jonathan <jhumma@pasen.gov>
Cc: Sheaffer, Kimberly <kimsheaffe@pa.gov>; Frantz, Jodi (Insurance) <jodfrantz@pa.gov>
Subject: Delivery of Insurance Department final-form regulation 11-259
Importance: High

Good Morning,

Please provide email confirmation that you have received this email and its attachment. Please find attached the final-form rulemaking package for Insurance Department Regulation # 11-259 (Chapter 84a Minimum Reserve Standards for Individual and Group Health and Accident Insurance Contracts). This final-form regulation updates Pennsylvania's standards to align with the most recent updates to the National Association of Insurance Commissioners (NAIC) Health Insurance Reserves Model Regulation (#10).

By correspondence dated November 25, 2020, the Independent Regulatory Review Commission (IRRC) indicated that the final-form regulation would be deemed approved if it was delivered without revisions and the committees do not take any action. The attached final-form regulation does not contain any substantive revisions from the proposed regulation, which was published at 50 Pa. B. 5260 (September 26, 2020).

Thanks,

Richard

Richard L. Hendrickson, Esq. | Department Counsel
Pennsylvania Insurance Department
Governor's Office of General Counsel
1341 Strawberry Square | Harrisburg, PA 17120
Office: 717.787.2567 | Fax: 717.772.1969
rihendrick@pa.gov | www.insurance.pa.gov | www.ogc.pa.gov

Stephen Hoffman

From: Mahjoubian, Micah <Micah.Mahjoubian@pasenate.com>
Sent: Friday, July 9, 2021 10:05 AM
To: Hendrickson, Richard
Cc: Sheaffer, Kimberly; Frantz, Jodi (Insurance)
Subject: Re: Delivery of Insurance Department final-form regulation 11-259

Senator Street and I have received the Insurance Department final-form regulation 11-259. Thank you.

Micah Mahjoubian
Policy Director
Office of Senator Sharif Street

Democratic Executive Director
State Government Committee

215-432-1068 (cell)
215-227-6161 (district office)
717-787-6735 (Harrsiburg office)
www.senatorsharifstreet.com

Pronouns: He/Him/His

From: Hendrickson, Richard <rihendrick@pa.gov>
Sent: Friday, July 9, 2021 9:45:55 AM
To: Mahjoubian, Micah <Micah.Mahjoubian@pasenate.com>
Cc: Sheaffer, Kimberly <kimsheaffe@pa.gov>; Frantz, Jodi (Insurance) <jodfrantz@pa.gov>
Subject: Delivery of Insurance Department final-form regulation 11-259

■ EXTERNAL EMAIL ■

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Thanks,

Richard

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Office: 717.787.2567 | Fax: 717.772.1969
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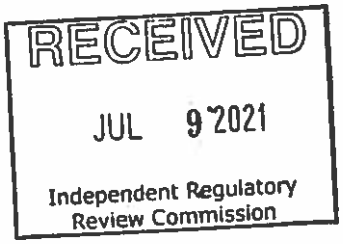
Stephen Hoffman

From: Jessica Valen <JValen@pahousegop.com>
To: Hendrickson, Richard
Sent: Friday, July 9, 2021 2:35 PM
Subject: Read: Delivery of Insurance Department final-form regulation 11-259

Your message

To:
Subject: Delivery of Insurance Department final-form regulation 11-259
Sent: Friday, July 9, 2021 6:35:34 PM (UTC+00:00) Monrovia, Reykjavik

was read on Friday, July 9, 2021 6:35:29 PM (UTC+00:00) Monrovia, Reykjavik.



Stephen Hoffman

From: Cohn, Alan J. <ACohn@pahouse.net>
Sent: Friday, July 9, 2021 11:53 AM
To: Hendrickson, Richard
Cc: Frantz, Jodi (Insurance); Sheaffer, Kimberly; Keller, Joseph
Subject: Re: Delivery of Insurance Department final-form regulation 11-259

Received ,

Alan

Sent from my iPhone

On Jul 9, 2021, at 9:46 AM, Hendrickson, Richard <rihendrick@pa.gov> wrote:

> Good Morning,
>
> Please provide email confirmation that you have received this email and its attachment. Please find attached the final-form rulemaking package for Insurance Department Regulation # 11-259 (Chapter 84a Minimum Reserve Standards for Individual and Group Health and Accident Insurance Contracts). This final-form regulation updates Pennsylvania's standards to align with the most recent updates to the National Association of Insurance Commissioners (NAIC) Health Insurance Reserves Model Regulation (#10).
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>
> Thanks,
>
> Richard

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<DeLUCA - Regulation 11-259, Chapter 84a 7-09-21.pdf>