

**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.

Authority

The provisions of this Chapter 84a issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); amended under sections 301.1 and 311.1 of The Insurance Department Act (40 P. S. §§ 71.1 and 93), unless otherwise noted.

Source

The provisions of this Chapter 84a adopted October 22, 1993, effective October 23, 1993, 23 Pa.B. 5012, unless otherwise noted.

Cross References

This chapter cited in 31 Pa. Code § 73.138 (relating to financial statement reserves); 31 Pa. Code § 89a.116 (relating to reserve standards); and 31 Pa. Code § 89a.118 (relating to premium rate schedule increases).

§ 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.

Authority

The provisions of this § 84a.1 amended under 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 of 1921 (40 P. S. §§ 71.1 and 93).

Source

The provisions of this § 84a.1 amended September 17, 1999, effective September 18, 1999, 29 Pa.B. 4865. Immediately preceding text appears at serial page (254607).

Notes of Decisions

General Comments

Approval of rates and reserves are matters within the exclusive jurisdiction of the Insurance Department and are based on statutory formula, actuarial information and discretionary determinations. *Ciamaichelo v. Independence Blue Cross*, 814 A.2d 800 (Pa. Cmwlth. 2002); appeal granted at 829 A.2d 1158 (Pa. 2003).

§ 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 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 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.

Source

The provisions of this § 84a.2 amended July 14, 2006, effective January 1, 2007, 36 Pa.B. 3367. Immediately preceding text appears at serial page (297036).

84a-2

§ 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.

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.

Authority

The provisions of this § 84a.3 amended under 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 of 1921 (40 P. S. §§ 71.1 and 93).

Source

The provisions of this § 84a.3 amended September 17, 1999, effective September 18, 1999, 29 Pa.B. 4864; amended July 14, 2006, effective January 1, 2007, 36 Pa.B. 3367. Immediately preceding text appears at serial pages (297036) to (297037) and (260245) to (260247).

§ 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 appli-

cable 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.

Authority

The provisions of this § 84a.4 amended under 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 of 1921 (40 P. S. §§ 71.1 and 93).

Source

The provisions of this § 84a.4 amended September 17, 1999, effective September 18, 1999, 29 Pa.B. 4864; amended July 14, 2006, effective January 1, 2007, 36 Pa.B. 3367. Immediately preceding text appears at serial pages (260247) to (260249).

Cross References

This section cited in 31 Pa. Code Ch. 84a Appendix A (relating to specific standards for morbidity, interest and mortality).

§ 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 determi-

nation. 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.

Source

The provisions of this § 84a.5 amended July 14, 2006, effective January 1, 2007, 36 Pa.B. 3367. Immediately preceding text appears at serial pages (260249) to (260250).

§ 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 cer-

tifies 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 must 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 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 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.
- (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.

Authority

The provisions of this § 84a.6 amended under 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 of 1921 (40 P. S. §§ 71.1 and 93).

Source

The provisions of this § 84a.6 amended September 17, 1999, effective September 18, 1999, 29 Pa.B. 4864; amended July 14, 2006, effective January 1, 2007, 36 Pa.B. 3667; corrected March 9, 2007, effective January 1, 2007, 37 Pa.B. 1125. Immediately preceding text appears at serial pages (320429) to (320433).

Cross References

This section cited in 31 Pa. Code Ch. 84a Appendix A (relating to specific standards for morbidity, interest and mortality).

§ 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.*

(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:

<i>Duration</i>	<i>Adjustment Factor</i>
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

<i>Duration</i>	<i>Adjustment Factor</i>
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.

(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) applied to all contracts.
 - (II) If reserves are calculated on the standard defined in I(a)(5)(i)(A), future calculations must be on that basis.
 - (ii) Claim Reserves: Claim reserves are to be determined as defined in § 84a.4(c)(2).
- (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 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) applied to all contracts.

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

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

Authority

The provisions of this Appendix A amended under 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 of 1921 (40 P. S. §§ 71.1 and 93).

Source

The provisions of this Appendix A amended September 17, 1999, effective September 18, 1999, 29 Pa.B. 4864; amended July 14, 2006, effective January 1, 2007, 36 Pa.B. 3367. Immediately preceding text appears at serial pages (260255) to (260257).

Cross References

This appendix cited in 31 Pa. Code § 84a.4 (relating to claim reserves); 31 Pa. Code § 84a.6 (relating to contract services).

[Next page is 84b-1.]

84a-20

(320440) No. 382 Sep. 06

Copyright © 2006 Commonwealth of Pennsylvania